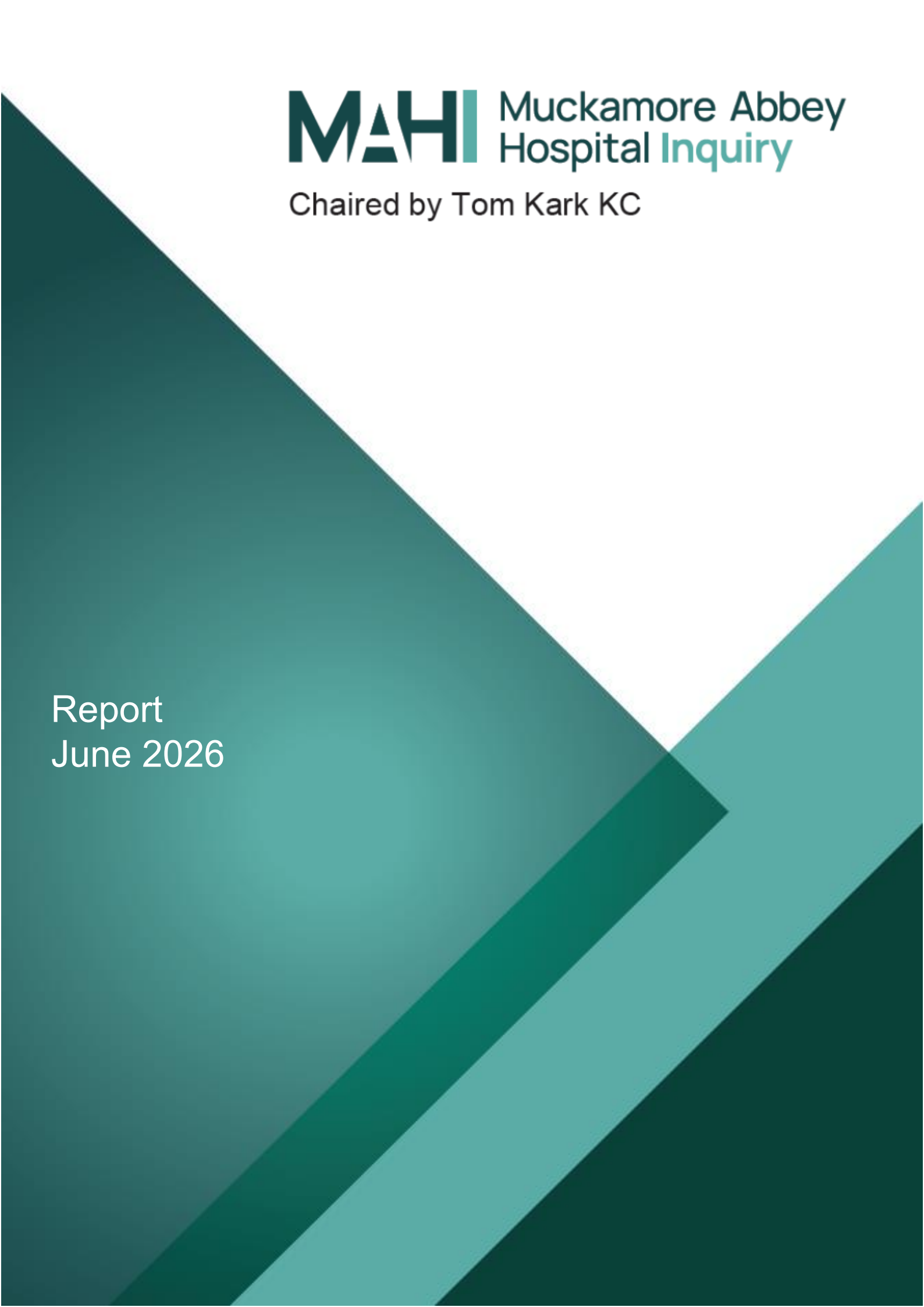




MAHI Muckamore Abbey Hospital Inquiry

Chaired by Tom Kark KC

Report
June 2026

Report of the Muckamore Abbey Hospital Public Inquiry

Inquiry website: www.mahinquiry.org.uk

Copyright of the Report ©
The Muckamore Abbey Hospital Inquiry

The original content may be reproduced free of charge in any format or medium,
provided that it is used accurately and not in a misleading context,
and provided that the title of the source publication is given and
the copyright acknowledged.

Third parties may hold copyright in quotations and images which have
been reproduced in the Report under section 46 of the Copyright,
Designs and Patents Act 1988 and it should not be assumed that any permission
has been given for further reproduction of such material.

Tom Kark KC, Dr Elaine Maxwell and Professor Glynis Murphy have asserted,
in accordance with section 78 of the Copyright, Designs and Patents Act, 1988,
their right to be identified as the authors of this work.

ISBN 978-1-0369-9150-0

Printed by GPS Colour Graphics Ltd

Signed in accordance with section 24(4) of the Inquiries Act 2005



Tom Kark KC



Dr Elaine Maxwell



Professor Glynis Murphy

Contents

Letter to the Minister of Health for Northern Ireland	iii
Executive Summary	1
Recommendations	59
Chapter 1 The Patient Experience	73
Chapter 2 Admission of Patients to MAH	151
Chapter 3 Care and Treatment at MAH	175
Chapter 4 Care Planning and Record Keeping	197
Chapter 5 Information Sharing and Co-Production	217
Chapter 6 Patients' Property and Finance	229
Chapter 7 Restrictive Practices	243
Chapter 8 Complaints and Concerns	279
Chapter 9 Previous Concerns, Previous Investigations and Warning Signs	303
Chapter 10 CCTV, 2017 Revelations and the Response	345
Chapter 11 Safeguarding	379
Chapter 12 Staff and Ward Management	413
Chapter 13 Senior Management and Trust Board Governance	447
Chapter 14 External Agencies Inspection and Oversight	491
Chapter 15 Resettlement	537
Chapter 16 Planning and Funding of Learning Disability Services in Northern Ireland	587
Chapter 17 Managing the Delivery of Service for People with Learning Disabilities and Autistic People	607
Chapter 18 Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty	621

Appendix 1	Inquiry Terms of Reference	645
Appendix 2	Definitions of Abuse	649
Appendix 3	Safeguarding Reviews and Inquiries into Abuse in Care Settings for Adults with Intellectual and/or Developmental Disabilities in the UK	657
Appendix 4	What Good Management and Governance Looks Like	675
Appendix 5	Summary of the Six Independent Reports Received by the BHSCT Board after 2017	687
Appendix 6	Previous Inquiries into Services at BHSCT	693
Appendix 7	Acronyms in the Report	697

The following summary and report contain content which some may find distressing

Muckamore Abbey Hospital Inquiry

Mr. Mike Nesbitt MLA
Minister
Department of Health
Castle Buildings
Stormont
Belfast
Northern Ireland
BT4 3SQ

18 June 2026

Dear Minister,

I now submit to you the final report of the Muckamore Abbey Hospital Public Inquiry Panel.

Following revelations in 2017 of the abuse of patients by staff at Muckamore Abbey Hospital, your predecessor Robin Swann in 2020 ordered that a Public Inquiry be held into that abuse and related matters. I was appointed to Chair that Inquiry in June 2021 and my panelists Dr Elaine Maxwell and Professor Glynis Murphy were appointed later that year.

Through December 2021 to March 2022, I conducted engagement sessions at venues across Northern Ireland to promote the Inquiry and explain to those who were interested how the Inquiry would approach its work. The Inquiry was also publicised in the press, on radio and other media.

The first formal hearing day was 6 June 2022, and the first witness gave evidence on 28 June 2022. In total the Inquiry heard from 235 witnesses including a number of service users and over 90 relatives of service users. Approximately 40,000 documents were provided and considered by the inquiry.

Although the Inquiry took steps to make the process as easy as possible, for many witnesses, especially the service users of MAH and their relatives, giving evidence was an arduous and emotional journey. It was also difficult for the many members of staff who came forward, and I would like to commend all of the witnesses for coming to assist the Inquiry.

As you will be aware, the Inquiry was ordered to be held at the same time that investigations by the PSNI into the abuse were conducted and, at the same time as individuals were being charged and taken to court. Although at the time of writing, no one has yet faced a Crown Court trial, the Inquiry had to be conducted so that it did not interfere with the criminal process. This was not an easy task and resulted in some of the evidence having to be given under restriction orders so that it was not heard by the general public.

The Inquiry hearings were concluded on 10 March 2025. Later, representations were made on behalf of a number of the relatives of service users that they should be allowed to provide up to date information about how resettlement was or was not working in Northern Ireland. The Panel agreed to that request, and those sessions were conducted from 3 to 6 June 2025. The Panel heard from 15 participants and that information helped to inform the recommendations.

Many people suffered at MAH, their lives were made needlessly miserable. They are some of the most vulnerable people in our society and they were failed badly by the health system which was meant to care for them and protect them.

In this report we have focused as far as possible on systemic issues which can be remedied. Some of the remedies are simple. Others are more challenging but we have worked to make our recommendations specific to the issue we found wanting, measurable by the organisations responsible for implementation, achievable by those organisations, relevant to the issues that need to be addressed and time bound in terms of implementation.

Although this Inquiry has now concluded its work, the duty of implementing the recommendations made here lies with you and your successors in office, as well as with all those organisations responsible for implementing reform.

As you will well know, a Public Inquiry is not an end in itself. Such an effort and the expenditure of so much money is only justified in order to reform a system which has failed the public.

Northern Ireland is a relatively small jurisdiction and the people of Northern Ireland, and particularly those affected and their relatives, will be watching to see how implementation of the recommendations is carried out.

Organisational restructuring is not always conducive to continuity in healthcare and we are not suggesting that further restructuring would help. But fundamental reforms are needed and we hope they will be progressed earnestly and rapidly. If they are not, local MLAs and MPs should not expect those affected to remain silent for very long.

I want to express my gratitude again to my panelists Dr Maxwell and Professor Murphy and to the entire Inquiry team. We are all very grateful to have had the opportunity of contributing to an Inquiry which addressed such a fundamental failure in the care of individuals who deserved far better from the health service.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'T. Kark', with a horizontal line underneath.

Tom Kark KC

Chair

Executive Summary

Introduction

1. This summary contains an overview of the contents of our report. The report is inevitably lengthy and detailed. It is not possible to summarise the whole of its contents in a few pages, and we have not tried to do so. The purpose of this summary is to describe in broad terms the contents of the report and the main conclusions we have reached. We hope that it will assist readers in understanding the scope of the report and directing their attention to the parts of greatest interest to them. However, there is no substitute for reading the report itself.
2. This Inquiry was set up as the result of the discovery of abuse by staff of patients at the largest hospital in Northern Ireland, which cared for people with learning disabilities and mental health problems. The revelation in 2017 of the abuse of patients at Muckamore Abbey Hospital shocked the relatives of those patients, the health community and the whole of Northern Ireland.
3. Patients were abused at Muckamore Abbey Hospital (MAH). It is important to state that bold and simple fact. The abuse did not involve every patient nor every member of staff, nor a majority of the staff. But many patients had their lives made miserable by systematic bullying by certain members of staff whose job it was to look after them. It also appears that some patients suffered a high number of incidents, others very few or none. It is also important to state, however, that no adjudication is made by the Panel in this report in respect of individual incidents in relation to which evidence was heard.
4. Institutions caring for people with learning disabilities and autistic people are known to be high-risk environments. Across the United Kingdom and Northern Ireland, abuse of people with learning disabilities has recurred in institutional, hospital and community settings over many decades. There have been numerous well-publicised Serious Case Reviews and Inquiries into such abuse. The Inquiry found that many of the conditions found in previous abuse inquiries, both in Northern Ireland and in Great Britain, existed at MAH, yet were not identified as

signals of heightened risk, despite the setting itself and the patient cadre being at obviously high risk.

5. We recognise that for many individuals with learning disabilities and autistic people, whether in a hospital or elsewhere, the term 'patient' is offensive. That term has been used throughout the Inquiry to describe the individuals receiving care in MAH. Where appropriate we have avoided the term and used 'service user', 'person' or 'individual' instead. However, the word 'patient' makes stark the power differential between the person receiving care and those who provide it. That power differential is an important factor and exacerbates the vulnerability of those within the hospital setting. We hope therefore that the reader will understand our use of the term in certain circumstances.
6. In the Inquiry we have often heard the term 'vulnerable'. The patients were vulnerable in the sense that the vast majority of them had learning disabilities and/or were autistic people, which made it far easier for them to be abused. Many of the patients were non-verbal. They were easy targets for those with malign intent. It would however be too easy simply to blame the individuals involved and to say, where there are those with bad intent it is practically impossible to stop them acting on it. The reality is that there were multiple contributory factors allowing the circumstances that put the patients in this position and that contributed to the reason why some staff acted as they did.
7. It is perhaps obvious that the factors that allow for a situation in which a member of staff chooses to abuse a patient, and that set the culture in which such abuse is witnessed by others but not prevented or reported by them, are many and complex. We examine those factors with care in this report. We examine the management systems in place, the staffing of the hospital, the training of those staff, the governance of the hospital and the Belfast Trust that managed it, as well as the external agencies that might have spotted what was going on but did not.

8. The investigation of abuse of patients at MAH was triggered by the discovery of CCTV footage that had retained recordings of public parts of the hospital between March and September 2017. Examination of that footage led first to an internal investigation and shortly thereafter to the involvement of the Police Service of Northern Ireland (PSNI).
9. Many of the families of patients were traumatised by the news that their relatives had been abused and were understandably very angry that they and their relatives who were patients at the hospital had been so appallingly let down by the health system. This Inquiry has faced many challenges, but the first major struggle was one that families of individuals, with great tenacity and energy, overcame themselves, which was to get this Inquiry established. Robin Swann, then Minister for Health, announced this Inquiry on 08 September 2020. The relief that gave many was tangible, and was summed up by one witness who told the Inquiry:
- ‘Could I just take this opportunity not only on behalf of ourselves, as my son's family, to thank everyone involved in this Inquiry. It's meant so much to so many people and also to people whose relatives who have passed away, ... and I have to say that just a few months before it all was exposed, certainly on the BBC, I actually one day, and I have to tell you all this, one day I was coming away from visiting my son from that hospital and on the way past the main offices, I said a prayer and I said: “Lord, I would love that this was exposed, what goes on in this institution here”.” And the evening -- I just happened to be in my kitchen when it came on the BBC about the Inquiry and tears were literally running down my face, because I felt that prayer was answered’.*¹
10. Every Public Inquiry has its complexities but, in addition, this Inquiry faced the significant issue of contemporaneous criminal proceedings. By the time I was appointed to Chair this Inquiry in June 2021, the PSNI had already been investigating allegations of abuse of patients at Muckamore for some three years. Those investigations have continued as the Inquiry proceeded. We were told that it was the largest adult safeguarding investigation ever conducted in this jurisdiction and possibly in the UK. We understand that there are five committed trials waiting to start in the Crown Court here in Belfast, and there may be other trials thereafter. But no Crown Court trial has yet been held and none of the committed trials currently has a start date; that is, eight years after the

¹ P118's Mother Transcript – 9/10/23 – Page 158 – Line 2

investigations began and five years after this Inquiry was announced. The reality may be that criminal trials will not conclude either this year or quite possibly next year.

11. I have taken the view, in those circumstances, that it would be quite wrong either to delay this report or to fail to state plainly what we, the Panel, have found. To soften this report, or fail to mention important matters because there will one day be a Crown Court trial, would be failing in my duty to the Minister, who set the Terms of Reference out in detail, and a failure to meet the legitimate expectations of the families who called for this Inquiry and contributed so much to it. There is a danger also that in not speaking plainly, the force of our recommendations would be diminished. It is however important to stress that we have not sought to investigate any of the specific incidents likely to arise in the criminal trials and should make it clear that we have neither offered nor formed any opinion whatever on whether any of the current defendants are guilty or not of the offences with which they are charged.
12. We have not touched upon the guilt or innocence of any individual involved as a defendant in the trials or a suspect in the investigation, not only because that is not our function but because the purpose of this Public Inquiry is far bigger than the remit of the criminal process, which focuses upon narrow issues pertaining to the proof of specific criminal offences against specific individuals.
13. Our job is different. It is to deliver a report that, as set out in our Terms of Reference,² examines the issue of the abuse of patients at MAH; determines why the abuse happened and the range of circumstances that allowed it to happen; and to make recommendations to ensure that such abuse does not occur again at MAH or any other similar institution in Northern Ireland. Abuse within the Terms of Reference includes not only physical, sexual and emotional abuse, but also patient neglect, negligent care, improper use of patient finances and 'other misbehaviour towards patients'. The period of examination is between December 1999 and June 2021. The scope of the Inquiry has therefore been very extensive.

² Appendix 1 – Inquiry Terms of Reference

14. The Inquiry Rules 2006 that apply to England and Wales have not been enacted in Northern Ireland. At the start of the Inquiry, I indicated that I would apply the Inquiry Rules unless exceptional circumstances applied. No exceptional circumstances arose causing me to depart from the Rules and so they have been applied throughout the Inquiry as if they applied to Northern Ireland.
15. As Chair I have specific duties under the Inquiries Act 2005, and I have ultimate responsibility for the fair conduct of this Inquiry and the presentation of this report. But the evidence in its totality was seen and heard by the Panel and where 'we' or 'us' is used in this report, that refers to the work of the Panel as a whole.
16. I am enormously grateful for the massive contribution made by my Panellists Dr Elaine Maxwell and Professor Glynis Murphy to the Inquiry and to this report. Both are hugely knowledgeable in their fields of expertise. Dr Maxwell is a senior nurse who has sat on various Health Trust Boards in the UK as an Executive Director of Nursing and as a Non-Executive Director. Her knowledge of how hospitals work in practice, their management and her deep understanding of governance and patient safety have been invaluable. Professor Murphy is a practising clinical and forensic psychologist and academic at Kent University. She has worked with people with learning disabilities and autistic people for over 50 years in a variety of health and social care services and apart from her contribution to over 200 academic publications, she was responsible for the report on Care Quality Commission (CQC) inspections into the abuse of people with learning disabilities and autism at Whorton Hall in England. She has brought a depth of knowledge of the care of patients with learning disabilities and people with autism that has been invaluable. They have been assisted by researchers Anne McNulty and Emilia Ashley, for whose contribution into the analysis of service users' notes and quantitative data provided by the Belfast Health and Social Care Trust (BHSCT) to the Inquiry we are very grateful.
17. Inevitably some parts of this report deal with highly technical areas of healthcare, and it is understood that there will be many different readerships who will potentially have a different focus upon specific parts of this report. The report should however, of course, be read as a whole.

The Inquiry staff

18. The Panel owes a great debt of gratitude to many people who have worked on this Inquiry tirelessly and with great professionalism. We cannot name all here, but they include:
19. Sean Doran KC, who has led the counsel team and provided legal advice throughout the Inquiry. The role of counsel to a Public Inquiry is an exceptionally arduous one and Sean has acquitted himself in that role with great distinction as did the rest of his counsel team.
20. Stephanie Kennedy, Solicitor to the Inquiry, and her brilliant team of lawyers. We would also like to thank the previous Solicitors to the Inquiry, Lorraine Keown who guided the Inquiry throughout the hearings and Joan MacElhatton.
21. The Secretary to the Inquiry was Jaclyn Richardson, leading the dedicated administrative team. It is safe to say that every single person who has had any contact with this Inquiry will have been spoken to by Jaclyn, who has been a constant help to all. From the very beginning she was closely involved with every aspect of the Inquiry and her knowledge of all those involved has been invaluable. Towards the very end of the Inquiry her place was seamlessly adopted by Steven Montgomery, who did a brilliant job helping to bring this report to fruition. A list of all the Inquiry staff, past and present, can be found at page 58 and the Panel wishes to express its sincere thanks to each of them for their contribution to this Inquiry.

Geraldine O'Hagan

22. Mention should be made of Geraldine O'Hagan, a family liaison officer who sadly passed away during the course of this Inquiry. She supported countless families, both to cope with the CCTV revelations and thereafter supporting families and individual witnesses to provide their evidence to this Inquiry. She made a statement when she was very ill and died very shortly after giving evidence to the Panel. Her evidence is reflected elsewhere in this report.

23. She summed up the difficulties faced by many families:

'I believe there are too many unnecessary obstacles for families in delivering services for people with learning disabilities within the system. In my experience, the main obstacles continue to be poor communication, poor investment in community services, and an imbalance of power between those who deliver care and those in receipt of care'.³

Later she told the Inquiry:

'It's been nothing but a pleasure to work with the families and, you know, the fact that they actually allowed me into their lives, having had -- been given the information of what happened to their loved ones, and that I worked for a Trust that these other staff worked for, they were still able to welcome me into their homes and they put their faith and trust in me, and it has been nothing but an honour to work with the families'.⁴

24. Geraldine made a significant contribution, and we are very grateful for the dedication she showed to the families and to supporting this Inquiry.

Methodology – How the Panel approached the evidence

25. How have we, in the conduct of this Inquiry and in drafting this report, approached the significant task set for us of answering the Terms of Reference and in particular the headline objectives set out above?
26. We undertook this task by taking evidence on recurring themes in relation to the three core objectives. We did not seek to investigate each individual case, and we did not seek to estimate the frequency with which abuse may have occurred. Instead, we focused on themes arising from different accounts in order to identify the range of circumstances that allowed abuse to happen. For each theme, we have included illustrative examples (this does not mean that they are the only evidence we received on each theme). Some themes applied across the whole 22-year period under consideration, but others are more limited, generally referring to the period leading up to and beyond 2017, and where possible we will specify time frames.

³ Geraldine O'Hagan Transcript – 15/05/24 - Page 55 – Line 7

⁴ Geraldine O'Hagan Transcript – 15/05/24 - Page 58 – Line 26

27. The Panel has recognised that to fully understand how events unfolded at MAH, the evidence of patients and their families must be given equal weight to all other evidence. This approach keeps the Inquiry open to potential explanations of how circumstances allowed abuse to happen that more traditional approaches may overlook.
28. Patients and their families are experts by experience and are sometimes better placed than staff or health experts to comment. For example, when comparing the impact of MAH on a patient's wellbeing both before admission and after discharge or resettlement. The Panel also recognises the power imbalance between patients, their families and health and social care staff. This can mean that patients and families do not always share their views with staff. For example, an entry in the notes saying that the mother was satisfied with the care of her child does not automatically mean that a statement to the Inquiry later, saying something else, is incorrect. A relative may, by way of example, indicate satisfaction in the level of care if only in the belief that they are protecting a patient whose comfort and safety lie in the hands of staff once the relative has departed, or it may be that they only worry about what they saw or experienced at MAH when they get home after visiting their relative. For other reasons, written notes may not record the reality of the patient's experience.
29. At an early stage the Panel decided not to ask the Trust to provide all the patient notes, and this proved to be an early bone of contention with relatives interested in the Inquiry's work. In early correspondence with the Trust, BHSCCT provided what it said was an example of a file of patient notes. The notes had over 20,000 pages. Some of the records for patients who had lived permanently in MAH would have been significantly larger than that example. There was, in the Panel's view, a serious danger, if we asked for all the notes, of the Inquiry being overwhelmed with documentation that for many reasons may have been of limited value given our purpose.
30. The Panel, having heard evidence during the patient experience phases of the Inquiry, did in due course make several requests for patient notes; these were targeted requests and were known as Patient Document Requests or 'PDRs'. The

notes obtained were considered and some elements of those notes have, anonymously, been reflected in the report. However, the Panel notes that documents are completed for a range of reasons and cannot be understood to be a definitive account for different purposes to those for which they were written, such as a Public Inquiry. We have therefore not given more weight to documents, such as patient records, than we have to the family accounts.

31. Throughout the report the reader will find quotes from the relatives of patients talking about some aspects of a patient's life. It is important to bear in mind, through all the complex issues raised in this report, that although the residents of MAH are often referred to in this report as 'patients', this is about people and their lives.
32. All witnesses, patients, relatives, staff, Board Members and others have been approached as having equal value. Of course, following an assessment of that evidence, the Panel has formed views about the quality, credibility and accuracy of the evidence received.
33. The Panel has avoided adjudicating on which version of an individual incident or complaint is 'true' and has instead opted to identify issues that either occur frequently in the evidence or strike us as particularly pertinent to understanding why such incidents happen.
34. In instances where the Panel has formed a conclusion, it has done so applying the balance of probabilities. That means that the test it has applied is whether, taking all the information before the Panel into account, we have taken the view that something is more likely than not to have happened.
35. At an early point in the Inquiry (09 March 2022) I signed a Memorandum of Understanding with the PSNI and the Public Prosecution Service (PPS). This included a commitment to make every effort to ensure that the procedure and conduct of the Inquiry would respect the integrity of the investigation and prosecutions while continuing to address the terms of reference. As a result of that agreement, some evidence which would otherwise have been given in public

had to be given privately but, except on very rare occasions, Core Participants (CPs) were allowed to be present and to hear the evidence given. In writing the report we have cited some of that evidence and have put both the PPS and PSNI on notice that we intended to do so.

36. All service users and their related witnesses have been anonymised and given a 'P' cipher. Anonymity was waived in some cases where the relative giving evidence preferred to use their own name or the partial name of the service user involved. Quite often a first name was used, and where appropriate we have adopted that approach for the purposes of this report. It should be noted that the forename of any individual who is the subject of the alleged abuse in the prosecutions does not appear in the text of the report and has been ciphered in accordance with the MoU.
37. The majority of members of staff below management level were provided with 'H' ciphers. Only Core Participants who have signed a confidentiality agreement have been provided with the list of ciphered names. This was done for fairness to all, including members of staff, who may be indirectly implicated in abuse or who were not given the opportunity of refuting allegations made against them. This allowed all witnesses to speak freely and plainly. That use of ciphers has been retained in this report both for fairness and to ensure they do not suffer professional opprobrium in relation to complaints that the Panel has not investigated individually nor formed any conclusion.
38. Some witnesses were given 'full anonymity'. Those witnesses were provided with an 'A' cipher and Core Participants were not provided with their names. I only allowed anonymity when I was persuaded that this measure was fully justified and the witness could not have given evidence unless provided with anonymity. In general, where a witness asked for special measures, such as a screen to make it easier for them to give evidence, I allowed that to happen; this is in line with modern practice in both the criminal and civil courts. Several witnesses had professional intermediaries to assist them. Both witnesses and attending members of the public had counsellors made available to them who were present

on every day the Inquiry sat to hear evidence. They were well used and the Panel wants to express our gratitude to them for their sterling work.

39. Where we have referred to restricted material in the report, the original statement or transcript of that material will not be available to the general reader (i.e. those who are not Core Participants). There will also be reference in the report to other restricted material that, other than the reference to it made in this report, will for good reason have to remain restricted. While Core Participants will have had access to the great majority of that material, some of it, in its original form, will not be available if I have made a continuing restriction order over it. I will have done so in general terms to protect service users or staff identities or because only a small part of a much larger document has been cited and the redaction (editing to remove sensitive material) of the entirety of the rest would be disproportionate to any possible benefit.
40. Questioning of all witnesses was undertaken by the Counsel to the Inquiry team and, as far as possible, it was of a testing but non-hostile nature in keeping with the non-adversarial nature of a Public Inquiry. Questions asked by Counsel to the Inquiry were also informed by Core Participants, who submitted questions to the Counsel team in advance of witnesses giving evidence. Rule 10 of the Inquiry Rules allows the representatives of Core Participants to apply to ask questions of witnesses directly. Only one application was made, which after discussion with Counsel to the Inquiry was not pursued. There were no other Rule 10 applications. The Panel members also asked questions throughout.

Criticism letters

41. Rule 13 of the Inquiry Rules requires that anyone (including any organisation) who may be the subject of explicit or significant criticism in an Inquiry report is provided with a warning of the criticism and given an opportunity to respond. Warning letters were sent out between December 2025 and February 2026 to those whom the Panel was considering criticising in the draft report. Although, during the evidence, some witnesses were critical of members of staff, all those members of staff were ciphered, as they have continued to be ciphered in this report. Individual witness criticisms of others have not given rise to warning letters, provided the Panel has

not formed and expressed an adverse conclusion in the report. It is only where the Panel has formed an adverse conclusion and expressed an explicit or significant criticism in this report that a warning letter will have been sent.

42. Having sent out letters of criticism I was asked on a number of occasions to share parts of the report with the organisation or individual criticised, but in my view that would have been undesirable and unnecessary. The process as set out in the Rules is to share the potential criticism and the Inquiry did so; however, this may have had the result that recipients of the letters were unable to see the balancing remarks that we have often made in the report itself. It may therefore have appeared that the criticism was harsher than it truly was.
43. Some complained that they had not had matters contained in the criticism letters put to them during the course of the Inquiry. That was on occasions true, but because of the very large amount of material the Inquiry team had to analyse, including many Board public and confidential minutes, it would not have been practicable for all that material to be reviewed before the witnesses gave evidence. Had we done so the formal hearings would be unlikely to have finished in March 2025 as they did.
44. However, the purpose of the Rule 13 procedure of sending out warning letters is to give anyone who may be the subject of explicit or significant criticism the opportunity of responding to it prior to the report being published. Each individual and organisation made a response, and the Panel considered the responses to the letters of criticism very carefully and made a number of adjustments to the report where that seemed appropriate.

The BHSCT's approach to the Inquiry

45. Although there were a number of Core Participants, central to the Inquiry was the Belfast Health and Social Care Trust (BHSCT), which, for the majority of the period of the Inquiry's Terms of Reference, operated MAH. BHSCT took over from what was then the North and West Belfast Health and Social Services Trust (NWBHSST) in 2007, when all health trusts in Northern Ireland were reconfigured. Where in the report, therefore, there is reference to events at MAH prior to 2007,

any responsibility for those lay outside BHSCT's control. However, for the purposes of this Inquiry BHSCT has been treated as the legacy Trust for that which went before it.

46. In his opening address,⁵ leading counsel on behalf of the BHSCT (also referred to as the Belfast Trust) recognised on its behalf that it had 'failed in its core duties to look after the safety of its patients at MAH'. He assured the Inquiry of open, honest and transparent engagement with the Inquiry, saying that the Trust's staff were encouraged to participate. The Inquiry was told that the Trust was committed to learning as much as possible through the Inquiry process so as to make its ongoing and future provision of learning disability care both safe and fulfilling for people.
47. A Public Inquiry is not an adversarial forum, and it is generally not appropriate to adopt the techniques used by lawyers in commercial or criminal litigation. It was therefore of some concern to the Inquiry on how many occasions an adversarial and oppositional approach was adopted by the Trust to the Inquiry's methods. Correspondence emanating from the Trust's lawyers was frequently confrontational. This is perhaps best represented by their response to being warned of criticism in the report under Rule 13.
48. By reason of Rule 14 of the Inquiry Rules, the contents of the mandatory warning letters are regarded as confidential as between the Inquiry and the recipient. But that obligation of confidence may be waived in writing,⁶ and the Trust has asked the Inquiry specifically to reveal its refutation of many of the criticisms. The Trust's response to the 33 areas of criticism encapsulated in a 57-page schedule of criticism was 479 pages long.
49. The Inquiry was accused of a 'fundamentally flawed approach to the evidence'. On two occasions it was suggested that the Panel had arrived at a finding and criticism first and then tried to find evidence to support it. Of the 33 criticisms, only

⁵ BHSCT Opening Statement Transcript – 09/6/22 – Page 7

⁶ The Inquiry Rules 2006, Rule 14 (2) – <https://www.legislation.gov.uk/uksi/2006/1838/article/14/made>

a few were accepted by BHSCT and those only partially. In relation to 13 of the criticisms the Inquiry was asked:

‘If the MAH Inquiry refuses to remove or amend the proposed findings, or the criticism based thereon, in light of this response, then, as a matter of basic fairness in the context of the fundamentally flawed approach to evidence adopted by the MAH Inquiry, the Belfast Trust asks that the report of the MAH Inquiry reflects why the Belfast Trust does not accept that the proposed findings, or the criticism based thereon, are justified or fair’.

50. We considered the comments carefully and some criticisms were modified; however, including the Trust’s very lengthy refutation of the various criticisms as requested would extend this report beyond any reasonable length. In summary, the Trust complained that: ‘In several instances, the current proposed findings rely on belief evidence that is directly contradicted by the content of available objectively reliable records already in the possession of the MAH Inquiry’. It was said by the Trust that the proposed findings were not justified by the evidence relied upon, or that there was no sound evidential base for the proposed finding, and further it was said to be unfair to extrapolate from individual cases or limited examples, and that findings should be confined to individual cases. Further, the Trust pointed out that detailed analysis of service user notes would often run counter to the narrative of service user relatives in their evidence to the Inquiry. BHSCT suggested the notes should on each occasion be preferred to the oral evidence before the Inquiry.
51. We were disappointed to find that the BHSCT did not accept that the evidence given by families and patients should be given equal weight to records held by the Trust, and on each occasion where there was a conflict between the oral evidence of a witness and a written record, the Trust asked the Inquiry to rely on the records instead. We did not accept that proposal, nor the Trust’s general refutation of the criticisms, for the reasons given above.
52. We should say that the Trust complied with all of the Inquiry’s notices to provide documentation and it is not suggested that the Trust sought to conceal or hide any material from the Inquiry.

53. Lawyers are entitled to advise their clients in any way they see fit, but the client must make the ultimate decisions as to what approach to take either to litigation or to an Inquiry such as this. In this case the question must have been asked, 'what approach do we take to this Inquiry?' The attitude of the Trust, as represented by the correspondence sent on its behalf, and the response to the warning letter, does give rise to serious concern as to whether the Belfast Trust has the capacity to change its ways independently and without external forces brought to bear. In light of the adversarial approach taken to this Public Inquiry, we also considered the position of individual families attempting to challenge the Trust and how difficult a task that must on occasions have been. We note also that this is the second major Public Inquiry into BHSC within the past six years.

Meeting minutes

54. We have used Board and Board subcommittee minutes as a form of evidence as they are a contemporaneous record and not written with the benefit of hindsight. Publicly funded bodies are required to hold Board meetings in public and publish the minutes as a form of accountability to the taxpayer and wider public. The minutes of meetings are presented for approval at the next meeting, and any member of the Board or committee member is required to raise any inaccuracies or omissions before the minutes are approved. While recognising that not every comment or spoken sentence finds their way into the minutes of every meeting, nevertheless the Panel believes that any discussion not noted in the minutes is, by definition, not considered significant enough to be recorded.

A focus on systemic issues

55. The themes we describe largely relate to the experiences of patients, and the structures, processes and systems in place. Instead of focusing upon individual members of staff at ward level, we have focused our attention more on systemic issues, which gave rise to the circumstances that allowed abuse and poor care to occur. For example, we note the use of PRN ('pro re nata') sedation in a manner that was not therapeutic, but we recognise this was influenced in part by the absence of appropriate alternatives such as psychological interventions and the impact of staff shortages on effective de-escalation of behaviours that challenge. As a result, the use of PRN sedation became normal practice, and some staff may

have thought this was acceptable or even good practice. Nonetheless, for some of the patients it remains true that PRN sedation was used in a way that was restrictive rather than therapeutic, and which led to accounts from relatives of patients appearing in an overmedicated state.

The approach to the patient experience evidence

56. The report starts in Chapter 1 by recounting the experiences, as the relatives and some service users told the Inquiry, of the service users at MAH. Former service users and their families gave evidence to us of their experience at MAH over a long period stretching right across the Terms of Reference (ToR) from 1999 (and before) to 2021. Inevitably the great majority of that evidence was critical of the care the patients had received and critical of staff delivering that care.
57. It is important, however, to reflect that there were many members of staff who devoted a significant part of their working lives to caring for the patients at MAH and who took no part in the abuse and may not even have been aware of it. It is an unfortunate fact that the reputations of so many hard-working and well-intentioned members of staff have been unfairly tarnished by what happened. A great tribute should be paid to the many members of staff who worked at MAH diligently and with professionalism, those who continued to work there as evidence of abuse unfolded and those who continue to work as the hospital approaches final closure.
58. The Inquiry heard from over 90 relatives of service users (orally or by way of written statement) and received oral or written evidence from six people who were or had themselves been service users at MAH. In closing it was submitted by the Trust that, during the course of our ToR, MAH had care of over 740 patients, of whom approximately a little more than 10% were represented in the evidence from patients themselves or families. We note the percentage, but nevertheless we regard that number as very significant and, in addition to those witnesses, we heard about practice at the hospital from a large number of members of staff.
59. We have not sought to confirm each account, examine every complaint by a relative or service user, or determine the frequency of such experiences.

However, we have respected the families' accounts and used what families and service users have told us to develop themes that we tested against the evidence provided to us by members of staff and organisations. Instead of attempting to analyse individual incidents that gave rise to complaints, we focused on the relationship between different accounts to identify the range of circumstances that allowed abuse to happen.

60. Although some witnesses gave evidence of good practice, the great majority of the relatives and carers who gave evidence came to tell us about poor care and sometimes misconduct that had been reported to them by patients in the hospital, or which they had observed themselves or gleaned from partial accounts so far as their relatives were able to communicate. Common themes emerged across the accounts, and it became obvious that different families had had similar experiences from the hospital.
61. The use of restrictive practices is the area in relation to which the most obvious elements of what might be termed abuse were to be found. But the Inquiry was mandated to consider not only abuse itself but the range of circumstances that allowed it to happen.
62. In the Panel's view, some of the abuse came about as a result of what is termed 'the normalisation of deviance'. The allowance of poor care or neglect, and minor deviations from the rules and expectations of good practice, which in some parts of the hospital appear to have become normalised, may have led to the more generalised acceptance by some staff of poor standards of behaviour.
63. It is important therefore to understand the progression towards poor practice and other factors that may have influenced it before launching directly into the misuse of restraint. The report has therefore been deliberately constructed to allow the reader to appreciate the wider circumstances that appear to have led to the use of improper restraint and other physical abuse.

SUMMARY OF THE CHAPTERS

The Patient Experience and Admission of Patients to MAH (Chapters 1 and 2)

64. MAH was designed and built as a long-stay facility for people with learning disabilities and/or autistic people, and some were admitted through the criminal justice system into forensic care wards. The experiences of patients changed over time, as MAH changed from a long-stay placement with some very poor-quality buildings, to an assessment and treatment centre in modern but clinical buildings.
65. The Inquiry heard about people who were admitted as young as six years old and who moved through different wards as they grew older. Some patients were sent to other facilities and returned to MAH as resettlement failed. Others lived almost the entirety of their adult lives in the hospital. For some it was all they knew and they regarded it as their home for life.
66. The Bamford Equal Lives report published in 2005 advocated for the resettlement of all people with learning disability into the community, and that no one should remain in institutions such as MAH. But even prior to the publication of Equal Lives there had been an ideological shift, and in 2001 a phased closure of some of the wards had been planned. 2005/2006 marked the seminal closure of several wards, a renewed impetus towards community living and the opening of a new smaller core hospital designed for short-term assessment, treatment and transition. The ambition was for the hospital to change rapidly from a long-stay placement to a short-term assessment and treatment centre. The transformation took a very long time but gradually people's experiences began to change. This was both in terms of the mix of patients on the reduced number of wards and in terms of the approach to care.
67. The success of that change in policy would have required substantial concurrent investment in local community and social care, which, in reality, did not sufficiently meet the requirements to allow for the anticipated transition of patients from MAH. Although funding was increased it was not enough to create the necessary

infrastructure needed to look after patients being resettled from MAH in sufficient numbers.

68. This had the consequence of repeated failures of the resettlement of patients, the continued admission of people in crisis and the readmission to MAH of patients whose attempted resettlement had failed, all of which was despite the existence of policies that were intended to lead to its closure.
69. The patient experience revealed to the Inquiry most often through the eyes and experiences of the relatives spoke consistently of concerns about the appearance of unexplained injuries upon the patients as well as, for many, a lack of basic care for the needs of patients.
70. Because so many of the patients were non-verbal, establishing how an injury had been caused was often extremely difficult. Because of the nature of their disabilities, some patients will have caused injuries to themselves, to other patients and to members of staff. But once the existence of abuse through the incidents captured on CCTV came to light, many relatives who gave evidence understandably thought the worst and realised the possibility that at least some of the injuries seen upon the patients were a sign of deliberate abuse by staff. For some that is likely to have been true, but possibly not for as many as believed it. Some relatives commented, however, that patients seemed to receive injuries such as broken bones, black eyes and other bruises at MAH that they never suffered at home.
71. We heard extensive evidence concerning injuries sustained by patients, particularly bruises, unexplained marks and signs consistent with physical abuse. Some patients were verbal and were able to express that they had been assaulted by staff, but such direct evidence was very limited. Families described observing bruising to arms, legs, faces and torsos, including what appeared to be grip marks, finger bruises and injuries appearing in clusters.
72. Relatives reported being informed by staff that injuries were caused by self-harm, behavioural incidents or peer-on-peer violence. They were told their relative was

clumsy or may have fallen in the night. Over time, many families lost confidence in these explanations, especially where injuries were located on areas of the body difficult to self-inflict or appeared repeatedly in similar patterns. Sometimes injuries were unexplained even when a patient was supposed to be under supervision.

73. The Inquiry also heard evidence of physical abuse captured on CCTV, including forceful handling, dragging, pushing and inappropriate restraint. These incidents provided confirmation that unexplained injuries reported by families over many years could not be attributed solely to patient behaviour or peer-on-peer violence. The presence of injuries alongside incidents captured on CCTV demonstrated that earlier concerns had been justified and should have prompted urgent intervention.
74. The worry and trauma of believing that relatives had been harmed by members of staff was an enormous burden upon their families. The trauma and guilt felt by families for unwittingly exposing their relatives to harm, as expressed to the Inquiry, was for all no doubt a terrible responsibility. In truth, of course they bear no blame whatever, but the burden for many was expressed clearly through the families' evidence, which was often and understandably emotional.
75. Families' concerns were exacerbated by the lack of communication from staff at the hospital about when patients had been injured, and many complained of significant delays in injuries being reported to them. This occurred even on occasions when the patient concerned had been admitted to another hospital for treatment for injuries such as broken bones.
76. Some relatives spoke of the patients expressing fear of staff and some people demonstrated a strong reluctance to return to MAH, often after a weekend at home. More than one patient was described as refusing to get out of the car, others of screaming in protest, and others of spitting at members of staff to indicate dislike or removing their clothes.
77. Families described the emotional impact of repeatedly finding injuries without explanation, leading to fear, guilt and loss of trust. Some were reluctant to

challenge staff, concerned that doing so might worsen treatment for their loved ones. Many lacked confidence that their relatives would be kept safe.

78. The Panel concluded that injuries such as bruises and marks were not isolated or incidental; they were visible indicators of systemic failure. Dealing with each incident individually resulted in the inability of the organisation to recognise patterns, escalate concerns and protect patients, and allowed physical abuse and neglect to continue unchecked, causing lasting harm to patients and profound distress to their families.
79. These findings underscore the need for vigilant observation, rigorous investigation of injuries, transparent communication with families, and immediate safeguarding action whenever physical harm is suspected within institutional learning disability care settings nationally.
80. The Inquiry heard that personal care and hygiene was often lacking. The attention paid to personal appearance and washing at home was often not replicated at the hospital. Descriptions were given of patients being unkempt, with dirty hair and smelling of body odour and urine. On some visits relatives noted that incontinence pads were full or fingernails had faeces under them.
81. There were complaints about a lack of care about appropriate clothing. Not only would patients be dressed inappropriately or in another patient's clothes, but sometimes even on family visits the clothing was soiled with urine or faeces. Despite the attention given to MAH following the CCTV revelations these issues continued to occur.
82. Families provided accounts of a lack of attention to the physical health needs of the patients. Teeth and nails were sometimes neglected, particularly toenails, which were sometimes allowed to grow so long as to cause serious discomfort.
83. Significant weight gain as well as weight loss for others were continuing problems. We heard about several patients who became obese, and weight gain could be dramatic. Weight gain was exacerbated by a lack of activity and the Inquiry heard

that diet and weight were not always actively monitored, even though some patients became obese. Other patients who required assistance with eating lost significant amounts of weight.

Care and Treatment at MAH (Chapter 3)

84. Traditionally the medical model of care requires assessment, diagnosis and admission for treatment. In physical health that will often mean by medication or an operation. The medical model for learning disability has historically meant removal from society and management by medication and, where possible, the provision of suitable activities.
85. At MAH, even after 2006 when there was meant to be a shift in emphasis to prepare patients for resettlement and life in a community setting, the medical model still continued to be used, and the availability of psychological input was very limited. Few patients had positive behaviour support plans and very few experienced any psychological interventions. Occupational therapy to help develop the patients' life skills and speech therapy to help develop alternative means of communication were both extremely limited.
86. The lack of therapy and the absence of active support of life skills prevented the enhancement of everyday living and social skills and made it less likely patients could be resettled effectively. For some, their everyday life skills actually reduced as a result of their admission to MAH and so they were less prepared for life outside of hospital.
87. In later years, particularly after 2013, there were complaints about a lack of activities for patients. The recreation hall, which had been described as the hub for many activities, was demolished in the early 2000s, and other activities were reduced over time. There were significant staff shortages that got steadily worse and which meant the unavailability of staff to ensure day care activities, and day care activity workers had to be used on wards. This led to boredom and dysregulated behaviour, which in itself led to restraint and sometimes seclusion.

Care Planning and Record Keeping (Chapter 4)

88. Care planning is fundamental to safe, effective and person-centred care. Care planning involves assessing patients' physical, psychological and social needs, identifying risks, setting goals and specifying interventions, including medication, observation levels, daily living support and therapeutic activities.
89. A consistent theme in family evidence was their limited awareness and involvement in care planning. Families told the Inquiry that they were often unaware that formal care plans and risk assessments existed and were not routinely given access to them. This was evident both in the late 1990s and decades later, including for patients admitted in 2017.
90. Care records at MAH evolved from wholly paper-based systems to partially electronic records from around 2013. For several years, records were split between paper and digital systems, resulting in duplication, omissions and confusion. Access to computers on wards was limited, making real-time documentation difficult. Some staff reported that electronic records were hard to navigate, and it was unclear how non-registered staff (HCAs) accessed care plans.
91. The named nurse model was intended to provide continuity and oversight, but chronic staffing shortages, increasing reliance on temporary staff and high nurse turnover, particularly after 2017, meant that care plans were often completed by staff unfamiliar with the patient. By 2019, deputy ward managers were frequently responsible for care plans rather than the patient's named nurse.
92. Healthcare assistants (HCAs) provided most direct service user care but often had limited or no access to full care plans, relying instead on task lists provided at the start of shifts. This reduced the ability to deliver person-centred care.

Information Sharing and Co-Production (Chapter 5)

93. Co-production is an important tool to ensure that those with the best knowledge of the person with learning disabilities or autism, often including their families, can provide effective input into the design and delivery of care and support. Co-production can be best defined as active partnership, shared decision-making and

recognition of families' expertise. Many patients at MAH had complex, lifelong needs, with families often providing care and support over many years, and so, often, it was the family relatives who knew the patient best.

94. Families described not being informed of their rights when relatives were detained under the Mental Health (NI) Order 1986. Many believed decisions were made without consultation, leaving them feeling excluded from their loved one's care. Although some consultants reported meeting families on request, involvement was inconsistent and depended largely on individual clinicians rather than a systematic approach.
95. From the mid-2000s, MAH increasingly functioned as an assessment and treatment centre, with care planning dominated by a medical model particularly focused on medication management. Admissions were frequently justified to families on the basis that medication changes could only safely be carried out in a hospital setting. However, families frequently raised concerns about medication changes, PRN (as-needed) medication usage and lack of feedback about their impact. Requests for information and explanation about medication regimes were not always answered.
96. Effective co-production should have offered an opportunity to maintain continuity, reduce distress and promote person-centred care. Despite this, the Inquiry found that MAH largely operated within a paternalistic model, where information was shared selectively and decisions were taken by professionals rather than jointly with patients and families.
97. Families consistently described holding detailed, practical knowledge about their loved one's behaviour, communication and coping strategies. Many believed that if this knowledge had been recognised and embedded in care planning, episodes of distress, sedation, restraint or seclusion could have been avoided.
98. Many families reported a decline in communication quality over time, citing difficulties contacting wards, limited updates, lack of clarity about who to speak to and failures in digital communication systems. Some described repeatedly

providing the same information, such as patient passports detailing preferences, triggers and communication needs, only for it to be lost or not transferred when a service user moved wards.

99. At the same time, families described a loss of structure, activities and life skills following admission. The vast majority of patients had learning disabilities or autism and required routine, familiarity and personalised approaches. Families reported that information they provided about calming strategies, communication methods (such as Makaton or Picture Exchange Communication System (PECS)), and medical needs was not consistently incorporated into care plans. As a result, some lost previously held skills of daily living.
100. The Inquiry repeatedly heard that families were informed of decisions rather than involved in making them. Admission to MAH was often presented as the only or 'best' option, without discussion of alternatives. This approach continued after admission, with ward moves, changes in care and major operational decisions frequently made without consultation and sometimes without prior notice.
101. Examples of poor communication included families being told shortly before, or even after, patients were moved between wards. Such changes often occurred without adequate preparation for the patient, such as the use of social stories or advance behavioural planning, leading to distress, deterioration in mental state and, in some cases, physical decline.
102. Several systemic barriers limited co-production at MAH. Families reported not being able to visit during early stages of admission, removing opportunities to share crucial information. Many struggled to identify a consistent point of contact or key worker. Multidisciplinary team meetings sometimes included families, but most commonly only at admission or discharge stages.
103. Experiences of co-production in resettlement planning were mixed. While a small number of families reported positive involvement, the majority described exclusion from decisions, despite their ongoing role as future carers.

104. Co-production was neither consistently understood nor systematically practised. Families who knew patients best were not reliably involved in care planning or decision-making, resulting in lost opportunities to prevent distress and promote wellbeing. Care remained largely standardised rather than personalised, and policies and service planning reflected professional priorities rather than lived experience.
105. Many families felt marginalised, disenfranchised and emotionally exhausted by repeated efforts to be heard. This exclusion not only damaged trust but also contributed directly to poorer patient outcomes, as staff lacked critical knowledge about patients' needs, preferences and coping mechanisms.

Patients' Property and Finance (Chapter 6)

106. Many families expressed concern about the handling and use of cash brought in for service users by families and the retention and accounting of benefit payments. There was a lack of transparency around the accounting of cash and other property, leading to suspicions of misuse. Evidence from families, former patients, staff testimony, inspections and audits demonstrated that vulnerable patients were exposed to an unacceptable risk of financial loss, misuse of funds and distress arising from missing or poorly managed personal belongings.
107. The Panel found there were long-standing weaknesses in governance, oversight and transparency in relation to the accounting and recording of service user finances.
108. Responsibility for MAH transferred from the NWBHSST to the Belfast Health and Social Care Trust (BHSCT) in 2007. BHSCT relied on legacy policies until the introduction of a learning disability-specific finance and property policy in 2015. Even thereafter, assurance mechanisms were weak and unevenly applied across wards. Regular audits that had been undertaken by NWBHSST were no longer undertaken for many years under BHSCT.

109. In practice, financial governance arrangements varied significantly. Small amounts of service user cash were held on wards in locked drawers, while larger sums and valuables were retained by the hospital cash office. Despite formal requirements for reconciliations and checks, evidence showed that record-keeping was often poor, managerial oversight sporadic, and access to cash insufficiently controlled. Families commonly reported bringing in regular amounts of money or being asked to provide cash (e.g. for takeaway meals or for specific items such as new clothes) without receiving receipts or clear accounts of expenditure. Many were refused information about balances or spending, even where they had supplied the funds or held legal authority.
110. A recurring concern was the discrepancy between expected and actual balances when patients were discharged or died, sometimes after many years of benefit payments. Financial records, where provided, were frequently coded, opaque and difficult for families to understand. Former patients and families gave accounts of money going missing, weak controls over drawer access and disputed or allegedly falsified documentation. Taken together, this evidence pointed to systemic weaknesses rather than isolated failings.
111. Although there was no direct evidence of the theft of service user money, the lack of accounting controls and transparency over how money was handled and accounted for left many relatives understandably suspicious that money was not properly accounted for and may have been misused.
112. Serious concerns were also raised about the management of personal property. Families described clothing being poorly maintained and personal items, including sentimental possessions, toys and bedding, going missing without explanation. Although a system existed for recording the deterioration and disposal of property, it was inconsistently followed, particularly as staffing changed and reliance on temporary staff increased.
113. The Panel found that BHSCT failed for several years to carry out required audits or provide assurance that statutory safeguards were being met, despite holding substantial sums of money for individual patients. We concluded that BHSCT did

not put in place robust, transparent or consistently applied systems to safeguard patients' money and property at MAH. In a setting where patients were very vulnerable, this lack of effective assurance significantly increased the risk of misuse, loss and erosion of trust.

Restrictive Practices (Chapter 7)

114. There is, perhaps obviously, an elevated risk of the inappropriate use of restrictive practices with individuals with learning disabilities and/or autistic people. The Inquiry heard a significant body of evidence about the use of restrictive practices at MAH, including physical restraint, seclusion and the use of PRN (as required) medication. The Panel identified serious and persistent concerns regarding the frequency, rationale, recording and governance of restrictive practices over a prolonged period.
115. Over the time frame covered by the Inquiry, the definition and understanding of restrictive practices evolved significantly. Practices once regarded as customary or benign, such as 'low-level' physical holds, locked rooms or enforced time spent in a garden or in low-stimulus rooms, came to be recognised as restrictions on liberty and, in some cases, as deprivations of liberty engaging human rights protections. However, policy development, staff training and oversight at MAH did not keep pace with this evolving understanding. As a result, staff often operated under inconsistent or outdated frameworks, contributing to confusion over what constituted acceptable practice.
116. Evidence presented to the Inquiry demonstrated a pattern of frequent use of physical restraint, seclusion and PRN medication, sometimes in circumstances where the use of de-escalation or other preventative, person-centred or behavioural interventions might have reduced or avoided the need for restrictive measures. Many staff lacked specialist behavioural training, particularly in earlier years, limiting their ability to recognise triggers, respond therapeutically to distress or de-escalate situations proactively. Structural pressures, including ward closures, mixing of patients with very different needs, environmental factors (such as noise and others' distress or aggression) and long-standing staffing shortages, contributed to patient boredom and distress and increased the likelihood of

challenging behaviour, creating a cycle in which restrictive practices became normalised.

117. Seclusion was a particular area of concern. Although policies on seclusion became increasingly prescriptive over time, including requirements for monitoring, the Inquiry heard evidence that implementation was inconsistent, sometimes inadequate and not effectively audited. Witnesses responsible for viewing historic CCTV footage and other witness testimony suggested that seclusion was at times used punitively, or as a matter of routine rather than as a last resort after efforts at de-escalation had failed. Episodes of seclusion were not always accurately recorded, and some practices, such as keeping patients in the 'garden', or segregation in bedrooms, low stimulus rooms or pods, fell outside formal seclusion policies despite involving significant restriction of liberty. This blurred the distinction between therapeutic interventions and seclusion, increasing the risk of unlawful practice.
118. Among relatives there was a lack of understanding about the use of seclusion and what the seclusion room looked like. Some families believed the seclusion room was just a quiet comfortable room and were very shocked when confronted with the reality.
119. The use of PRN medication as a form of restrictive practice was also problematic. Although guidance emphasised that PRN medication should only be used with a clear therapeutic rationale and as a last resort, families frequently described experiencing their relatives as sedated, disengaged or 'zombified'. The Panel accepted that this was not necessarily an indication of overmedication by use of regularly prescribed drugs but may have reflected the use of PRN medication to control behaviour when other non-medical approaches had either not been available or not been attempted. Nevertheless, the result was understandably unacceptable to the relatives witnessing the effects.
120. While staff reported a gradual shift away from reliance on medication and towards close observation, the Inquiry found little evidence of systematic monitoring or trend analysis of PRN usage across the hospital until very late in the period

reviewed. This represented a missed opportunity to identify patterns of overmedication and address underlying causes of distress, such as unmet physical, sensory, emotional or environmental needs.

121. Governance and oversight of restrictive practices were inadequate. Although data on restraint, seclusion and incidents was collected and reported internally, the Inquiry found limited evidence of effective senior management challenge, trend analysis or sustained action to reduce use. This lack of scrutiny allowed deviations from policy to become embedded over time. The Panel identified this process as a form of 'normalisation of deviance', whereby repeated departures from expected standards became accepted as routine practice in the absence of corrective action.
122. Families' experiences further underscored these failings. Some relatives felt they were not given the information they needed to understand the medication the patient was on, even when they challenged staff. Concerns were also raised that PRN was being used as a first response rather than appropriate de-escalation or positive behaviour support. Many relatives reported that they were not adequately informed about the nature, frequency or legal basis of restrictive practices, including seclusion and PRN medication. When information was provided, it was often general or incomplete, leaving families shocked when later evidence revealed the extent of restrictive interventions used.
123. The Panel concluded that a combination of environmental pressures, staffing constraints, poor staff training, insufficient behavioural supports, weak governance and limited transparency led to the overuse and misuse of restrictive practices at MAH, causing avoidable distress and harm to patients. While improvements were noted in later years, particularly following the 2017 revelations and subsequent inspections, these changes came after long-standing systemic failures.

Complaints and Concerns (Chapter 8)

124. The Panel examined how complaints were raised, recorded and managed at MAH during the period covered by the Inquiry, and how patients and families experienced the complaints process. Evidence revealed widespread confusion,

fear and mistrust among families, alongside systemic weaknesses in complaint handling, oversight and organisational learning.

125. Many family members found the complaints system opaque and difficult to navigate, with little clarity about how complaints were investigated, how decisions were reached or what outcomes, if any, resulted. Many were unaware that they could escalate their concerns to the Trust's complaints department. A recurring theme was a lack of trust in the complaints process.
126. Some families complained of concerns being dismissed and there was a widespread complaint about a lack of information or support about any investigation process.
127. At Trust level, complaints policies evolved over time, with BHSCCT retaining legacy arrangements when it assumed responsibility for MAH in 2007. Although formal processes existed, the Inquiry found that complaints were often handled informally at ward level and not consistently recorded. This made it impossible to establish how many concerns were raised informally or whether they were appropriately investigated.
128. A small number of formal complaints were recorded over more than two decades. This low volume did not reflect an absence of concern but instead suggested that families either lacked confidence in the system, did not understand how to complain or feared repercussions. Some complaints were paused or effectively stalled when safeguarding, disciplinary or criminal investigations were underway, with families receiving little explanation or regular updates. In several cases, complaints remained unresolved for years, undermining their purpose and causing lasting distress.
129. Families' lived experiences revealed further shortcomings. Many reported finding out about injuries, assaults or significant incidents only during visits, or after long delays. Others described communications they perceived as defensive, dismissive or designed to protect the institution rather than investigate the facts. Some believed that staff were effectively 'investigating themselves', creating

perceptions of bias and eroding confidence in outcomes. Even when complaints were upheld in part, families often felt responses lacked empathy, apology or accountability.

130. Fear was a major barrier to complaint-raising. Witnesses described explicit or implicit warnings suggesting that complaining could affect their relative's care or future admissions. Patients themselves were sometimes frightened to speak up. Some witnesses told the Inquiry that they were uncertain whether to complain at all or feared that raising concerns would negatively affect their loved one's care, jeopardise their place at MAH or result in retaliation. Some witnesses described feeling intimidated or discouraged from speaking out. The Inquiry heard evidence that these fears were not unfounded, contributing to a silencing effect within a highly vulnerable population.
131. Governance and oversight arrangements were also found wanting. Although complaints data was presented in dashboards and discussed at MAH management meetings, there was limited evidence of robust analysis, challenge or sustained organisational learning. A 2017/2018 internal audit of complaints handling at MAH gave only limited assurance, identifying significant weaknesses in record-keeping and control frameworks.
132. The Panel found that although complaint management policies existed, the system did not work effectively for patients or families at MAH. Information about how to complain was inadequate, complaints were not consistently recorded or progressed, investigations were often slow or inconclusive, and families were insufficiently informed or supported. Investigations were often inconclusive because there was no supporting evidence.
133. Although we found that complaints alone were an unreliable indicator of care quality in such a vulnerable setting, there was a demonstrable need for clearer processes, stronger advocacy, better recording and proactive approaches to understanding patient and family experience through the use of information garnered from complaints.

Previous Concerns, Previous Investigations and Warning Signs (Chapter 9)

134. The Panel considered whether warning signs of abuse and serious failings existed at MAH prior to the 2017 CCTV revelations, whether they were recognised as such and how earlier investigations, particularly the Ennis Ward investigation, were managed and acted upon. We concluded that if taken cumulatively rather than in isolation, there were several signs that should have prompted earlier and more decisive intervention.
135. Evidence before the Inquiry demonstrated that concerns about abuse and inappropriate care at MAH extended back well before the Inquiry's Terms of Reference.
136. From the late 1990s onward, new frameworks for complaints, safeguarding and serious adverse incident (SAI) reporting were introduced across Northern Ireland. However, the Inquiry heard that there was ongoing uncertainty about how and when to apply these processes. Peer-on-peer abuse, unexplained injuries and behavioural incidents were often regarded as unfortunate but routine aspects of life in a learning disability hospital, rather than indicators of systemic risk. As a result, incidents were frequently handled informally at ward level or addressed as discrete events, without escalation or thematic analysis.
137. Between 2010 and 2017, the risk at MAH increased. Staffing shortages intensified, particularly in wards caring for patients with complex needs and challenging behaviour. Allied health professional input remained severely limited, with insufficient psychological treatment, occupational therapy and behavioural support. Ward environments were described as poor or degrading in places, off-ward activity levels declined, and patients were increasingly confined to wards as resettlement slowed and services contracted.
138. During this same period, incident data showed substantial and sustained increases in peer-on-peer and patient-on-staff aggression, even as the inpatient population reduced, indicating a rise in intensity. These trends were visible through Datix reporting, safeguarding referrals and internal reports, yet were not

translated into a strategic response. Better reporting, an explanation often given, was not a sufficient explanation for the rise in known incidents.

139. The Ennis Ward investigation of 2012 stands out as a critical warning moment. Allegations made by external staff visiting MAH from Bohill Care Home described verbal and physical abuse of patients by MAH staff, leading to police involvement, a prolonged adult safeguarding investigation, senior management intervention and extensive ward monitoring. Although the investigation ultimately concluded that there was insufficient evidence to substantiate a finding of institutional abuse, it nonetheless revealed a ward under severe strain: chronically low staffing, an unsafe and unsuitable environment, minimal therapeutic input, high levels of peer-on-peer violence and staff struggling to manage complex care demands. Two members of staff were prosecuted for criminal offences, but these cases did not ultimately lead to any convictions.
140. Senior figures across the Trust and regulators were aware of these findings. Meaningful improvements were made to the Ennis physical environment and staff training, yet the Inquiry found that the lessons from Ennis were treated as ward-specific rather than as signals of potential wider failure. There was no Trust-wide examination of whether similar risk factors existed across other wards at MAH, nor was there sustained follow-up to assess whether the underlying conditions that created risk had been resolved. The focus remained on whether individual acts of abuse could be proven (which they were not), rather than on the systems, staffing and culture that made abuse more likely.
141. Governance arrangements compounded these weaknesses. Adult safeguarding sat largely outside standard clinical governance frameworks, and findings from safeguarding investigations were not routinely integrated with complaints data, SAI reports or incident trend analysis. Board-level oversight focused on assurance that procedures existed rather than on whether cumulative evidence pointed to escalating risk. Although senior leaders were aware of staffing shortages, rising aggression and repeated safeguarding activity, these issues fell off Board agendas for extended periods.

142. The Panel concluded that MAH exhibited multiple, persistent and well-documented warning signs long before 2017: sustained understaffing; inadequate specialist supports; unsafe environments; escalating violence and restraint; frequent safeguarding referrals; family complaints; and a geographically and culturally closed institution. While individual allegations were often investigated, the system failed to connect the dots. No single mechanism brought together incident reporting, safeguarding intelligence, complaints and workforce pressures in a way that would have revealed the scale of risk.
143. In retrospect, the Inquiry found there was more than sufficient information available to alert the Trust, commissioners and regulators to the potential for abuse, even where individual allegations could not be substantiated to criminal or disciplinary standards. The failure was not a lack of data, but a failure of interpretation, integration and leadership. Warning signs were present, visible and repeatedly raised; decisive, system-wide action did not follow.

CCTV, 2017 Revelations and the Response (Chapter 10)

144. Closed circuit television (CCTV) played a pivotal role in uncovering abuse at MAH. We examined the circumstances in which CCTV was installed, and how the resulting evidence was managed after serious safeguarding concerns emerged in 2017. Without CCTV, the abuse of patients is unlikely to have been exposed, and the Inquiry itself may never have been established. Nevertheless, the use of CCTV is a complex issue, and its use has to be carefully considered, regulated and monitored.
145. We received evidence about how initial discussions around the installation of CCTV arose as early as 2007, primarily in response to concerns about staff safety and disputed accounts following restraint incidents.
146. Funding for CCTV installation was eventually secured in 2014, and cameras were installed in communal areas of Cranfield and Sixmile wards between February and July 2015. However, the system was installed long before a final policy governing its use was approved. As a result, there was a significant period during which cameras were operational, yet staff, patients and families were unclear about

whether CCTV was live, how footage would be accessed and under what authority. This delay reflected broader governance weaknesses and an inability to manage the risks and sensitivities associated with CCTV in a learning disability setting.

147. Although the policy was finally approved in mid-2017, the system had in fact been recording continuously for several months, retaining approximately six months of footage. This became critically important following a staff report in August 2017 alleging that a patient had been struck by a member of staff on the Psychiatric Intensive Care Unit (PICU). When managers reviewed the CCTV footage to confirm the reported incident, they discovered not only that the incident had been recorded, but that other unreported incidents were visible on the footage.
148. This discovery marked a turning point. Safeguarding procedures were triggered, the PSNI was notified, and what became known as the 'historic CCTV recordings of 2017' were identified. The scale and seriousness of what was revealed on CCTV profoundly shocked senior managers. The abuse of patients appeared to have occurred openly, often in communal areas and sometimes in the presence of other staff, without being reported or challenged.
149. The Panel heard a significant amount of evidence about the complex and deeply flawed process by which CCTV footage was reviewed by the BHSCT. Several areas were covered by multiple cameras, resulting in thousands of hours of footage to review. Initially, a decision was taken to examine a 25% 'dip sample' of the historical footage, focusing on daytime hours. External viewers, largely retired social workers, were recruited to screen the footage and complete viewing forms flagging potential incidents. These forms were then passed through MAH management to the Designated Adult Protection Officers (DAPOs), who determined whether safeguarding or criminal referrals were required.
150. As increasing numbers of concerning incidents were identified, the sampling was expanded first to 50% and, following intervention by the Department of Health (DoH), eventually to 100% of footage. However, the staged approach had serious consequences and made the task of Family Liaison Officers (FLOs) much harder. Families were sometimes informed of later incidents before earlier ones, causing

confusion, distress and loss of trust. The sheer volume of footage, the absence of a clear audit trail and the lack of a robust, independent process undermined confidence in the management of the response. There were issues around the threshold being applied by different staff and DAPOs for referral of an incident and no effective quality assurance.

151. There were acute tensions between MAH management, the DAPOs, Human Resources and the PSNI. DAPOs reported being under-resourced, overburdened and insufficiently supported while undertaking distressing and complex work. They raised concerns that access to CCTV footage was controlled by individuals based at MAH, compromising independence, and that pressure was exerted to work quickly rather than thoroughly. Some DAPOs reported hostility from MAH staff, felt unsafe on site and experienced professional isolation.
152. Serious difficulties also arose regarding the handling and security of CCTV evidence. In 2019, the PSNI lost confidence in assurances that all footage had been reviewed and decided to seize the CCTV hard drives to ensure evidential integrity. The seizure itself corrupted the system, which had to be rebuilt (though there was no suggestion of the footage itself being compromised). This led to further disruption and delay, including periods when no footage could be accessed by the Trust. Over time, the PSNI assumed primacy in reviewing historical footage relevant to criminal investigations.
153. The discovery of the abuse had a profound impact on families. Being informed that CCTV had captured abuse involving their relatives caused shock, guilt, anger and lasting emotional harm. Many families questioned how abuse could have occurred undetected and expressed fears that further mistreatment may have occurred in areas not covered by cameras. While FLOs were widely praised for their compassion, they too reported being placed under pressure, discouraged from open engagement with the PSNI and ultimately this Inquiry, and caught between the competing demands of the Trust, the police and distressed families.

154. The Panel found that the systems and structures in place were wholly inadequate to manage the scale of abuse uncovered by CCTV. The lack of independence, inconsistent decision-making, poor coordination and failure to anticipate conflicts of interest significantly compounded the harm already done. CCTV was essential in revealing the truth at MAH, but the Trust was unprepared for the consequences of that revelation. The Panel concluded that CCTV can be a powerful safeguarding tool in high-risk settings, but only if accompanied by clear policy, strong governance, independent oversight and a culture that prioritises transparency and accountability over institutional protection. A clear policy and approach are needed where there is multiple rather than individual incidents of harm or abuse that require investigation.
155. While recognising that the management of MAH faced a very difficult situation, the failure to manage this well led to multiple suspensions and replacement of staff with HCAs and temporary staff who did not know the patients, and many of whom were untrained in caring for patients with severe learning disabilities.
156. This led to an environment that continued to be unsafe for patients.

Safeguarding (Chapter 11)

157. The Inquiry explored safeguarding arrangements at MAH and the Panel considered how effectively systems designed to protect highly vulnerable adults functioned in practice.
158. Safeguarding is a basic responsibility within Health and Social Care, particularly in institutional settings caring for people with learning disabilities, who are at heightened risk of abuse, neglect and exploitation. Although safeguarding policy and structures in Northern Ireland evolved significantly during the period under review, we concluded that shortcomings in implementation, oversight and governance allowed harm to persist and risks to go unrecognised.
159. Northern Ireland remains unique within the UK in lacking dedicated adult safeguarding legislation, although it is hoped this is soon to be remedied and we considered the new Adult Protection Bill passing through the Assembly.

Responsibilities instead rested on a complex framework of guidance, professional judgement and organisational processes. At MAH, this complexity contributed to confusion about thresholds, responsibilities and escalation, particularly in relation to institutional and peer-on-peer abuse.

160. The Panel found that safeguarding systems were fragmented and insufficiently integrated with the Trust's wider clinical governance and risk management arrangements. Safeguarding investigations were structurally separated to preserve independence, but this separation limited organisational learning. Information from safeguarding referrals, incident reporting systems, complaints, SAls and PSNI involvement were not routinely triangulated. As a result, patterns of harm, particularly high levels of peer-on-peer abuse, aggression and allegations of staff abuse, were not identified or addressed at a system level.
161. Ward reconfigurations linked to patient resettlement at MAH had unintended consequences that increased the risk of abuse. Staff recruitment freezes and the mixing of patients with differing needs led to a rise in peer-on-peer abuse and patient-on-staff assaults.
162. High levels of peer-on-peer abuse signal a poorly controlled environment and may also be a marker for other forms of abuse, including staff-on-patient abuse, which is far less likely to be voluntarily reported. Failure to monitor the incidence of peer-on-peer abuse at MAH was a missed opportunity to monitor the overall culture of care.
163. Because peer-on-peer abuse in learning disability services is not considered intentional, it was managed locally rather than through the Adult Safeguarding Gateway. This meant that managers failed to recognise the escalating risks between 2011 and 2014 at MAH, despite data being available via Datix. The Clinical Governance team failed to highlight these trends, and there was limited awareness beyond ward staff of the increasingly violent environment and its impact on both patients and staff.

164. We had particular concerns about safeguarding record-keeping. Investigations often lacked clear documentation, coherent analysis and recorded conclusions. Reviews of safeguarding files between 2012 and 2017, and again after 2017, identified disorganised records and inconsistent practice, making it difficult to determine whether procedures were followed or whether protective actions were effective. Independent advocacy was rarely evident, particularly in cases involving allegations against staff. These weaknesses undermined confidence in the safeguarding process and limited accountability.
165. There is evidence that concerns about abuse at MAH were raised through multiple channels years before the 2017 CCTV revelations. Incident data, safeguarding referrals, staff reports and external inspections all pointed to a deteriorating and increasingly violent environment. However, organisational responses focused on individual incidents rather than on systemic issues such as staffing shortages, ward moves, patient mix and lack of therapeutic activities. The Board and senior leadership placed undue reliance on the existence of policies and on executive reassurance, rather than interrogating safeguarding data for trends, outcomes and effectiveness.
166. The response to the 2017 allegations represented a belated shift in approach. The scale of abuse uncovered through CCTV review led to unprecedented numbers of staff suspensions and intensified scrutiny from regulators and the DoH. However, the focus remained largely on individual culpability rather than on understanding and addressing the environmental and organisational conditions that enabled abuse. The disruption caused by mass suspensions and the increased reliance on agency staff, often without learning disability expertise, introduced new safeguarding risks, which were insufficiently assessed or mitigated.
167. The safeguarding system at MAH was reactive rather than preventative, process-driven rather than outcome-focused, and insufficiently connected to the Board's oversight responsibilities. The failure to recognise peer-on-peer abuse as a key indicator of environmental failure was a critical missed opportunity to identify wider risks, including staff-on-patient abuse.

168. We concluded that safeguarding arrangements at MAH did not provide effective protection for vulnerable adults. Earlier recognition of systemic risk, supported by meaningful data analysis, clearer accountability and stronger Board-level challenge, could have prompted intervention well before 2017. The lessons from MAH underline the need for adult safeguarding to be given equivalent status to child protection, to be made a Delegated Statutory Function (DSF) and therefore included in DSF reports, supported by transparent reporting, consistent standards and a clear focus on preventing harm rather than responding after abuse has occurred.

Staff and Ward Management (Chapter 12)

169. The report examines how staff and ward management arrangements at MAH evolved over time, and how workforce planning, leadership instability, skill mix deficits and structural policy decisions combined to undermine the delivery of safe and humane care. The Panel concluded that staffing challenges at MAH were long-standing, well-documented and increasingly severe, yet were never adequately resolved. These systemic workforce failures significantly increased patient vulnerability and contributed to the conditions in which abuse was able to occur and persist.
170. MAH originated as a long-stay institutional hospital for people with learning disabilities. As policy shifted from the late 1980s onwards toward resettlement and community-based care, the hospital's role was expected to diminish. However, while resettlement policies gathered pace, MAH continued to house a highly complex and increasingly challenging inpatient population. This created a fundamental mismatch between workforce funding models based on a shrinking, settled population and the evolving reality of patients requiring high levels of observation, behaviour management and specialist learning disability expertise.
171. Planning for this transition was inadequate. Workforce strategies assumed that staff posts could be released incrementally as patients were discharged into the community and resettled. In practice, fixed overheads meant that staff funding could not be released quickly enough to support the creation of community services, resulting in a 'chicken and egg' situation: patients could not be

discharged due to lack of community provision, but staffing budgets were simultaneously constrained by planned hospital closure. This failure was foreseeable and had already been experienced when another Trust (Western Health and Social Care Trust) withdrew its patients (and its funding) from MAH in 2007, necessitating emergency bridging funding to keep MAH operational.

172. As resettlement stalled, the profile of patients remaining in the hospital changed significantly. Those discharged first were often more independent and less challenging, leaving behind patients with acute mental illness, high levels of autism, forensic needs and severely challenging behaviour. Staffing models, skill mix and training frameworks did not adjust accordingly. As early as 2012, managers were reporting dangerously low staffing levels and escalating risks; staffing was entered onto risk registers locally and corporately by 2014. Despite this, there was no sustained, funded response.
173. Staffing shortages were persistent from at least 2009 onwards and worsened significantly after 2012, when recruitment freezes and temporary contracts became common due to the anticipated closure of MAH. Experienced Registered Nurses in Learning Disabilities (RNLDs) left, while newly qualified staff were often employed on short-term contracts with limited prospects, and so recruitment was harder. At the same time, community services increasingly competed for the same workforce. MAH became heavily reliant on bank and agency staff, many without specialist learning disability training. This was significantly exacerbated by the suspensions following the CCTV revelations. By 2020, fewer than a quarter of staff nurses at MAH were substantive employees, undermining continuity, supervision and therapeutic consistency.
174. Skill mix was a critical weakness. The ratio of registered nurses to HCAs was frequently below safe levels, and in some wards fewer than half of staff were registered nurses. HCAs, who provide the majority of direct patient care, had no specialist training requirements and relied heavily on informal learning. Supervision was inconsistent, and clinical supervision arrangements fell far below what would be expected in a high-risk inpatient setting. This created a

task-focused culture where staff prioritised basic physical care over personal and therapeutic engagement.

175. Leadership and governance exacerbated these problems. From 2011 onwards management became less stable, MAH experienced repeated turnover in senior management, including at Service Manager, Co-Director and Directorate levels. During critical periods, posts were left vacant or covered on an interim basis, weakening strategic oversight and continuity. Ward managers, who play a central role in setting standards and managing poor practice, often received little formal leadership training or support. The Trust was unable to demonstrate that ward leaders were equipped to challenge problematic behaviour that fell short of disciplinary thresholds.
176. A further cultural vulnerability arose from the long-established practice of recruiting from local families. While initially regarded as beneficial, familial relationships among staff made it harder to challenge unacceptable behaviour, contributing to a closed culture characterised by loyalty to colleagues over patients. Despite awareness of this risk, governance systems failed to identify or manage conflicts of interest effectively.
177. Medical and allied health provision was also insufficient. Patients at MAH effectively lost access to routine primary care for many years, with psychiatrists managing both mental and physical health needs. This left patients in MAH in a worse position than those in the community. Allied health professional input, such as psychological treatment, speech and language therapy, occupational therapy and pharmacy was limited or inconsistent, reducing opportunities for preventative and therapeutic interventions and increasing reliance on restrictive practices.
178. Staffing deficits worsened dramatically following the 2017 CCTV revelations, when large numbers of staff were suspended or left the service. The resulting dependence on agency staff, often without learning disability expertise, further destabilised wards and reduced patient safety. Protection plans were implemented without adequate assessment of the staffing capacity required to deliver them, paradoxically increasing risk.

179. Throughout this period, senior leadership and the Trust Board repeatedly reassured themselves and external bodies that staffing was safe, even as the regulator and whistleblowers raised escalating concerns. Risks identified at Directorate level did not consistently reach the Principal Risk Register, limiting Board scrutiny. Regional commissioners and the DoH were aware of staffing pressures but did not effectively performance-manage the Trust or intervene decisively.
180. MAH was asked to deliver increasingly complex, high-risk care within a shrinking, inadequately planned workforce model. Chronic understaffing, unstable leadership, poor skill mix and insufficient supervision created a fragile environment in which safeguarding risk increased steadily. These conditions were not incidental but systemic, and they played a central role in enabling the failures exposed by the Inquiry.
181. At MAH, persistent workforce fragility was normalised rather than treated as an intolerable risk, with profound consequences for patients and staff alike.

Senior Management and Trust Board Governance (Chapter 13)

182. The Inquiry heard a significant amount of evidence relating to how the governance arrangements at BHSCT operated during the period relevant to the Inquiry, and how failures in Board-level oversight, assurance and risk management contributed to prolonged harm to the highly vulnerable patients at MAH.
183. Effective governance is fundamental to any large organisation and particularly to an organisation providing care to vulnerable people. In this case, while extensive governance structures existed, they consistently failed to work to bring relevant information to the Board of BHSCT, and to translate information into understanding of risks or into an active response. There was a resulting lack of insight by the Board into the difficulties faced at MAH. Despite MAH being a high-risk environment, it rarely found its way into the Board considerations until the 2017 revelations.

184. We outline the complex statutory and organisational framework within which Health and Social Care Trusts in Northern Ireland operate.
185. BHSC's Board comprised executive and non-executive directors (NEDs) with collective responsibility for strategy, assurance and governance rather than operational delivery. While formal structures aligned with accepted governance models, including committees, directorates and a Board Assurance Framework (BAF), the Board's practice was characterised by an over-reliance on executive reassurance, limited interrogation of data and insufficient challenge of clinical and social care risks. NEDs frequently lacked the specialist knowledge necessary to scrutinise and challenge reassurances given by executive directors.
186. A central failure identified by the Inquiry was the Trust's focus on governance *processes* rather than *outcomes*. Reports to the Board emphasised the existence of policies, action plans and committees but rarely demonstrated whether these arrangements were effective in protecting patients or improving care. Incident reporting, safeguarding referrals, complaints and staff intelligence were routinely aggregated at Trust level, masking significant variation at hospital level and thus obscuring sustained patterns of harm at MAH. As a result, warning signs, including escalating violence, peer-on-peer abuse, seclusion, dangerously low staffing levels (recorded as early as 2012), staffing instability and safeguarding referrals, were normalised rather than treated as indicators of systemic failure.
187. Risk management arrangements were similarly deficient. Risks from MAH were often downgraded or removed as they ascended the risk register hierarchy, even when underlying conditions persisted or deteriorated. Risks affecting specific services were smoothed out through aggregation and failed to reach the Board as Principal Risks. Independent assurance, such as internal audit, focused heavily on procedural compliance and only followed up 'limited assurance' findings, leaving significant residual risks unaddressed. The Trust rarely tested whether mitigating actions were effective in practice or reduced patient harm.
188. The Board's awareness of risks at MAH developed slowly and reactively. Concerns about abuse, violence and unsafe conditions were evident to senior

management from at least 2010, yet these were not escalated appropriately to the Board or acted upon decisively. When allegations involving CCTV footage emerged in 2017, the Trust created multiple oversight groups and commissioned a series of reviews. However, there was limited evidence that recommendations were tracked, and implementation was inconsistent. There was little evidence that the reviews and recommendations improved the service users' experience or their safety.

189. Even after external regulators raised serious concerns, including the issuing by the Regulation and Quality Improvement Authority (RQIA) of Improvement Notices in 2019, the Board continued to accept assurances that care was safe, often disputing regulators' findings without providing robust supporting data. Senior leaders failed to reconcile contradictory evidence from inspections, incidents, safeguarding reviews and staffing data. Crucially, the Board did not adequately address structural risk factors such as chronic staffing shortages, excessive use of untrained agency staff and inappropriate ward mixes. Reassurances provided by executive directors were not properly scrutinised for any underlying supporting data.
190. False reassurance was provided to external bodies, including to the DoH, that the hospital was safe to operate when in fact it should probably have been recognised that it was not.
191. RQIA frequently reported concerns but the Trust Board and its senior managers failed to connect the dots between the risk factors for abuse: shortage of staff; lack of therapeutic activities; increase in peer-on-peer and patient-on-staff incidents; increase in seclusions; and increase in use of agency staff (to name but a few).
192. The Panel concluded that BHSCT's governance system failed at multiple levels. It did not integrate information across different assurance routes, failed to identify and act on patterns of harm, and lacked the curiosity, expertise and challenge necessary to safeguard highly vulnerable patients. Governance arrangements prioritised reassurance (comfort giving) over assurance (data and outcomes

based), and process over outcomes, resulting in delayed recognition of serious risk and preventable harm.

193. The Panel concluded that earlier and more effective Board intervention based on rigorous analysis of data and outcomes could and should have prevented the events that unfolded at MAH.

External Agencies Inspection and Oversight (Chapter 14)

194. We examined the role played by external organisations responsible for inspection, regulation, investigation and oversight of services at MAH. We concluded that, although multiple agencies were involved with MAH over many years, none succeeded in identifying, preventing or stopping abuse before it was revealed, exposing significant limitations in the external oversight framework.
195. Several agencies had statutory or quasi-statutory responsibilities relevant to MAH at various times but for much of the period of our Terms of Reference the RQIA was the principal external regulator of MAH following the transfer of the Mental Health Commission's functions in 2009.
196. Between 2009 and 2019, RQIA conducted over 100 inspections of MAH, initially at ward level and later using a whole-hospital approach. These inspections frequently identified problems such as staffing shortages, safeguarding weaknesses, excessive restrictive practices and governance failings. However, the inspection methodology relied heavily on documentation review and there was limited involvement with staff, patients and families, providing only a snapshot of practice.
197. Inspectors acknowledged that staff behaviour changed when inspectors arrived on the wards and that therefore they were unlikely to observe 'normal' ward culture. Despite having statutory powers to do so, RQIA did not review CCTV footage at MAH, even after CCTV was viewed by the Trust and by PSNI and serious concerns were raised. While it is accepted that review of CCTV footage may not form a part of every inspection, where concerns are raised the RQIA should be in a position and willing to ask to review a sample of the CCTV. The most critical RQIA findings

emerged only after abuse had already been uncovered, when there was a significant focus on MAH.

198. The Patient and Client Council was intended to represent the interests of service users and support families, including through complaints advocacy. However, prior to 2019, it had limited visibility of MAH as an institution, supported relatively few MAH-related cases and was largely unknown to many families.
199. Evidence to the Inquiry suggested that families repeatedly raised concerns through various routes but felt unheard, contributing to a loss of confidence in advocacy and oversight mechanisms.
200. PSNI's role differed fundamentally from that of regulatory bodies. Its statutory responsibility was to investigate potential criminal offences, operating through joint safeguarding protocols with health and social care services. Prior to 2017, hundreds of staff-on-patient incidents were reported to police, yet few resulted in prosecution and fewer still in conviction and penalty. Evidence indicated that allegations were often discounted for a multiplicity of reasons, which included the perception of patients as unreliable witnesses and the high evidential threshold for criminal proceedings.
201. Some staff who had reported matters to PSNI reported feeling ostracised by other members of staff and made to feel uncomfortable at work and were thus dissuaded from doing so again.
202. The extensive police investigation following the discovery of CCTV footage (Operation Turnstone) revealed the scale of abuse but has taken many years to progress and has still not been resolved, leaving families without timely, or indeed any, resolution.
203. Overall, the Panel concluded that external inspection and oversight failed to operate as an effective safety net. Warning signs, including staffing instability, increased violence, high use of restrictive practices and repeated complaints, were

visible and known but not interpreted as indicators of potential abuse. Oversight was reactive rather than preventive.

204. The central lesson is that external regulation and investigation must extend beyond procedural compliance and episodic inspection. For services caring for highly vulnerable people, effective oversight requires proactive, risk-based approaches that: examine culture; triangulate multiple data sources, including where appropriate the use of CCTV; engage directly with families and, where possible, patients; and act decisively when conditions associated with abuse are present.

Resettlement (Chapter 15)

205. The Bamford Review and, in particular, the Equal Lives report (2005) set out a transformative vision for learning disability services, centred on inclusion, person-centred support and community living. It set clear objectives and timelines for resettling long-stay hospital residents and closing institutional provision, supported by evidence that community-based care was both more cost-effective and associated with better quality of life. However, these ambitions were by no means fully implemented. Targets for resettlement were repeatedly revised, delayed or abandoned, with MAH remaining open far beyond the many planned closure dates of 2002, 2011, 2015, 2019 and most recently 2025.
206. The failure to deliver resettlement at pace stemmed from multiple, interrelated causes. These included: insufficient and poorly coordinated funding, particularly the lack of 'bridging finance' during the transition from hospital to community; fragmented responsibilities across government departments; misalignment between health, housing and social care funding streams; and the absence of a coherent regional commissioning strategy. Community infrastructure, such as supported living, day opportunities, and respite and crisis response services, was underdeveloped and inconsistent across Trusts, leading both to delayed discharges and avoidable admissions and readmissions to MAH.

207. The process of resettlement itself was variable. Where it was well planned, involving families, allowing adequate preparation and ensuring staff had the skills to meet complex needs, resettlement frequently succeeded. Evidence presented to the Inquiry, including independent evaluations and family testimony, consistently showed that many individuals experienced significant improvements in quality of life once living in the community, including greater autonomy, improved relationships, increased social participation and enhanced wellbeing. Most families who were initially apprehensive or resistant to resettlement later reported clear 'betterment'.
208. However, we also found serious weaknesses in the process of resettlement. Some placements failed due to poor assessment, inadequate preparation, insufficient staff training or lack of ongoing community support, resulting in distress and, in some cases, readmission to MAH. Families often felt marginalised, uninvolved, poorly informed and excluded from key decisions, and many were unaware of alternatives such as direct payments. Delays were particularly pronounced for individuals with the most complex needs, who frequently waited the longest for suitable placements, and some of whom continue to wait.
209. Following the exposure of abuse at MAH in 2017, resettlement efforts were further disrupted by crisis management within the hospital, staff suspensions and leadership instability. An independent review of the resettlement programme in 2022 concluded that leadership and governance had been inadequate, that oversight focused on monitoring rather than driving delivery, and that Belfast Trust in particular struggled to maintain progress in resettlement.
210. In part because of the managerial and political focus on MAH there is a real danger that inappropriate placements have been and will continue to be made to meet expedient needs rather than focusing upon the needs of the service user and betterment.
211. Although resettlement has demonstrably improved outcomes for many individuals, its delayed and inconsistent implementation prolonged unnecessary institutionalisation and risk. Without sustained commitment, coordinated planning,

adequate resources and meaningful involvement of families, the promise of policy reform was not fulfilled. The lessons from MAH underline the need for a robust, regionally coordinated resettlement strategy that prioritises individual needs, safeguards quality and resists expedient decision-making. Resettlement is far more likely to succeed where there is good co-production and full involvement of families and carers, the process is not rushed, and time is spent fully acclimatising the person. The individual must be fully assessed as to needs and staff fully trained.

212. Further there is a continuing need for an emergency respite service and crisis support teams to avoid failed resettlement and readmission to hospital.

Planning and Funding of Learning Disability Services in Northern Ireland (Chapter 16)

213. The Panel received evidence about the planning and funding of disability services.
214. Commissioning of services at MAH failed to consider the primary care and health promotion needs of people with learning disabilities and long-stay patients at MAH were left without primary care services.
215. No evidence was provided to the Inquiry that the impact of service reductions at MAH, including overall staffing and day care provision, was evaluated. Nor was there consideration of how the lack of community crisis intervention services contributed to costly inpatient admissions, a feature of the system that we heard about frequently from patients' relatives and staff.
216. Despite the fact that policy across Northern Ireland consistently endorsed the replacement of institutional care with community living and supporting services for those with learning disabilities well before the Bamford Equal Lives Review, we found there was a persistent gap between stated policy ambitions for community-based care and the practical realities of service delivery, funding and workforce capacity.

217. While the policy direction was clear, implementation was slow, fragmented and inadequately resourced.
218. Funding arrangements further constrained progress. From 2009 onwards, financial pressures intensified due to efficiency savings requirements and reductions in public spending. Attempts to change have been stifled by a lack of adequate funding and preparation of suitable community facilities and services. MAH continued to operate as a long-stay setting long after its reduction or closure had been envisaged. Resettlement was slower than policy aspirations and has still not been completed for all patients at MAH. Although overall expenditure on learning disability services increased, funding was constrained by rigid programme structures, squabbles between Trusts as to the funding of patients, and an inability to move resources flexibly from hospital to community provision. Investment in community infrastructure often lagged behind frequently stated policy aspirations to reduce inpatient capacity.
219. Although there were several structural changes that aimed to improve integration and accountability across the system, they did not generally result in more effective planning or delivery of learning disability services. Responsibility for commissioning, performance management and quality oversight was frequently dispersed, limiting clarity and responsiveness. The Inquiry found little evidence that learning disability services benefited from sustained, system-wide strategic planning.
220. Overall, we found there was a failure to align policy, funding, workforce planning and accountability that prevented meaningful transformation of learning disability services. The absence of a coherent, long-term, system-wide approach contributed directly to sustained institutionalisation of individuals at MAH and to risks in care quality and safety.

Managing the Delivery of Service for People with Learning Disabilities and Autistic People (Chapter 17)

221. We consider the way service delivery was organised and managed and how problems at MAH could and should have been identified.
222. While resettlement was a DoH priority, little consideration was given to how to provide a high-quality service at MAH until resettlement was completed. Failure to develop sufficient community service across the region led to continued requests for admissions, often in times of crisis, placing further strain on MAH's capacity and complicating efforts to progress resettlement.
223. In 2001 clinical governance was introduced across the UK and mandated in Northern Ireland in 2003, and we look at how the system of clinical governance, which includes the monitoring of quality, functioned. Monitoring of quality requires oversight. The organisational restructuring of the Trusts placed MAH several levels from direct oversight of the BHSCT Board and so the system depended heavily on accurate, timely information and clear accountability.
224. The complexity of BHSCT services meant it needed excellent data and governance to maintain effective operational oversight of the quality of care delivered at MAH. In reality the governance structures were ineffective and contributed to an environment where individuals in MAH were not adequately safeguarded.

Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty (Chapter 18)

225. Northern Ireland has a detailed legislative framework governing mental health, learning disability and deprivation of liberty. The Mental Health (Northern Ireland) Order 1986 (MHO) and the Mental Capacity Act (Northern Ireland) 2016 (MCA 2016), together with their respective Codes of Practice, articulate clear principles of dignity, least restriction, proportionality and respect for autonomy. They also provide mechanisms for detention, deprivation of liberty (DoL), review by an independent tribunal and external oversight. However, evidence before the Inquiry demonstrates that these protections did not translate into meaningful safeguards

for patients at MAH, where serious neglect, abuse, misuse of restraint and medication, loss of property and the risk of financial mismanagement occurred. Further, there was significant confusion expressed by relatives as to the rights of themselves and patients at MAH under the law to challenge admission or continued detention.

226. Detention under the MHO 1986 is not capacity-based and allowed individuals with learning disabilities to be detained for lengthy periods without a structured best-interests analysis. Although the MCA 2016 represents a significant and progressive reform, centred on presumption of capacity, best interests and graduated safeguards, its impact during the Inquiry period was limited. The Act was only partially commenced in 2019, near the end of the relevant time frame. Full implementation has yet to occur, leaving an unresolved and confusing interface between the MHO 1986, the MCA 2016, common law principles and the High Court's inherent jurisdiction.
227. Until now there has been no specific legislation focusing upon adult safeguarding in Northern Ireland. The draft Adult Protection Bill represents an important development, creating an Adult Protection Board, providing additional protections for adults at risk of harm and imposing specific duties upon Trusts to make inquiries and intervene where an adult may be at risk. Other welcome developments include introducing an obligation to ensure there are sufficient Adult Protection Social Workers to carry out necessary functions and ensure that they are competent to do so.
228. However, the Panel considered that, as currently drafted, the enforcement mechanism relating to provider liability based on proof of a 'gross breach' by the organisation may be difficult to establish and unlikely on its own to drive meaningful improvement in patient safety. We have suggested an alternative approach placing the onus upon Trusts to demonstrate that they have taken all reasonable and practical steps to avoid the breach that occurred. This would place a duty upon Trusts, not simply to have policies in place, but to be able to demonstrate a proactive approach to ensuring the outcomes of the policies are audited and shown to be as effective as possible.

229. The Bill also does not address critical gaps identified by the Inquiry, including the absence of adult safeguarding as a delegated statutory function and the lack of a statutory duty of candour, although we understand that in the latter regard the issue is currently under consideration in the Assembly. We recommend such a duty is imposed throughout the system.

Redress

230. There is one aspect of our Terms of Reference (ToR) we have not addressed in the main report and only do so here. That is that under ToR 24 (g) we may, dependent upon our findings, make recommendations in relation to the requirement or desirability of the provision of redress to meet the particular needs of victims of abuse within MAH. First, we note the specific terms of this paragraph in the ToR and that it focuses on the victims of abuse within MAH. We received limited submissions from Core Participants in relation to this paragraph of the ToR and no evidence was submitted to assist the Panel (nor did we invite any).
231. There is no doubt that patients did suffer as a result of abuse within MAH but to try to assess the extent of such abuse in relation to individual patients or the nature of the harm caused is sadly beyond our capacity. One form of partial redress for the victims of the abuse at MAH would be the betterment of their remaining lives outside of MAH and ensuring that such abuse can never take place again in Northern Ireland, which can best be achieved by implementing the recommendations we have made in this report. In relation to direct redress, including the consideration of financial compensation, however, our recommendation would be that the DoH should set up a small working party to consult with patients, service user groups and individuals connected to those who have suffered abuse at MAH in relation to what form redress might properly take.

Conclusion

232. One witness, a nurse and sister to a service user at MAH, reflected upon her experience with MAH:

'The entire system must change, mindsets must change, and people with learning disabilities must be viewed as valuable members of society in their own right, instead of lesser beings who do not feel pain or are just there for other's amusement. If this mindset is not changed then abuse will not end with the planned closure of MAH but will continue in other institutional settings.

The Belfast Trust and other agencies, such as Adult Safeguarding, RQIA, PSNI, HSENI, and other professional bodies must share the awful blame for ignoring and allowing the continuation of these terrible abuses. It is incumbent upon them all and this Inquiry to ensure that a repetition of these events cannot and will not happen again. It has suited Belfast Trust to allow MAH to remain a place apart and for these vulnerable people to be kept out of the public eye. Also, for families to be actively discouraged from participating in their relatives care by telling them that the professionals know best and can provide best care.

Families should be encouraged to interact with others rather than being kept apart. Only if all these things are taken on board, changed, and actively pursued will care in the future look better for our loved ones and allow them to live brighter much enriched lives. We owe it to them all'.⁷

233. We are grateful for the opportunity to have examined the wider system and cultures that led to the abuse, neglect and poor care provided to some patients at MAH.
234. We have tried to focus on the big picture, the systemic and organisational issues that resulted in the abuse, rather than focusing upon the individuals who behaved as they did. Focusing on the organisational and cultural issues is in our view the only way that abuse, neglect and poor care are likely to be avoided in the future. This is true not only for a large institution such as MAH but all the smaller facilities offering care to those with learning disabilities and autistic people.
235. MAH, we expect, will soon discharge and resettle its few remaining patients (and may have done so by the time of publication). But this report must inform all other institutions providing care to individuals with learning disabilities across Northern Ireland and hopefully elsewhere. The consequences of allowing the

⁷ P90's Sister Transcript – 11/10/23 – Page 124 – Line 14

circumstances that led to the abuse and neglect seen by this Inquiry to arise again do not bear consideration.

236. The often-quoted phrase attributed to Mahatma Ghandi is as relevant now as it ever was: 'The true measure of any society can be found in how it treats its most vulnerable members'. There is a high duty to look after the most vulnerable members of our society, and those with learning disabilities and autism are entitled to the same human rights as other citizens and deserve to be supported to live full lives with dignity, care, kindness and humanity. We hope this report will assist those responsible for their care to bring that into reality.

A handwritten signature in blue ink, appearing to read 'Tom Kark', with a horizontal line underneath.

Tom Kark KC
Chair

THE INQUIRY TEAMS

Current and past

Counsel to the Inquiry

Sean Doran KC

Secretaries to the Inquiry

Steven Montgomery

Jaclyn Richardson

Counsel Team

Denise Kiley KC

Mark McEvoy BL

Sophie Briggs BL

Shirley Tang BL

Rachel Bergin BL

James Toal BL

Judith Coulter BL

Thomas Stewart BL

David McAvoy BL

Rachel McGookin BL

Secretariat Team

Catherine-Anne Andrews

Finola Friel

Claire Hylands

Daniel McCarthy

Laura Boyd

Kerry Close

Karen McGuigan

Ray Mullan

Cara O'Doherty

Niamh Proctor

Yvonne Worthington

Solicitors to the Inquiry

Stephanie Kennedy

Lorraine Keown

Joan MacElhatton

Researchers

Emilia Ashley

Anne McNulty

Solicitor Team

Orla Henderson

Rachel Nethercott

Julieanne Coleman

Mairead McDowell

Leeanne Thornton

Colette Tubridy

Security

Gerard 'Rab' Kelly

David 'Davy' Rainey

RECOMMENDATIONS

	General Implementation – 3 recommendations	Organisation/s responsible for implementation
R1	The implementation of the following recommendations should be monitored by the DoH and progress should be reported to the DoH Permanent Secretary. To ensure progress is made, an implementation consultation group, which should include service users and the relatives of service users, should be created and be involved in the monitoring and reporting process.	DoH
R2	The DoH should indicate publicly within six months of this report which recommendations it accepts and those it does not accept (and why). This should include the recommendations for all organisations for which the DoH holds primary responsibility. In relation to those recommendations that are accepted, any not implemented, or where there is a failure substantially to progress the recommendation within 12 months, should be brought to the attention of the DoH Permanent Secretary.	DoH
R3	With the exception of Recommendations 88 and 89 (R88 & R89) any other organisation that does not accept a recommendation for which it is named as responsible, should write within three months of this report to the DoH Permanent Secretary to explain why it does not accept the recommendation. In respect of any recommendation not implemented or where there is a failure substantially to progress the recommendation within 12 months, that should be brought to the attention of both the DoH Permanent Secretary and the Minister of Health.	HSCTs; RQIA; PCC
Chapter 2 (Admission of Patients to MAH) – 3 recommendations		
R4	Prior to the decision to move a service user to a different facility there must be discussion with the staff regularly caring for them, the relevant multidisciplinary team (MDT), the person's family where practicable and the person themselves where possible, to consult with them about the potential move.	HSCTs, private and 3 rd sector care providers
R5	Any service user with a learning disability should have a named person (a key individual) responsible for their care plans and this person should be involved in and record the discussion with the family and the discussion with any relevant MDT and sign off the final decision. (And see Recommendation 99 (R99) below.)	HSCTs, private and 3 rd sector care providers
R6	The named person responsible for the care plan must both review and approve the preparation of anyone with a learning disability transferring to a new environment within or external to the Trust in which they are cared for. This approval must be recorded in the healthcare notes.	HSCTs

Chapter 3 (Care and Treatment at MAH) – 5 recommendations

R7	While patients remain in hospital pending resettlement, there should be a focus on enhancing their independent living skills, tailored to their physical and mental capacity.	HSCTs
R8	Medication should never be used simply to subdue people in the absence of other forms of treatment and good quality care. DoH should issue a regional audit pro forma to measure compliance with National Institute for Health and Care Excellence (NICE) guidelines and Trusts should conduct quarterly audits. These audits should be part of an RQIA review as well as an agenda item at the accountability meetings with the Permanent Secretary of Health.	HSCTs; Chief Pharmaceutical Officer of the DoH
R9	Each facility or service should have an integrated workforce plan that includes all allied health professionals (AHPs) and all staff involved in patient care. This should be based upon the assessed needs of the service user and must include protected time for staff to consult with each other.	HSCTs, private and 3 rd sector care providers
R10	It is critical for the wellbeing of people with learning disabilities and autistic people that they are well supported by, and have access to, AHPs including psychologists, speech and language therapists (SALTs), occupational therapists (OTs), podiatrists and dieticians. These AHPs need to be well integrated into daily life in service users' homes and their recommendations, including positive behaviour support plans, need to form part of care plans.	HSCTs
R11	Like anyone else, people with learning disabilities and autistic people require a variety of meaningful activities on a daily basis to enhance their quality of life. Every person should have an individualised activity schedule, including leisure activities and skill-building activities, and staff should be trained in 'active support' so that they can deliver this.	HSCTs, private and 3 rd sector care providers

Chapter 4 (Care Planning and Record Keeping) – 5 recommendations

R12	Care plans must be live, person-centred documents. This requires joint ownership with people with learning disabilities and their families rather than simply professional records. While professionals necessarily lead assessments, families should be actively involved in identifying needs. Resulting care plans should be shared with the service user themselves (where appropriate) and families, who should be able to challenge and further contribute to them. People with learning disabilities and/or families should receive a copy of the care plan at agreed intervals and whenever significant changes occur.	HSCTs; private and 3 rd sector care providers
R13	All staff involved in delivering care, including healthcare assistants (HCAs), must have full access to the care plan.	HSCTs; private and 3 rd sector care providers
R14	Observation records detailing all use of restraint and seclusion should be completed by the individual observing. In HSCT facilities, if the observer is unregistered, a registered staff member should countersign the entry rather than create a second-hand record. In private and 3 rd sector facilities the individual in charge of the shift must countersign and report to the Registered Home Manager at the earliest reasonable opportunity. Sufficient electronic terminals should be available to ensure easy access for inputting records for all staff.	HSCTs; private and 3 rd sector care providers

R15	Care plans should be regularly evaluated to assess their impact on people's wellbeing. This is the responsibility of the care team and should include formal, documented input from the service user themselves (where appropriate) and families. Additionally, there should be regular independent reviews overseen by the Public Health Agency (PHA) to assess any deviation from best practice, both in the written plan and in daily care delivery. These reviews should be shared with people themselves and families.	HSCTs; PHA; private and 3 rd sector care providers
R16	If a care plan cannot be delivered due to issues, such as staffing shortages, this should be recorded as 'missed care' using the Trust's or organisation's incident reporting system.	HSCTs; private and 3 rd sector care providers

Chapter 5 (Information Sharing and Co-Production) – 6 recommendations

R17	Creating a co-produced care environment, where people with learning disabilities, families and professionals work collaboratively, requires a fundamental shift in practice. As well as organisational commitments, staff will need education and facilitation to transition to this way of working. Specific training in co-production should be designed and delivered to all those caring for people with learning disabilities and autistic people. Service users and families should be offered the opportunity to attend where appropriate.	DoH/SPPG
R18	Specific processes rather than policies should be designed to ensure there is good communication with families and carers to ensure co-production takes place and is effective. Evidence of co-production should be an element of clinical audit of people's healthcare records.	CNO; CSWO
R19	The 2006 Quality Standards for Health and Social Care should be amended to require HSC organisations to provide all people with learning disabilities, and if they lack capacity, their family or advocate, with the opportunity to share in all decision-making about their care plan, including assessments, treatment plans, evaluations of care and placements. The RQIA should include performance against the new standard in its announced inspections.	DoH/SPPG; RQIA
R20	Properly trained independent advocates should be made available to service users and families to support effective communication with staff and for raising concerns and complaints. DoH/SPPG should specify the level of advocacy services required for people with learning disabilities in the annual commissioning plan.	DoH/SPPG
R21	All providers of learning disability services should appoint a human rights officer, as seen in Sheffield Health Partnership University NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust. This role should support staff and monitor the progress of the service towards a human rights-based, co-produced service.	HSCTs
R22	All documents relevant to the service user's experience and intended for their information must be made available in Easy Read format.	HSCTs, private and 3 rd sector care providers

Chapter 6 (Patients' Property and Finance) – 5 recommendations

R23	All organisations taking responsibility for property and/or finance for people with learning disabilities and autistic people should institute regular checks of adherence to their policies. This includes local checks, corporate checks and periodic internal audit checks.	HSCTs, private and 3 rd sector care providers
R24	Policies must be specific as to records to be kept and for routes to disclosure for relevant family members and people with learning disabilities and autistic people themselves where possible.	HSCTs, private and 3 rd sector care providers
R25	The records kept must be easy to manage by staff and easily comprehensible to others, including people with learning disabilities and autistic people, carers and relatives.	HSCTs, private and 3 rd sector care providers
R26	Information about the use of cash and other property and six-monthly accounts (or such period as appropriate upon discharge of the person) should be available to the service user concerned where possible and to the family where appropriate. Where appropriate an Easy Read version should be made available.	HSCTs, private and 3 rd sector care providers
R27	RQIA should examine the provider organisation's internal assurance processes and make recommendations where they are insufficient.	RQIA

Chapter 7 (Restrictive Practices) – 10 recommendations

R28	The Restraint Reduction Network identifies six principles to avoid the use of restrictive practice. While there is evidence that some Trusts have adopted these principles, further action is needed to ensure the principles are fully embedded. These principles must be embedded in policies and practices. The principles are: i. Organisational commitment – led by executive directors ii. Performance monitoring – using metrics to track restrictive practices iii. Human rights-based education – comprehensive training for staff iv. Personalised reduction plans – tailored strategies for individual patients v. Service user involvement – engaging patients in shaping restraint reduction strategies vi. Post-incident support and learning – structured debriefing and reflection for both patients and staff	HSCTs; private and 3 rd sector care providers
R29	All facilities providing residential services for people with learning disabilities and autistic people should provide sufficient psychology input for each patient, to obviate the need for restrictive practices in all but the most exceptional circumstances.	HSCTs, private and 3 rd sector care providers
R30	HSCTs should appoint a non-executive director (NED) to act as a champion for restraint reduction, with a mandate to hold executive directors accountable for delivery.	HSCTs
R31	The effectiveness of the education programme for staff in relation to restraint reduction should be measured through defined data metrics. This is to ensure that every instance of restraint is clearly justified and appropriately utilised.	NIPEC

R32	HSCTs should implement a comprehensive set of balanced performance measures across all services for people with learning disabilities, including those commissioned from third-party providers. These measures should include: • Trends in the use of restrictive practices • Trends of aggressive behaviour incidents, including peer-on-peer aggression and patient-on-staff aggression • Positive experience, including quality of life measures.	HSCTs
R33	To ensure meaningful interpretation of these trends, all HSCTs should adopt statistical process control (SPC) charts, as developed by Walter Shewhart in 1939. SPC charts use calculated upper and lower control limits to distinguish between normal variation in a stable process and significant long-term shifts in performance. These charts provide a clear visual flag as to when further investigation is warranted, promoting a data-driven approach to service improvement.	HSCTs
R34	All HSCTs should develop two clear operational debriefing policies. The first should apply to both staff and people with learning disabilities and autistic people who are involved in, or affected by, aggressive behaviour. A separate debriefing after any restraint or seclusion incident should also be developed. This should include both staff and people with learning disabilities and autistic people, and should specify that debriefing should be facilitated by staff outside of the immediate service delivery unit.	HSCTs; private and 3 rd sector care providers
R35	Given the elevated risk of inappropriate use of restrictive practices with individuals with learning disabilities and/or autistic people, BHSCT and all HSCTs should automatically place any inpatient facility or facility for people with challenging behaviour on its risk register.	HSCTs; private and 3 rd sector care providers
R36	Use of seclusion should be considered an extraordinary and exceptional intervention. Each intervention should be subject to a serious event audit, conducted by a professional outside the service provider's learning disabilities services. This audit should be shared with the person's next of kin and the RQIA.	HSCTs; private and 3 rd sector care providers
R37	Education and training on the use of restrictive practices should be grounded in human rights principles and the dedicated human rights specialist appointed in accordance with Recommendation 21 (R21) should work with staff on this approach.	HSCTs; private and 3 rd sector care providers

Chapter 8 (Complaints and Concerns) – 7 recommendations

R38	People with learning disabilities and autistic people and their families should be provided with clear, written information outlining the available pathways for raising concerns. This information should clearly distinguish between an enquiry, a concern and a complaint. Individuals should then be asked to select the option that they feel best aligns with their needs. This selection should be recorded at ward or residential level and confirmed with the individual raising the issue.	HSCTs; private and 3 rd sector care providers
R39	People with learning disabilities and autistic people and their families should be provided with a short description of how best to record and present concerns so as to be effective.	HSCTs; private and 3 rd sector care providers
R40	In HSCTs all complaints, regardless of whether they are resolved immediately at ward level, should be recorded in the Trust's electronic complaints management system. In private and third sector facilities the Registered Home Manager should be informed of all concerns raised and must record such concerns and any action taken.	HSCTs private and 3 rd sector care providers

R41	Complainants should immediately be informed of how their complaint will be managed (locally or through the corporate complaints process) along with a clear explanation of the corresponding level of investigation and oversight this entails.	HSCTs; private and 3 rd sector care providers
R42	Complainants must be regularly updated and informed of the progress of any investigation, including when the process concludes without a specific finding.	HSCTs; private and 3 rd sector care providers
R43	All complaints managed at corporate level and rated as red (using the red, amber and green (RAG) rating matrix) should be shared with all non-executive directors (NEDs) on the Board.	HSCTs
R44	Complaints alone are a poor indicator of quality of care, particularly in a vulnerable population such as those admitted to MAH. A low volume or absence of complaints does not necessarily indicate that care provided is good or satisfactory. Organisations must find proactive approaches to assure themselves and the public that high standards of care are being provided, such as using a validated system to explore the experience of people with learning disabilities and autistic people on a quarterly basis, including regular person and family surveys or interviews. In a learning disability setting, interviewers must be trained in effective methods of communication. Complaints should be analysed for themes quarterly and triangulated with themes from incident reporting and RQIA inspection reports, and displayed on a public dashboard as well as online.	HSCTs, private and 3 rd sector care providers

Chapter 9 (Previous Concerns, Previous Investigations and Warning Signs) – 4 recommendations

R45	Incident reports of any violent or aggressive behaviour by either people with learning disabilities and autistic people or staff should be analysed and trend data reported on every HSCT Board's quality and safety dashboard. In private and third sector care a similar system must be in place.	HSCTs, private and 3 rd sector care providers
R46	Where people with learning disabilities can participate, the provider should actively seek their lived experience feedback in relation to staff attitudes and behaviours on a quarterly basis through an external and independent agency (perhaps to be undertaken by the PCC), and report this to a public part of a Board-level committee and also publish it on the provider's website.	HSCTs and PCC
R47	The provider should actively seek family or carer feedback on the service user's experience on a quarterly basis via an external agency and report the findings to the public part of a Board-level committee minutes (where these exist) and publish them on the provider's website.	HSCTs, private and 3 rd sector care providers
R48	HSCTs must review and improve governance of safeguarding to ensure that findings from different safeguarding investigations are considered holistically, synthesised and presented to the public part of a Board-level committee.	HSCTs

Chapter 10 (CCTV, 2017 Revelations and the Response) – 12 recommendations

R49	Hospital settings for people with learning disabilities and autistic people are very high-risk environments for abuse and poor practice, partly because those admitted tend to show high rates of challenging behaviour. Therefore, all such settings (including community-based settings for those with challenging behaviour) should consider the installation of CCTV in the public areas, for the protection of vulnerable individuals and for staff. There should be appropriate consultation with families and the service users themselves as to the installation and use of CCTV in any facility where those with learning disabilities and with challenging behaviours are resident.	HSCTs; private and 3 rd sector care providers
R50	Guidelines should be agreed in relation to providing CCTV systems in residential and day services where requested. Guidelines should be agreed by HSCTs, resettlement service providers, families and people with learning disabilities about the use of CCTV in public areas and in some circumstances in private areas such as bedrooms and bathrooms, alongside strict controls on access to the footage.	HSCTs; private and 3 rd sector care providers
R51	The installation of CCTV in non-public areas should be considered only where this will be in the best interests of the individual service user and following full consultation taking the views of relevant carers, service users (where possible) and relatives fully into account.	HSCTs; private and 3 rd sector care providers
R52	Policies governing the use of CCTV should be agreed only after consultation with staff, residents and their families using the service.	HSCTs; private and 3 rd sector care providers
R53	Policies should include careful consideration of the circumstances in which the CCTV should be viewed; for example, that it should be viewed when concerns are raised by residents, families or staff about abuse or maltreatment.	HSCTs; private and 3 rd sector care providers
R54	Viewers of the CCTV should be independent of the setting, i.e. not involved in day-to-day care of the residents.	HSCTs; private and 3 rd sector care providers
R55	Oversight of the CCTV analysis should sit outside the setting in which the CCTV is recording, and should include audits of referrals and outcomes.	HSCTs; private and 3 rd sector care providers
R56	Policies should include clear guidance and definitions of behaviour and circumstances in which information should be passed to PSNI about possible offences.	HSCTs; private and 3 rd sector care providers
R57	Policies should be clear about the circumstances in which a regulator, such as RQIA, could access the CCTV.	HSCTs and RQIA; private and 3 rd sector care providers
R58	Those drafting the policy should consider whether CCTV could ever be used for staff training and, if so, how this would be done.	HSCTs and professional officers of the DoH; private and 3 rd sector care providers
R59	All service users and their families should have the CCTV explained to them in easily understood language and with easy access materials, so that they are aware that it is for their protection, and so that they understand when it can be accessed and by whom.	HSCTs; private and 3 rd sector care providers

R60	All staff should receive training on the reasons for the use of CCTV and the processes for its analysis.	HSCTs; private and 3 rd sector care providers

Chapter 11 (Safeguarding) – 8 recommendations

R61	Vulnerable children and adults are inherently more susceptible to abuse or neglect than other people. Adult safeguarding should be formally recognised as a statutory function, equivalent to child protection.	DoH and NI Assembly
R62	Metrics on both child and adult safeguarding processes should be reported monthly via a safeguarding dashboard, with the same visibility and status as monitoring elective surgery or emergency department waiting times. These metrics should be publicly available.	HSCTs
R63	Incidents of peer-on-peer abuse should be included in adult safeguarding metrics and included on a published safeguarding dashboard.	HSCTs
R64	The dashboard should include the number of allegations reported, together with the screening decision (referral to the Adult Safeguarding Gateway, referral to the joint protocol or no further action). Particular scrutiny should be given to allegations of abuse by staff that are screened out due to lack of supporting evidence. The DoH Northern Ireland should develop such a dashboard to be used across the health and social care sector within six months.	DoH/SPPG, HSCTs
R65	There should be common standards for the conduct of safeguarding investigations. These should be drafted and approved by the Northern Ireland Adult Safeguarding Partnership (NIASP) and adopted by the DoH as policy.	NIASP and DoH
R66	A quarterly multidisciplinary audit of 10% of safeguarding files per ward or residential unit should be conducted. Findings must be integrated with incident data and reported to the Executive Team, NEDs and the Strategic Planning and Performance Group (SPPG).	HSCTs
R67	Where there is evidence or suspicion of widespread abuse involving multiple staff and residents, focusing solely on individual perpetrators is insufficient. An independent review of enabling conditions should be conducted separately from case-specific or PSNI investigations. This review must be led by investigators with appropriate expertise in safety science to support rapid system-level changes. PHA, in conjunction with the Chief Social Work Officer (CSWO), should issue guidance for such reviews.	HSCTs; PHA; CSWO
R68	Protection plans should include an assessment of risks arising from the plan itself. Where multiple protection plans are in place for vulnerable adults within a single unit, cumulative risks arising from those individual protection plans across all residents must also be evaluated.	HSCTs

Chapter 12 (Staff and Ward Management) – 6 recommendations

R69	Staffing should be based on service user needs rather than a fixed budget, using daily acuity measures designed specifically for units caring for people with learning disabilities. These should include enhanced supervision requirements, personal care support and therapeutic activities. Service managers should receive weekly reports of data of the staff hours needed per day per ward or facility. Monthly reports of these figures should be published by ward or facility by the Department of Health (DoH). This should apply to all facilities in which people with learning disabilities are resident, including private and third sector provision.	HSCTs; DoH; private and 3 rd sector care providers
R70	Clinical supervision (where individuals' practice with individual patients is discussed) should be mandatory for all ward staff, including healthcare assistants, and should occur monthly. Clinical supervisors should be trained in the conduct of sessions and the outcomes for continuing development should be recorded on personal files.	HSCTs; Clinical Education Centre (CEC)
R71	All healthcare assistants working with people with learning disabilities and autistic people should be provided with training, which should include specialist learning disability training as well as basic positive behaviour support (PBS). They should be required to complete successfully an examined course (with particular focus on behaviours that challenge) within six months of appointment, in addition to their induction. Consideration should be given to creating a Northern Ireland-wide course.	CNO; CEC
R72	SPPG must commission a review of the potential models for supervision of staff in private and third sector services commissioned by HSCTs, including all associated costs.	SPPG
R73	Consideration should be given to enhancing the post of healthcare assistant by creating Band 4 associate practitioners in both hospital and community settings in order to increase the skills of those providing the majority of direct care, and also to provide a career pathway that will retain these staff. Such posts must be in addition to, and not a substitution for, the correct number of registered nurses.	HSCTs; DoH
R74	Consideration of staffing (including skill mix as well as total numbers) should be a mandatory part of safeguarding investigations in all settings.	HSCTs

Chapter 13 (Senior Management and Trust Board Governance) – 7 recommendations

R75	There must be understanding of both individual untoward events but also (and more importantly) systems and trends. Creating and maintaining effective governance for complex systems requires specialist skills. While this is largely recognised within finance governance, only superficial consideration is given to clinical and social care governance. Boards should appoint an Executive Director of Clinical and Social Care Governance because of their specialist training and expertise in this area (rather than assign it to the existing clinical or social care leads and then provide top-up training). The DoH must produce guidance in relation to the necessary competency and skills for this role.	HSCTs; DoH

R76	NEDs should be selected for their expertise across a range of skills and at least one should have extensive experience of clinical or social care governance and be appointed as a senior independent director with that responsibility. The DoH should make training in Board-level clinical and social governance available to all NEDs.	HSCTs; DoH; HSC Leadership Centre (HSCLC)
R77	The DoH Permanent Secretary should commission triennial reviews of each Board's collective performance in clinical and social care governance.	DoH Permanent Secretary
R78	HSCT Board audit committees should consider all internal audit recommendations and require directorates to provide updates on implementation three months, six months and one year after the internal audit report is received, and three monthly thereafter if still not fully implemented.	HSCTs
R79	The DoH should commission the HSC Leadership Centre to develop a learning framework for all Board members. All Trust Board directors should be required to undertake an examined course in governance (including both financial and clinical/social care governance, including patient safety). Annual assessments as to the effectiveness of Board performance should be undertaken by PHA.	DoH; HSCLC; PHA
R80	Consideration should be given to the creation of a role for a NED in each HSCT with the specific remit to receive confidential reports from members of staff. The individual should receive training via a programme focused on safeguarding and patient safety. It should be the duty of that NED to actively to seek out information and to ensure there are various routes by which staff at every level can report, anonymously if necessary, concerning behaviour or issues that could put patient safety at risk.	HSCTs
R81	The DoH should establish an expert clinical/social governance advisory function to support providers.	DoH

Chapter 14 (External Agencies Inspection and Oversight) – 8 recommendations

R82	RQIA should consider developing a risk-based way of predicting which services are in difficulty. It is well known that certain aspects of services tend to be associated with abuse: service users who are vulnerable, who have few communication skills; service users with behaviour that challenges; services with poorly trained staff, insufficient staff, poor staff management, high sickness levels and high use of agency staff. Every inspection in services for these vulnerable populations must include a line of enquiry focusing on the possibility of abuse. This would be informed by a live dashboard, which should include warning signs such as staff shortages, the high use of agency staff and peer-on-peer abuse, by way of example.	RQIA
R83	The RQIA needs to reconsider whether to make use of CCTV when it is in operation in a service it is inspecting where concerns have been raised.	RQIA
R84	RQIA needs to consider adopting a measure of service culture specific to learning disability services for use in its inspections. Such measures have already been developed for learning disability residential settings.	RQIA
R85	RQIA needs to spend proportionately more time talking to patients/residents, and its staff need to be trained in specific communication techniques such as Makaton and Talking Mats.	RQIA
R86	The PCC should support service users/families and provide information on what constitutes good quality care for people with learning disabilities and autistic people, and how to spot when care is falling short.	PCC

R87	The PCC should take further steps to ensure that health service users, including carers and families of people with learning disabilities and autistic people, are aware of its statutory functions and the assistance it is required to provide with respect to complaints.	PCC
R88	PSNI needs to improve its processes for the review of live investigation files, and have an effective escalation process when progress is delayed. PSNI should consider how it assures the quality of the reviews of live investigation files. Senior officers should assess a significant sample of reviews to ensure all possible action has been taken to conclude the investigation and that delays are escalated promptly.	PSNI
R89	The Department of Justice should review the timeliness of the handling of each aspect of the prosecution system that has led to the delay in bringing those accused of causing harm to patients to trial.	Department of Justice

Chapter 15 (Resettlement) – 11 recommendations

R90	A regional standing committee of people with learning disabilities and autistic people and their relatives should be established, to be consulted by the DoH and other bodies on services for learning disabilities and autistic people. This should be funded by DoH and potentially facilitated by the PCC. The participants in this committee should be reimbursed for taking part.	DoH/SPPG
R91	There needs to be a recognition that those service users in Northern Ireland yet to be resettled (if there are any by the time of publication of this report) will require a higher level of funding due to their needs and behaviour that challenges. A highly qualified team must be formed to progress their resettlement. An example of such a model might be the special development team in England.	DoH/SPPG
R92	Families should be provided by the relevant Trust with a time frame for resettlement and relevant financial information. Families should also be afforded an appropriate amount of time to consider resettlement options.	HSCTs
R93	There needs to be a clear regional view of all services available in the community, especially given the variety of services and providers of services now available. The service map recommended in 2022 must be regularly updated to reflect available services and vacancies, searchable by both families and care managers.	HSCTs/DoH/ SPPG
R94	There will be a continuing need, which must be met, for new and ongoing community-based support for young people and adults with learning disabilities and autistic people whose families become unable to cope full time. This means there is a continuing need for a range of types of provision and well-coordinated support services in addition to the usual community learning disability team. These will include intensive support teams, community forensic teams, assessment and treatment services in the community, and emergency respite services. The availability of these must be monitored and published on the DoH website. These teams and services, some of which exist in parts of Northern Ireland but not all, need to have open referral systems, so that families can self-refer.	HSCTs/DoH/ SPPG
R95	HSCTs must develop registers of those at risk of requiring unplanned inpatient treatment, similar to the NHS England 'blue light protocol', in order to target community resources efficiently and prevent the person having to leave their home in the community.	HSCTs

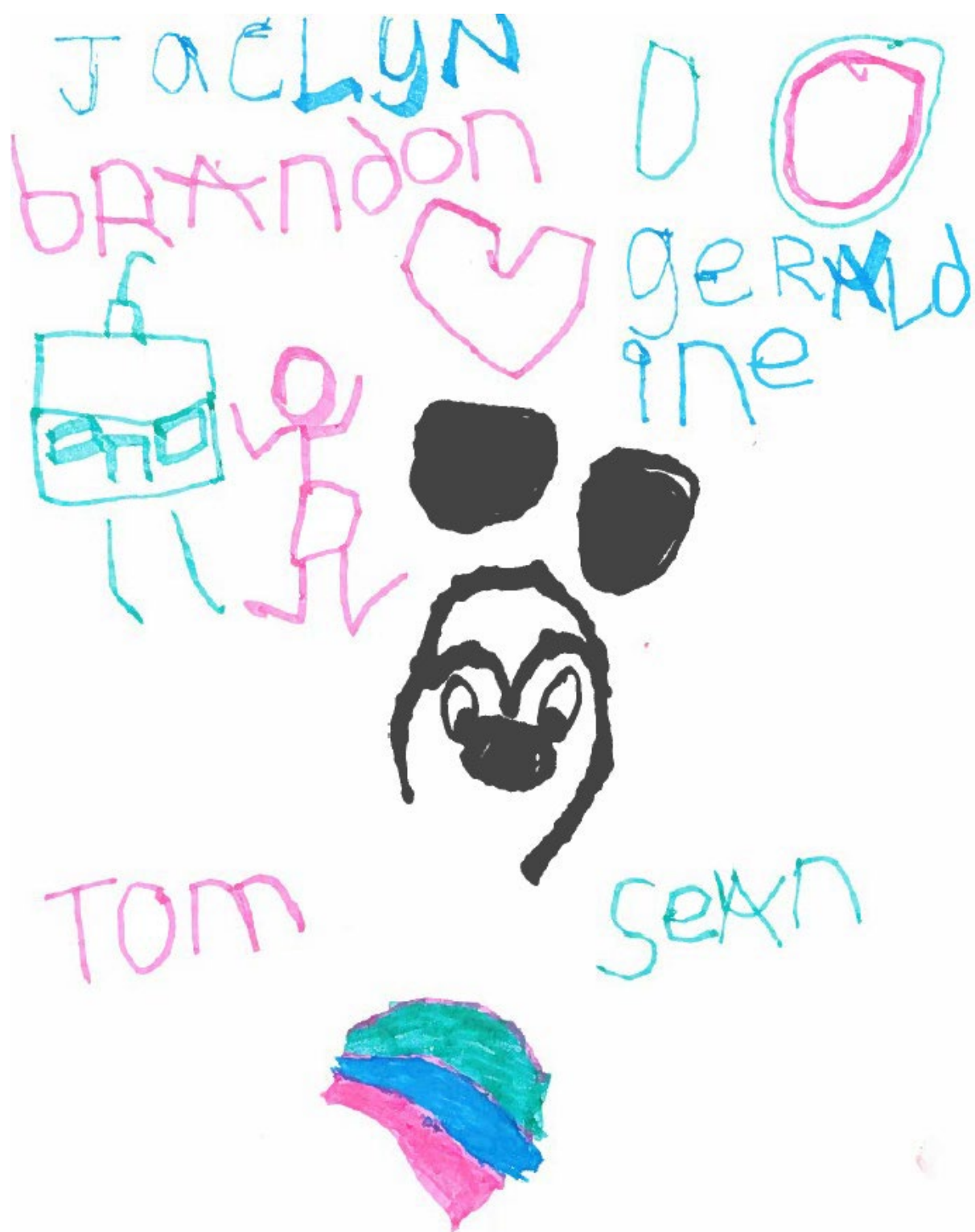
R96	SPPG must ensure that people with learning disabilities and autistic people have access to mainstream (i.e. the same services that are available to those without a learning disability) mental health services, with appropriate adjustments for their disabilities.	DoH/SPPG
R97	The SPPG must ensure that commissioning includes provision for people with learning disabilities and autistic people cared for in any facility to have fully funded access to primary care services. These may be provided by LD nurse practitioners/LD nurse consultants. Local commissioning groups (LCGs) should monitor this provision.	DoH/SPPG/LCGs
R98	The DoH must devise ways to recruit and retain more allied health professionals and social care staff in the community for autistic people and people with learning disabilities.	DoH/SPPG
R99	Communication between the HSCTs and/or resettlement service providers and families and people with learning disabilities should be more open and transparent. Each service user/family should have appointed to them a key individual who is responsible for ensuring both the family and the service user are consulted and kept informed in relation to considerations of resettlement, including the staff training of the proposed resettlement. The key individual should also be in a position to assist with advice on direct payments. (See also Recommendation 5 (R5) above.)	HSCTs
R100	Trusts, private and 3 rd sector care providers must ensure that person-centred day activities (including supported employment where appropriate) should be available and offered to all people with learning disabilities and autistic people. This should be monitored through Trust delivery plans.	HSCTs; private and 3 rd sector care providers

Chapter 16 (Planning and Funding of Disability Services in NI) – 3 Recommendations

R101	Planning and commissioning services for people with learning disabilities and autistic people should be done as a single process across the whole system (including primary care, housing, benefits and independent and third sector providers of services). There must be a risk assessment that assesses how the impact of change in one part of the system impacts on another part (e.g. how failure to invest in community early intervention services impacts on resettlement). The risk assessment should be multi-agency and include housing, private and third sector providers as well as health and social care.	DoH/SPPG; NIHE and DfC
R102	DoH should establish a comprehensive, centralised workforce intelligence function, similar to those in the rest of the UK, within 12 months of the publication of this report. The learning disability service model must include a fully funded, comprehensive workforce model, together with a transition plan to enable the current workforce to deliver the new model.	DoH
R103	A live dashboard of performance, quality and safety indicators within learning disabilities must be developed and made publicly available within 12 months of the publication of this report.	DoH/SPPG

Chapter 18 (Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty) – 2 recommendations

R104	A statutory duty of candour should now be enacted in Northern Ireland so that: (i) Every healthcare organisation and everyone working for them must be open and honest in all their dealings with service users and the public. (ii) Where harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances. (iii) Full and honest answers must be given to any question reasonably asked about treatment by a service user (or duly authorised representative). (iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission. (v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission. (vi) Healthcare organisations that believe or suspect that treatment or care provided by them has caused harm to a service user must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances. (vii) Registered clinicians and other registered healthcare professionals who believe or suspect that treatment or care provided to a service user by, or on behalf of, any healthcare organisation by which they are employed has caused harm to the service user must report their belief or suspicion to their employer as soon as is reasonably practicable.	DoH
R105	Consideration should be given to a different approach to the prosecution of organisations for failing to prevent deliberate harm being caused by their employees, such as by applying a reverse burden to the offence. This would require any organisation, such as an HSCT, to prove that, where deliberate harm had been caused to a service user by any individual employed by that organisation, that it had taken all reasonable and practicable steps to prevent such deliberate harm to service users, or alternatively, that that it was not practicable or not reasonably practicable to do more than was in fact done.	DoH
Redress – 1 recommendation		
R106	In relation to direct redress, including consideration of financial compensation, we recommend that the DoH set up a small working party to consult with patients, service user groups and individuals connected to those who have suffered abuse at MAH in relation to what form redress might properly take.	DoH



Artist – Ex MAH service user who visited the Inquiry

Chapter 1

The Patient Experience Evidence from Patients and their Relatives about Care at Muckamore Abbey Hospital

Introduction

- 1.1 This chapter focuses solely on what we will describe as ‘the patient experience’. In reality it reflects the evidence predominantly from the relatives and their lived experience of having their own sons, daughters, brothers and sisters and loved ones receiving care at Muckamore Abbey Hospital (MAH).
- 1.2 The Inquiry heard evidence about the patient experience both before and after 2006, when the hospital changed from a long-term placement and home for many to an assessment and treatment centre. While some themes were constant, others differed.
- 1.3 It is important to identify what is meant by the term ‘abuse’, and in Appendix 2 we have set out in some detail the background to the various interpretations and uses of that word. But, as with the structure of the Inquiry, it is important to put front and centre the patients’ and families’ experience of the hospital and what they saw and felt as amounting to abuse. When we talk about ‘abuse’ we will focus on instances when members of staff, of whatever seniority, misused their position of trust in relation to patients under their care. We also heard about frequent violent interaction between patients; those instances are categorised as peer-on-peer abuse, and although it is a very different issue from staff-on-patient abuse the failure to prevent it may amount to poor care. As we will discuss elsewhere, peer-on-peer abuse may also be a red flag for staff-on-patient abuse.
- 1.4 The Inquiry Panel heard multiple accounts of concern from the relatives of patients at MAH. Many saw signs of what could have been abuse but, since the majority of patients were non-verbal and many had high levels of disability, proving that their loved one had suffered injury at another’s hands was nigh on impossible. Many patients did exhibit signs of ‘self-harm’ such as hitting or biting themselves or knocking their heads against walls. There were frequent cases of patients

striking or attacking each other. Before CCTV was introduced, whatever was happening at MAH was hidden behind closed doors. Families, already troubled by the admission to an institution of their loved son, brother, sister, daughter or grandchild, have had to endure the further guilt of feeling that they placed their loved one in a place where they were deliberately harmed:

'I keep asking myself why did I let this happen to my brother. I blame myself. I should have spoken to a solicitor or went to my minister. The serious injuries to P17's legs should never have happened. All of the other incidents are links. All these links have come to form a heavy chain, and it is very difficult for me to carry with me every day. It hurts me to think about P17 feeling the same as I do'.¹

- 1.5 In their accounts to us therefore, many saw the potential for every mark or sign of distress they witnessed over the years to have been a mark of abuse. In reality, some may have been, but it is unlikely that all were. There were at MAH good, kind and caring staff as well as those with malicious, bullying and bad intent.
- 1.6 In the paragraphs that follow, we will recount the experiences of relatives and patients who recounted their stories to the Panel. At times it was harrowing for the witness as well as for the listener. For many it was a huge ordeal and required considerable courage. There will inevitably have been accounts which were affected by the age of some of the events and the fallibility of memory and by the more recent disclosures and revelations relating to abuse at MAH. We have made no judgements on the accuracy of each account, accepting, however, that all were given in good faith, to the best of the witness's memory, and those accounts deserve to be recognised and faithfully recounted here.
- 1.7 We will look at various accounts of potential and actual abuse, but it is also important to remember the psychological effect on the individual when physical harm was caused, or bullying was the daily expectation. To live day to day with the potential at any moment for bullying, in any of its many forms, or the potential for physical violence in a place from which you cannot escape, must be a deeply frightening and damaging experience.

¹ P17's Brother Transcript – 12/10/22 – Page 25 – Line 21

- 1.8 The following accounts comprise just a small selection of passages of evidence we heard. Many reflect incidents of abuse or evidence that some form of abuse may have occurred. None of the following accounts rely on the use of material from CCTV. The Panel spent several days watching CCTV and was shown examples of the abuse suffered by patients.
- 1.9 We heard from a number of witnesses who had been contacted by the Belfast Health and Social Care Trust (referred to as the Trust or BHSCT) or by the Police Service of Northern Ireland (PSNI) to inform them that, as a result of the review of CCTV material, it had been discovered that their loved relative had been the subject of abuse or poor practice at the hands of MAH staff. We have not revealed those accounts here, conscious that a number of those are likely to feature in the criminal trials to come and of our duties under the Memorandum of Understanding (MOU) with the PSNI and the Public Prosecution Service (PPS). It would not add to this report to recount those details, but the reader may be assured that the Panel has both seen examples of the incidents complained of and heard of them from witnesses directly. Nevertheless, we should mention at least the significant distress that such accounts caused to the parents and loved ones of patients subjected to these incidents.
- 1.10 All members of staff at ward level have been given a cipher (an 'H' cipher). They were ciphered when evidence was given, and those ciphers were used in the transcripts where those were made public, as the great majority were. In general, we have retained those ciphers here so that individuals accused of bad behaviour, but who have not had the opportunity to explain their actions, are not exposed publicly. Their names will however be known to Core Participants (via their access to the cipher list), each of whom has signed a non-disclosure agreement. On some occasions where behaviour amounting to potential criminality has been alleged, the cipher has been replaced simply with 'member of staff'. The individual allegations have not been investigated by the Panel, and there is the potential that some of that behaviour could form the subject of criminal investigation.
- 1.11 To investigate and form a conclusion about each of the complaints or allegations made would have extended this Inquiry well beyond an acceptable length. We

have avoided doing so but caution the reader to bear in mind that the individuals mentioned have not been given an opportunity for rebutting the accusations made. All patients have also been given a cipher (a 'P' cipher) to ensure confidentiality. All patients, relatives and carers who came to give evidence were given the option of using their name and surname instead of a cipher, or just their first name if they preferred. This preference was reflected in the published transcripts and as far as possible has been reflected here although some names have now been ciphered in order to comply with our duties under the Memorandum of Understanding with the PPS to protect the integrity of the criminal proceedings.

Unexplained injuries

- 1.12 Understandably, now that parents and other relatives know what they do about criminal arrests and trials, the CCTV review and its outcomes, any injury to their loved relative is now under suspicion as abuse by staff. While the Panel readily understands the anxiety and trauma caused to relatives by the CCTV disclosures, as well as the assumptions that are now made about abuse by staff, we have to be careful not to follow that reasoning without careful thought. Many relatives have now been contacted by the Trust or the PSNI and informed directly of abuse to their loved patient; this can only have increased their concerns and heightened their suspicions about every bump and bruise. Some injuries may have been caused by staff, some will have been caused by other patients, and some may have been either self-inflicted or simply caused accidentally.
- 1.13 We reflect below as faithfully as we can the experiences of the witnesses who came to assist the Panel, but would caution that as an independent inquiry panel we cannot properly draw the conclusion that any and every injury was caused by a member of MAH staff. Many will have been caused in other ways.
- 1.14 In MAH, there appeared to be a high incidence of patients injuring other patients and some families felt staff accepted this as normal. Unexplained injuries were often attributed to this or to self-harm, leaving any other explanation unexplored. Many families reported that they were rarely told by hospital staff about any injuries contemporaneously and many were only told after a significant delay. They would

come to visit and see injuries, very often bruising, but staff were often unwilling or unable to explain how they had happened:

'Each time an incident occurred, we were never given the full details of what happened or who was involved'.²

'Martin requires 24-hour care. He is constantly monitored, even when he is sleeping. A nurse will watch him on a monitor. On 5th September 2014, the Service Manager called my parents to advise that when Martin woke that morning, he had a large gash on his head and that the doctor had to be called. Martin had to receive four sutures for the injury. The Service Manager was unable to give any information as to how the incident occurred. My parents complained and asked how this could happen when Martin was under 24-hour care'.³

- 1.15 Many patients did exhibit self-injurious behaviour, but the methods used to control such behaviour and the rationale behind the methods sometimes caused concern to families. Martin exhibited self-injurious behaviour and would hit himself. To control that behaviour staff put Martin's arms into splints:

[Counsel]: *'And I think you also explained, though, that splints would occasionally have been used at that point in time?*

[P1's Sister]: *Yeah, yeah, to protect Martin, I suppose. We did, we questioned it and, now, splints --Martin would hit himself, so the splint would run from elbow to wrist, so it would be completely --you know, so he couldn't move his arms to hit himself.*

[Counsel]: *So the splints were used on the arms?*

[P1's Sister]: *Mm-hmm. And we raised it because if he fell or anything like that, obviously he couldn't put his hands down or, if he did, he would break his arms. But we were told that it was an accepted form of treatment. As I recall, they even gave us a document to show when it would be used in such things and in what circumstances. But we thought it was --you know, we brought up the issue that Martin has human rights here, like, that to be restrained in that manner, that it would cause more damage than good. And also, when Martin would -- if he was self-injurious and did something like that, it would precipitate it even more because he would get frustrated. So, we didn't think that it was a good way ... We wouldn't have used splints at home or anywhere else. You would have sat with him. That's the thing, Martin takes time and, if he's self-injurious, you sit with him and you don't lift your eyes off him. And I think the splints allowed people to just put them on and leave him and not monitor him'.⁴*

- 1.16 Even prior to the revelations on CCTV in 2017, staff were on occasion willing to report their colleagues where inappropriate behaviour occurred:

² P1's Sister Transcript – 28/06/22 – Page 25 – Line 26

³ P1's Sister Transcript – 28/06/22 – Page 22 – Line 17

⁴ P1's Sister Transcript – 28/06/22 – Pages 43-44

'In April 2015, my parents received another telephone call from a staff nurse at MAH. I don't recall her name. One of Martin's carers had assaulted him. She had hit him several times on the head, verbally abused him, pushed him violently into his wheelchair and held him in there'.⁵

'So, yes, our Police Liaison Officer was able to tell us that Martin -- so the [staff member] had been in the shower room -- and Martin always needs two carers, so, thank God, because obviously there was always someone there to witness then -- and either she took Martin's head and hit it off the shower, or she shoved him -- and she said she shoved him and he hit his head off the shower. The evidence was that she took his head and hit it off the shower, the tiled shower cubicle'.⁶

- 1.17 However, until the revelations on CCTV, many families put bruises and other marks down to self-injury; indeed, they were often told this by staff who could give no alternative explanation. Injuries were often explained by staff as being down to the disability of the patient, either falling or jerking, banging their head or arms or suffering a fit. No doubt on some occasions these explanations were true. However, the great number of incidents coupled with the later revelations of the CCTV have persuaded us that not all of these explanations can have been truthful. In some ways, whether such explanations were right or not, there could rarely be a full explanation that satisfied the relatives because it was the hospital's job to take care of these patients and ensure they did not come to harm. However, plainly deliberate abuse would be regarded as significantly worse. Some may of course have been self-inflicted injuries, some will have been injuries caused by other patients and some may have been the result of abuse or mishandling by members of staff. Parents giving evidence were understandably now sceptical of the explanations they had been offered:

'During P99's time in MAH, she sustained numerous injuries. I have never been provided with a proper explanation. P99 broke her leg in and around 2012. The first we were aware of was when we went up for a visit and saw P99 with a cast on her leg. There was no credible explanation as to how P99 broke her leg. Instead, it was explained that P99 got frustrated and aggressive when she wanted to get out of bed and was unable to do so, and that this contributed to her falling. Essentially, it was self-inflicted. My family had never known or seen P99 to be aggressive, so this did raise some uncertainty regarding the account provided. The nearest to aggression we had seen P99 display was her hitting her chest when saying love, to emphasise her feelings'.⁷

⁵ P1's Sister Transcript – 28/06/22 – Page 23 – Line 24

⁶ P1's Sister Transcript – 28/06/22 – Page 55 – Line 10

⁷ P99's Nephew Transcript – 14/09/23 – Page 32 – Line 1

'I started to notice injuries on P28 and we took photographs. I often saw unexplained bruises appearing. Around 4th March 2017, P28 appeared to have a bruise on his right eye. We complained to the staff - I cannot recall who - but this was explained away. They said that he might have hit himself with a toy or something. I attach a photograph of the bruising at H11. There was no investigation, to my knowledge. Around Wednesday, 19th July, I noticed more bruising on P28's arms. Alarm bells were ringing but there was nothing that we could do ... I complained to the staff - I cannot recall who but this was explained away. I am not aware of any investigation'.⁸

'Over the period 2010 to 2017, P99 would have presented with black eyes, a bruised face or other bruising. When my family asked about it, we would typically be told that P99 had fallen out of bed. P99's mother felt this was happening too often and I know she wanted to take it further. I feel very guilty about this because at the time, I talked her out of it. I could not believe that anything untoward was happening'.⁹

'When I went to MAH to visit P119, the staff were friendly, and I assumed they were doing their best for P119. I felt that they had taken on my role and were providing primary care to P119. I did not suspect that P119 could be coming to any harm. I did notice that there seemed to be many incidents which would result in P119 sustaining injury. She had bruises to her arms, her legs, and sometimes on her face. These were explained by the staff as P119's clumsiness or evidence of her frustration. I now do not accept this ... Upon reflection, I realise just how trusting and accepting I was. I deeply regret not questioning staff more and just taking their word for things, for believing that I had left P119 with people who would care for her properly'.¹⁰

'In or around April/May 2017, I took P119 out of MAH for lunch in Antrim town centre. We regularly took P119 to a fish and chip shop there as the staff were great with P119. On that occasion it was quite warm, and when we got into the chip shop I asked P119 to take her coat off. P119 was wearing a short-sleeved blouse and it could clearly be seen that P119 was covered in large bruises. When we brought P119 back to MAH and asked the nurses about the bruises, staff advised that they were from P119 throwing herself onto the ground and were self-inflicted. At the time I believed this explanation, but I now do not accept it. I asked why I was not informed and the staff apologised for not updating me'.¹¹

'At different times over the years our family has heard and seen things which have caused us concern. We noticed unexplained marks and bruises on Bryan's body, and we noticed that Bryan was less happy in MAH than at home. Bryan was not capable of telling anyone about the bruises or marks on his body. From in and around 2014 our family became worried about the frequency with which these marks were appearing. I started to keep systematic notes to have an accurate record. I would tell our mother about these marks. Our

⁸ P28's Mother Transcript – 28/09/22 – Page 34 – Line 12

⁹ P99's Nephew Transcript – 14/09/23 – Pages 32-33

¹⁰ P119's Mother Transcript – 28/09/23 – Pages 15-16

¹¹ P119's Mother Transcript – 28/09/23 – Page 20 – Line 7

mother was not trusting of the staff at MAH. She did not Trust anyone who was not a member of our family with him. This was because Bryan was non-verbal and unable to really communicate anything untoward happening to him. Our mother would tell us not to make an issue of the marks and bruises because Bryan lived there, and she was concerned that there might be repercussions for him. On the occasions when we did raise the issue of marks and bruises the staff would tell us that Bryan caused them to himself through self-injurious behaviour. In December 2020 Dr. H223 said that he thought Bryan was having a delayed reaction to the abuse he had suffered, which our family believed to be largely perpetrated by one patient. I refer particularly to examples of incidents between Bryan and other patients between 10th March 2014 and 21st November 2016 attached as above at Exhibit 2 which are entries of specific incidents from my notebook'.¹²

'Amanda was very quickly moved back to the Cranfield Ward after this. Within about one week of moving back to the Cranfield Ward, I recall that Emmanuel, my dad and I, went to visit Amanda. We were all brought into a room where Amanda was sitting. Amanda had the worst black eye I have ever seen. It was so badly swollen and black that her eye was completely closed over. The nurse advised us that she had fallen up against a wall. My dad said that the child definitely had been beaten up. The nurse played all of this down and I recall her saying to me "Don't let her pull at your heart strings". I don't recall the name of the nurse, but again I assume that all of this will be recorded in Amanda's hospital notes. I considered contacting the PSNI to report this as Amanda's eye was so bad. I did believe that the staff were beating here [her], but I also thought that nurses wouldn't behave in that way. I didn't pursue it any further. She was in MAH for another three to four years. Every other week that we visited, she would have black eyes. I recall that she had her front tooth broken once. She always had really lovely teeth. When we questioned the nurses about the continual injuries, we were advised time and time again that she had hit her head or fallen over during petit mal seizures as a result of her epilepsy. I asked why she wasn't being more carefully looked after, but no one ever had an answer for me'.¹³

'He would at times also have had cuts and bruising on his face. I remember raising this with the ward sister, whose name I do not recall, to be told that they had too many patients to look after and could not keep a close eye on everyone. She suggested that he may have fallen in the night. I also spoke with a social worker, H342, whose name I do not recall, who told me off the record that the cuts and bruises were not the result of an accident'.¹⁴

'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

¹² P90's Sister Transcript – 11/10/23 – Pages 95-96

¹³ P2's Mother Transcript – 29/06/22 – Pages 13-14

¹⁴ P69's Father Transcript – 23/11/22 – Page 121 – Line 21

were being honest, and we just accepted this but now we question everything'.¹⁵

- 1.18 Families often felt lost and powerless to ensure improvements were made and lacked confidence that their loved ones would be kept safe from harm:

'The details of these incidents involving Bryan give an indication of just how often he is hurt, how frequently it is an unexplained injury and how difficult it is to get anything tangible done to improve the situation. Quite frankly it is difficult to have any trust and confidence that Bryan will be safe whilst in MAH, but we have no option but for him to stay there until he could be resettled'.¹⁶

- 1.19 Becoming aware of allegations of abuse has also made some relatives question the medical interventions and treatment used on their loved one:

'In or around late 2016 early 2017, we were contacted by P119's consultant because he wanted to treat P119 with a series of electroconvulsive therapy or ECT sessions. It was explained to us that this would re-start her and that it may help to improve her mood. The proposed treatment of ECT was before we knew about the abuse that P119 had suffered. When I look back now at the decision to treat P119 with ECT, I question the true need for this treatment. I am concerned that P119's behaviour which MAH sought to treat with ECT may have been a reaction to the neglect and abuse she suffered at the hands of MAH staff. With my husband's knowledge as a learning disability nurse, I now know that ECT is an extreme treatment and should be considered as a treatment of last resort. Looking [back] on this period, in the light of the knowledge I now have about P119's abusive, I have very serious concerns about whether P119 required this treatment at all'.¹⁷

- 1.20 Families were often unaware of any internal investigations of these injuries and staff often appeared defensive:

'H44 was either standing or sitting at a table when he shouted over to me "Mr. Overend, the night staff on duty didn't notice anything coming off shift. It was only when morning staff went on that they noticed Michael. The nurse on duty is an excellent nurse and I would trust her with anybody"'.¹⁸

'In or around January 2012, P60 telephoned me and told me that he had been punched on the side of his head by a staff member. P60 told me that he had made a complaint about this within Muckamore, that he was lying sleeping in his bed when the staff member entered the room and punched him. [Another] staff member, H251, a safeguarding social worker rang me regarding this incident and said I had misinterpreted it. After P60 made this complaint, the staff member took sick leave. The staff member never returned to Muckamore

¹⁵ P36's Mother Statement – 28/9/23 – Page 19 (restricted)

¹⁶ P90's Sister Transcript – 11/10/23 – Pages 105-106

¹⁷ P119's Mother – 28/09/23 – Page 19 – Line 2

¹⁸ P11's Father Transcript – 06/07/22 – Page 15 – Line 16

*and to me this was a sign of guilt. I believe the staff member retired with an early retirement package’.*¹⁹

*‘Alicia told me that she had been physically abused in MAH. I raised with the head nurse that there was a bruise on the back of Alicia’s hand, but at the time I was not fully aware of the complaints procedure at the time. I cannot recall the name of the head nurse. There was no follow-up after I raised it with the head nurse. A patient also nipped Alicia’s arm and Alicia threw a cup in retaliation. This behaviour continued throughout Alicia’s time in MAH, and I believe that it was a learned behaviour from being in an inappropriate environment. This behaviour continues occasionally today’.*²⁰

- 1.21 When an investigation did take place, relatives appear on occasion to have received limited information or notice of meetings. Sometimes they felt intimidated and patronised:

*‘I suspect the treatment of P60 during this time was due to the complaints which my family made about the assaults on P60 ... When we complained to the ward manager ... they totally dismissed it. We also wrote to the service manager, H77, with these concerns. We subsequently received a letter which only provided 24 hours’ notice to attend a multidisciplinary meeting. We walked into the room and in attendance was approximately 12 professionals, including social workers and consultants. This was very intimidating we were told by H77 that Muckamore could do nothing further for P60 and he needed specialised treatment that he can only receive at a hospital in England’.*²¹

- 1.22 Relatives also felt powerless when compared with the system they were challenging:

*‘As a family, we made complaints to Muckamore about P60’s care and treatment. My parents were made to feel stupid for making complaints and made them feel that they did not know as much as the professionals. I really felt I could not turn to anyone, whether social worker or manager, service manager RQIA [Regulation and Quality Improvement Authority]; no one would listen’.*²²

- 1.23 Most of the patients were non-verbal or had very limited verbal communication. They could not therefore explain what had happened to them or why they were unhappy. However, the Inquiry heard from several relatives about patients expressing themselves in different ways and demonstrating fear or strong reluctance to return to MAH when they had been out with their families:

¹⁹ P60’s Sister Transcript – 20/09/23 – Page 20 – Line 3

²⁰ P109’s Mother Transcript – 21/09/23 – Pages 13-14

²¹ P60’s Sister Transcript – 20/09/23 – Pages 21-22

²² P60’s Sister Transcript – 20/09/23 – Page 24 – Line 5

'P16's behaviour was really heightened and he would bring this back home with him when he was back home for a visit. We would be able to calm him and his behaviours decreased, but then increased again when he knew he was going back. When I left him back to MAH, P16 would start pulling my hair and cursing. He would ramble off peoples' names. He would name everyone. When we got to MAH, sometimes P16 would get out of the car and sometimes he wouldn't. P16's reaction depended on who came out for him. I think that P16 is a very good judge of character and he will like people who like him. It's like P16 knows. He's very perceptive'.²³

'I can't remember anything physical marks on P16. I feel there were some indications that P16 was not happy returning to MAH and he disliked certain staff. I would have known, based on his behaviour, what staff P16 did not like. For example, he would hit out at me. He ripped his clothes off and lay on the ground. MAH would have to get another staff member to attempt to bring P16 in. P16 sometimes said that he didn't like a particular staff member. At the time, I didn't read much into this, as I thought that he just didn't want to give up the freedom and familiarity that he had at home. I remember when certain staff members came out that P16 spat at them. P16 knows this is a very bad thing to do and I would have said to them that P16 doesn't want to go in'.²⁴

'Roberta was moved to the adult ward for weekend respite care when she was 19 years old. She went from loving going to MAH to hating it. She would be kicking and screaming, not wanting to go. She began to say that someone was hitting her. Roberta did not give an indication of who was hitting her. Roberta could hit out, so I thought it was that, although I never received any incident reports from the staff. I thought it must have been another patient and never thought it could be a staff member. The penny never dropped with me. After all the news reports about MAH, I thought back and thought maybe it wasn't a patient. It is hard to get reliable information from Roberta. She lives in the moment and has no concept of time'.²⁵

'Peter would also shake his fists at certain workers, and when we asked the staff why he was doing that to them they said, "That's just how he gets on". With hindsight, my family remains concerned about the possible significance of Peter's behaviour, and we are worried that it might signify that he had been hurt'.²⁶

'P120 was permitted to come home at the weekends, so I did not have visits with him at MAH. I would have collected P120 from MAH and returned him there at the end of his visit home. It was a nightmare when returning P120 to MAH. He didn't want to be there. P120 would cry and say that he did not want to go back. He would refuse to get out of the car, fall to the ground and say that staff were hurting him and putting him in the naughty corner which I later

²³ P16's Mother Transcript – 20/09/22 – Pages 26-27

²⁴ P16's Mother Transcript – 20/09/22 – Page 39

²⁵ P23's Mother Transcript – 22/09/22 – Page 63

²⁶ P123's Sister Transcript – 28/09/23 – Page 45 – Line 1

learned meant the seclusion room. P120 seemed afraid to me, it was heartbreaking to watch and to have to send him back'.²⁷

- 1.24 Occasionally the Inquiry heard directly from patients themselves about abuse by staff:

'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"'.²⁸

And the witness later went on to say:

[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'.²⁹*

- 1.25 Relatives did not always hear directly from the hospital when their loved one had been injured:

'The whole time that Mary was in Muckamore, I never met a doctor who was involved in Mary's care. When Mary was in Muckamore we never got any calls to say that Mary had been in a fall or that she had been injured. When it was in the news about the whistleblower and the girl brought back from Australia, I got a phone call from Muckamore to say that Mary had been in an incident and had been hit in the mouth and was injured. A policewoman notified me that Mary had been involved in an incident. Muckamore told me nothing about it. H158 told me nothing about it. The policewoman kept me updated. A member of Muckamore staff, [named] ... had pulled a patient down. A patient, whose name Muckamore refused to tell me, had hit Mary. A [member of staff] had encouraged Mary to fight back. [They] had said to Mary "go on, hit her back you big softy". This must have been entertainment for them. [The member of staff] was investigated and was in the newspaper'.³⁰

- 1.26 Relatives were not always informed of events leading to attendance at a general hospital emergency department. P54's mother told the Inquiry that following a Freedom of Information (FOI) request she had obtained records covering the

²⁷ P120's Father Transcript – 20/09/23 – Pages 99-100

²⁸ P21 Transcript – 20/09/22 – Page 19 – Line 27 (restricted)

²⁹ P21 Transcript – 20/09/22 – Page 49 (restricted)

³⁰ P22's Sister Transcript – 22/09/22 – Page 23 – Line 1

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.³¹

1.27 P121's sister told the Inquiry:

'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'.³²

1.28 Many of the unexplained injuries appear to be related to the use of restraint and seclusion:

'Not long after she was admitted to MAH and during one of my visits, I saw that Kirsty had fresh bruises on her upper arms; I cannot recall the exact date but I always signed a register when I arrived so there should be a record somewhere of the dates of my visit. Kirsty said to me, Mummy, look at my arms. I was shocked and asked her what had happened. Kirsty said that she was being put in seclusion and didn't want to go so they held her down and forcibly put her in causing the bruises on her arms'.³³

'You can tell when P18 comes home that he is relieved to be home. I never question him why. On four or more occasions P18 came home covered in bruises on the back of his arms and legs. However, we did not think this was a concern as he sometimes needed to be restrained due to his behaviour, and none of the staff in Muckamore raised the bruises with me. I know that body checks are carried out on patients at Muckamore and records kept of bruising, etc. However, I never saw any body charts regarding checks being carried out on P18. I do not recall the dates of seeing bruises on P18'.³⁴

'When I saw bruising on P18, I just thought that the MAPA [Management of Actual or Potential Aggression] restraint used was the source of his bruising. I was not allowed to learn the MAPA training, despite asking, as P18 could be difficult to manage at home. I never raised a complaint around this'.³⁵

³¹ P54's Mother Transcript – 13/10/22 – Pages 60-63 (restricted)

³² P121's Sister Statement – 03/10/23 – Page 7 (restricted)

³³ P4's Mother Transcript – 28/06/22 – Page 139 – Line 6

³⁴ P18's Mother Transcript – 21/09/22 – Pages 13-14

³⁵ P18's Mother Transcript – 21/09/22 – Page 15 – Line 1

- 1.29 Some patients were verbal and able to explain what happened to them. However, given the circumstances of their admission, their complaints sometimes held little weight. As we mention elsewhere, patients could easily be classed as ‘poor historians’ or staff were simply uninterested. Shelley was admitted to MAH in 2016 under the Mental Health (Northern Ireland) Order 1986 (MHO). Her mother told the Inquiry:

*‘I had to wait a few days before calling MAH to allow Shelley to settle. When I telephoned a few days later, Shelley was tearful and wanted to come home. She told me that a member of the night staff at MAH, who I think was named [name], had hit her. She said that she was in the dayroom and she and another patient were making noise. It was something to do with the television but I cannot recall exactly what it was. Shelley told me that [a member of staff] hit her and the other patient a slap across their faces. When my husband and I visited Shelley shortly after she told me this, we noticed a red mark on the side of her face around her lower cheek/jawline area. I spoke to a member of staff at MAH about it, who said they would investigate. Later, they told me that the slapping incident did not happen. I do not remember the name of the person I spoke to and do not know how the incident was investigated’.*³⁶

[Counsel]: ‘Can you explain to the Panel what Shelley told you had happened?’
[P29’s Mother]: *Shelley had said her and the other patient were in the TV room, and I think they were arguing over either the -- what was on, or volume or something, and the member of staff came in and told them to be quiet. I think they wouldn’t or something, and the two of them got a slap across the face, according to Shelley’.*³⁷

*‘During our second visit with Shelley, I noticed that she had bruises on her arms and legs. I bought her new clothes shortly after she was admitted and when she tried the clothes on, I noticed she was bruised. When I asked Shelley how she got the bruises, she told me that she was dragged into her room by a member of staff, who had pushed her and she fell back into a chair. I checked Shelley for bruises and seen that she was bruised on the right side of her lower back. It looked like she fell. H40, consultant at MAH, referred Shelley to Antrim Area Hospital for an X-ray. The hospital recorded bruising. When I asked a member of staff at MAH how Shelley got the bruises, I was told that she tripped and she is very clumsy. I do not recall who told me this. When I visited Shelley, she told me there were good and bad staff in MAH’.*³⁸

- 1.30 Other relatives shared similar experiences:

‘I got the impression that P101 would be roughly handled by staff. The last time he spoke to me about MAH, he said he threw a bottle of shampoo and it hit a nurse called [name]. P101 said she took him into the room and she sat on him. P101 told me that he told her to get off and she said, “I can do whatever

³⁶ P29’s Mother Transcript – 11/10/22 – Page 9 – Line 5

³⁷ P29’s Mother Transcript – 11/10/22 – Page 24 – Line 13

³⁸ P29’s Mother Transcript – 11/10/22 – Pages 9-10

I want, you hurt my friend". P101 told me that [the member of staff] had the door locked'.³⁹

'Another patient would go into P60's room and use sectarian language and beat him up in his room. This patient would call P60 a "Fenian bastard". This was the language that was used when P60 was beaten up at the age of 21 years. The patient said he knew this because H512 had told him. This language was a trigger for P60. Staff were not involved in the sectarian abuse but they did not stop it. Another patient had to be moved because of sectarian abuse. This patient harassed P60 for months and months, saying things like "H512 told me your Daddy is dying". H512 would tell other patients things about P60's family and they would use this to taunt P60. Two days after our father died, P60 was beaten up in his room by a violent patient. I brought up the use of sectarian language by that other patient with H260, Assistant Ward Manager, and the effect on his PTSD [post-traumatic stress disorder] from the attack. She advised she asked someone to have a word. At the time H260 laughed when I raised it and says "He calls me a Fenian bastard all the time. Don't take it so personally"'.⁴⁰

'I recall a safeguarding incident over Christmas 2022. During a visit to P34 on the 31st December 2022, my mother spotted bruising on P34 's lower wrists. They appeared to her to be fading bruises in the shape of thumb marks. When she asked P34 what had happened, he told her the person who did it was [named]. When he was asked again the next day, he said the same name. There was no management on the ward on these two days so my mother was unable to report this'.⁴¹

'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'.⁴²

'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]'.⁴³

³⁹ P101's Mother Transcript – 13/09/23 – Page 57 – Line 11

⁴⁰ P60's Sister Transcript – 20/09/23 – Pages 37-38

⁴¹ P34's Sister Transcript – 09/10/23 – Page 48 – Line 1

⁴² P54's Mother Transcript – 13/10/22 – Page 47 – Line 14 (restricted)

⁴³ P121's Sister Statement – 03/10/23 – Page 8 (restricted)

- 1.31 P118 was verbal and was said by his family to know right from wrong. He was admitted to MAH when young and readmitted in 2009 until 2017 when he was discharged at the age of about 43. P118's mother told the Inquiry:

'As well as mental abuse, P118 endured physical abuse from various staff members while in his bedroom and shower room. P118 informed me that on one occasion, two care workers ... were supposed to be supporting him to shower, dress and go to the toilet. P118 had requested help with toileting from [the care workers] but they refused to help him. As P118 did not want to be left unclean he again requested help. He was told by one of the staff members to do it himself. This refusal created a trigger which resulted in P118 shouting at the staff to come and help him. At this point [one of the care workers] caught P118 around the neck forcing him against the wall. P118 was then forced to the floor where the other staff member ... kicked P118 with his booted foot in his buttock area. P118 was in the Killead Ward when this incident occurred. I reported the incident to the senior Staff Nurse ... He promised to investigate the incident and speak with the staff. I was not informed any investigation ever occurred. In any event, the two staff members involved remained working at the hospital. [One of the care workers] was moved to another ward soon afterwards. P118 was afraid to report the incident as he thought the two staff members would come back and attack him again'.⁴⁴

- 1.32 P124 was readmitted to MAH in 2007. In December he returned home for a visit, and it was noted by his mother that he had a large bruise from hip to knee. P124 then role-played being flung against a door frame. A meeting was held with senior staff. P124's mother told the Inquiry:

'At the [meeting] we asked for an explanation as to where the significant bruise had come from and how it happened. We explained to the staff what P124 had role played for us at home. H77 and other professionals advised "We just don't know what happened to P124". I reminded them that P124 was in their care when he sustained this injury and so they should know what happened to him. H77 said, "Well, I can't, we don't know". P124's father pointed out to H77 that staff must have seen what had happened as there was a night station that observed the whole room. H77 advised that his staff did not see what happened to P124. Ultimately the meeting ended as we were [not] getting any further explanations from the staff'.⁴⁵

'P129 also complained to my mother and I that the staff used to do things like put salt in his tea. We did not believe him at first but when we were visiting P129 at one time, the staff brought us some tea. We tasted his and it was full of salt'.⁴⁶

⁴⁴ P118's Mother Transcript – 09/10/23 – Pages 114-115

⁴⁵ P124's Mother Transcript – 20/09/23 – Page 112 – Line 4

⁴⁶ P129's Brother Transcript – 20/09/23 – Page 151 – Line 19

- 1.33 P129 was verbal and in MAH from 1995 to 2004. His brother described to the Inquiry what P129 had told him:

'P129 told me that he was physically assaulted by the MAH staff. P129 was full of bruises and he had several broken bones whilst at MAH. P129 showed me the bruises on my visits but he would always check in case the staff were watching. He was worried that he would be caught by them, and he was scared of them. He showed me bruises on the front and back of both arms, and he pulled up his top to show me bruises right down the side of his back. He also suffered a broken hand and a broken arm but I do not know how those injuries happened. When my mother complained to the staff, they said that the bruises and injuries were caused by other patients fighting with P129 or that P129 was kicking off. When P129 said it was the staff, the staff said he was talking nonsense'.⁴⁷

- 1.34 Alicia was frequently admitted to MAH between November 2008 and July 2018. Her mother told the Inquiry:

[Counsel]: 'When you say that you reported them, you reported those incidents, I don't want you to name names but if you can tell us by perhaps reference to their role, who would have you reported those things to on?

[P109's Mother]: So, nurses and senior staff. I would have said, like, why is Alicia bruised or why isn't she being protected, and this shouldn't be happening. You know, obviously I was deeply concerned and Alicia was upset by it. So, of course as a mother I raised those concerns.

[Counsel]: And that was raised verbally, was it?

[P109's Mother]: Yeah, uh-huh.

[Counsel]: What responses did you get?

[P109's Mother]: Usually the response would be, oh, there was incidents on the ward, and it was another patient and, you know, we used intervention and that was the reasons for the bruising and injuries on Alicia.

[Counsel]: How satisfied with those responses were you?

[P109's Mother]: Not satisfied whatsoever. But, you know, I would not have been aware of how a complaints process would have worked; I wouldn't have understand that there was a safeguarding process. I do realise now'.⁴⁸

- 1.35 Even when a serious unexplained injury that led to hospitalisation occurred, there was little attention paid to contacting the next of kin:

'I recall one Saturday ... when the postman arrived with a letter from the Hospital. The letter said that P17 had had a small accident and asked me to contact the ward. I was annoyed at this as I had given the staff on at least two occasions my new telephone number, so I was not sure why they were writing to me. I telephoned Muckamore and spoke to a nurse. I cannot recall her name but she told me that P17 had had a fall the previous Saturday. I complained to her that someone should have contacted me before now. She said that they had tried to ring me but could not get me. I was angry at this. I

⁴⁷ P129's Brother Transcript – 20/09/23 – Pages 150-151

⁴⁸ P109's Mother Transcript – 21/09/23 – Pages 60-61

*immediately went to the Royal Victoria Hospital to see P17. There, I learned that he had fallen the previous Saturday in MAH in his bedroom. He required two sets of operations as he had broken multiple bones in both sets of knees, legs and ankles’.*⁴⁹

- 1.36 Serious injuries were sometimes left unexplained even when the patient should have been supervised:

*‘On one occasion P128’s arm was fractured, but no-one in MAH could say how he sustained the injury. This happened in Movilla B, but we cannot recall the date. We were informed when P128 was brought to the hospital. I, Doreen, went to the hospital and the x-rays showed the fracture. The hospital did not put a full cast on P128’s arm. He picked at it overnight and it came off. If anyone had been checking on P128 they would have noticed that he had picked his cast off. After this, nothing more was said or done to discover how P128’s arm was fractured. Staff failed to address the issue at all. We felt like we were up against a brick wall as to how this happened’.*⁵⁰

*‘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’.*⁵¹

- 1.37 However, P5 had a much better experience once she moved ward:

*‘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’.*⁵²

- 1.38 P127, an ex-patient of MAH, explained that staff deliberately acted differently when relatives were present from the way that they acted when alone with patients:

⁴⁹ P17’s Brother Transcript – 12/10/22 – Pages 21-22

⁵⁰ P128’s Father Transcript – 25/09/23 – Pages 11-12

⁵¹ P5’s Mother Transcript – 29/09/22 – Pages 16-17 (restricted)

⁵² P5’s Mother Transcript – 29/09/22 – Page 18 (restricted)

'I cannot remember any of the staff's names on Donegore Ward but they were mainly women. None of the staff were nice to me or the other patients. They would be all nicey-nicey when my family or other people came to visit but when the parents went home, they would were not nice. The staff treated us like rubbish. They did not speak to me in a nice way. I cannot remember anything in particular that they said as it was too long ago and I try not to remember it. The staff would pull you about and grab you, and they did not treat me nicely. It was mainly two female staff that did it and it was always in my room, not in the ward where people could see'.⁵³

- 1.39 Even with patients who were verbal and who later alleged that they had been subject to abuse by staff there appears to have been real concern about speaking out even after they had left MAH. One witness told the Inquiry that he had asked his relative about what had happened to him in MAH but the only response he would get was 'You do not tell'.⁵⁴

- 1.40 Other witnesses also told the Inquiry that they thought that their relative was frightened about speaking up:

'There was also a period when P34 was not sleeping. He was very restless. His medication was being adjusted all the time to try and deal with it and I am concerned about the effect of that on his brain. It now distresses me, with knowing what I know, that P34's unhappiness and unsettled behaviour may have been indicative of him being abused. P34 did not have self-injurious or self-harming behaviour when he was at home, nor did he show aggression towards others. He was always happy when people were happy around him. I believe P34 developed this aggression whilst in MAH. It was around this time in 2013 when I just felt something was not right in MAH. I do not know what was making me feel that way. I was afraid and it was starting to really impact my mental health. P34 would have told me certain staff members were bad. I would try and reassure him and I would tell him I was going to speak to the doctor about this but then he would say no, they were not bad. I believe P34 was afraid of the consequences'.⁵⁵

'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

⁵³ P127 Transcript – 20/09/23 – Pages 140-141

⁵⁴ P9's Brother Transcript – 30/06/22 – Page 17 – Line 2

⁵⁵ P34's Mother Transcript – 09/10/23 – Pages 18-19

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'.⁵⁶

- 1.41 As discussed elsewhere, there was a significant amount of violence between patients. Of course, the environment is such that some patients can become violent or 'have a moment' and may attack another patient. One of the jobs of the staff on the ward in these circumstances is to watch what is happening on the ward and look out for any triggers that may escalate into violence. Plainly patients should feel safe in their lived environment and should be protected but this is not always possible. However, P57's brother, who worked for Positive Futures and spent some time working at MAH as a support worker in 2008, told the Inquiry how he heard staff talking about using one patient, 'known to be a scrapper', to interject between other patients:

[Chair]: 'You did speak about comments from some members of staff about putting a particular patient in between other patients, or to stop fighting?

[P57's Brother]: Yes.

[Chair]: Can you remember the circumstances in which you overheard that conversation?

[P57's Brother]: They were just casual conversations on the sofa, trying to fill time, and potentially staff coming off with phrases or stories in the past. They weren't bravado phrases or anything like that, but that's one statement that stood out for me, that patient in particular was bit of a scrapper "and we used to put him in amongst patients".

[Chair]: Everybody knew that you were not a member of the MAH team, as it were, so they knew that you were a visitor?

[P57's Brother]: Yes.

[Chair]: But they seemed comfortable enough to talk about it in your presence?

[P57's Brother]: Yeah, and that surprised me at the time. It doesn't surprise me now, given why we're all here, or if you look at the Ennis Report because it was the same sort of circumstances. They're an outside organisation. It surprised me at the time but not now.

[Prof Murphy]: Do you think it was bravado sometimes amongst staff in those settings?

[P57's Brother]: I don't think it was bravado because it was that standoffish atmosphere that existed. We were the last people, group of workers, that they would have been trying to impress. I got the impression that they sort of thought, well, you don't know what you're in for. So, I didn't think those comments were bravado by any means. I think they were just off-the-cuff, reckless comments'.⁵⁷

⁵⁶ P54's Mother Transcript – 13/10/22 – Pages 31-32 (restricted)

⁵⁷ P57's Brother (and support worker with Positive Futures) Transcript – 21/09/23 – Pages 137-138

- 1.42 P8 appeared to his mother to be unpopular with staff. She told the Inquiry of one occasion when P8 was injured by another patient:

'During the course of the first year that P8 was in Muckamore, he advised me that another patient pushed him onto the ground outside in the garden. He told me that staff members tried to make out that he had fallen over a plant pot. My son is not stupid and knows what really happened to him. His injuries were a badly cut and scored knee, cut and scored hand and a cut and scored elbow. I cannot recall any further details around this'.⁵⁸

- 1.43 Putting aside the question of harm caused by members of staff, patients are entitled to be protected from harm, whether from themselves or from other patients. That protection was plainly not always provided as it should have been. P90's sister recounted a history of assaults on her brother by another patient without effective intervention to resolve the issue. Ultimately, this lack of attention was captured on CCTV:

'These incidents of assaults on Bryan by the other patient had been ongoing since the 10th March 2014 and November 2016 as detailed in my handwritten notebook entries at exhibit 2. I have also included my own typed version of these notebook entries. I recall that by the 6th November 2014, a further 11 incidents were reported to me by staff where Bryan had been slapped, kicked, bitten, nipped or hit by this other patient. I spoke to Dr. H30 about Bryan being repeatedly assaulted and I was assured that there was a plan to separate Bryan from the patient who was mainly involved in the assaults. However, there was no sign of any effective plan and in 2015 I was informed by staff of a further 15 assaults on Bryan by this patient. Although Bryan was moved from Moylena ward to Erne Ward on the 18th February 2016, the patient that had been assaulting Bryan was moved with him. The staff seemed to do little to protect Bryan. There is CCTV footage of an incident on the 21st January 2020 showing two members of staff supposedly providing one to one observation of Bryan, using their phones and ignoring repeated assaults on Bryan by the other patient who succeeded in pulling off Bryan's top and throwing it out of the window. It was retrieved by one of the staff who used it as a game with the other member of staff, throwing it back and forth which escalated the other patient's behaviour'.⁵⁹

'The Belfast Trust reported the incident to the PSNI with the other patient as the primary victim and Bryan as the secondary victim. It required the DAPO [designated adult protection officer] to alert the CCTV viewers that concern was shown for Bryan. I re-referred this incident to the PSNI with Bryan as the primary victim. The PSNI referred it back to the Belfast Trust as a single agency investigation. I understand that both staff members, who were from an agency, were dismissed'.⁶⁰

⁵⁸ P8's Mother Transcript – 26/09/23 – Page 22 – Line 2

⁵⁹ P90's Sister Transcript – 11/10/23 – Pages 84-85

⁶⁰ P90's Sister Transcript – 11/10/23 – Page 97 – Line 13

1.44 Other relatives related further experiences of unprevented interpatient violence:

'Stephen was bitten twice on this ward. The first time was after about six weeks. He was bitten on the hand by another patient. Someone phoned to tell us at home on a Friday and we saw him on a Sunday during our visit. I can't recall the date or the name of the staff member. We were never told very much about what happened, just that it was another patient and they were separated. They were very short staffed. There was never any investigation'.⁶¹

'He doesn't like being where he [is] - he doesn't like Muckamore. He doesn't like being there. There was a time where he was sitting having his breakfast and a patient came over and kicked him. He's had water threw over him, coffee threw over him, which is lucky enough they give it at a certain temperature. The time he was in his bedroom and he had to lock the door, and I was FaceTiming him because he was - I think it was during the pandemic, and I was talking to him and I could - that's the only time I ever seen his bedroom. But the patient was kicking the door and threatening to kill him. And I waited for a couple of minutes to see if any staff would come, but nobody came. So I had had him on my mobile, so I went on the landline and I phoned up the ward and I says "look, he's down there kicking that door, scaring him, threatening him to kill him", I says, "you need to send someone down to get him away from that room", and they did like. But I mean he shouldn't have been allowed to be standing there kicking and threatening to kill him. It shouldn't have took me to have to phone them and tell them, you know, get away from him. But it just goes to show what goes on if you're not watching, you know'.⁶²

'In 2010/2011, P20 had an ear bitten off. MAH telephoned our mother in her nursing home to tell her. P20 was treated in Antrim Area Hospital for this injury. I heard this information through our mother, so I am not sure who injured P20 and I don't know who the witnesses were. In February or March 2012, P20 had his ear bitten off again. MAH telephoned our mother in her nursing home to tell her. I heard this information through our mother, so I am not sure who injured P20 and I don't know who the witnesses were'.⁶³

1.45 Sometimes families extrapolated what may have occurred from later events and reactions. P29's mother told the Inquiry:

'Before being admitted to MAH, Shelley loved going to the swimming pool. Shelley cannot swim but she loves being in water. Shelley refused to go to the swimming pool at MAH. When I asked her why, she said "They are bad in there". To avoid going to the pool, she told staff she was on her period. After leaving MAH, Shelley went back to the swimming pool and enjoys it again'.⁶⁴

⁶¹ P3's Brother Transcript – 05/07/22 – Page 10 – Line 11

⁶² P18's Mother Transcript – 21/09/22 – Pages 21-22

⁶³ P20's Brother Transcript – 21/09/22 – Page 65 – Line 15

⁶⁴ P29's Mother Transcript – 11/10/22 – Page 10 – Line 21

- 1.46 On very rare occasions family members witnessed what appeared to be improper behaviour by staff:

'I remember one particular incident in Cranfield. I was visiting Shelley and had bought her new pyjamas. I forgot to bring them in so went out to my car to get them. On my way back into Cranfield, I saw Shelley walking through the main room carrying a basket of laundry which she would give to the staff. A member of staff, who I believe was called [name], walked towards Shelley and forcibly pushed her backwards. Shelley stumbled but she did not fall. I remember feeling shocked at seeing this. When I went back into the building, I asked [the member of staff] why she pushed Shelley. She said that Shelley was violent, but this was not true as I seen what happened. When I left MAH, I telephoned the ward about the incident. They said that they had no record of the incident and told me that I should have reported it at the time. When I asked staff at MAH to look at the CCTV footage, they told us that it was not working'.⁶⁵

- 1.47 There were also allegations made of sexual interference:

'I believe it was in and around the early 2000s when one weekend we were bringing Ciaran home. He was very quiet in the car on the way home. As soon as we got home, we stripped Ciaran off to give him his shower and we found his penis was completely black with bruising. From we left MAH until we got home would have been no more than 45 minutes. I called our own doctor at the health centre, who came to our house to examine Ciaran. The doctor noted the injury to Ciaran 's penis. Body checks were supposed to take place at MAH immediately before a patient was taken home. We were told by staff at MAH that body checks were carried out. We took him back to MAH the next day, and they said it must have happened after the body check was carried out. MAH staff did not confirm when the body check had taken place. I cannot recall who I spoke to at MAH at the time to report this, but it was never taken any further by MAH. We contacted Anne Blake, who was an MLA [Member of the Legislative Assembly], and Jeffrey Donaldson, at the time our local MLA ... My husband and I attended a meeting at the time at MAH in relation to the incident with the bruising on Ciaran 's penis. I cannot recall everyone who was at the meeting but I believe it would have been H50, the MAH social worker, and nurses from the ward. I do not recall all the detail of what was discussed at the meeting, however I believe that a decision was taken that Ciaran would have one-to-one supervision with a nurse on M7B going forward'.⁶⁶

'On one occasion after P128's arm had been fractured whilst he was in Movilla B and he had been moved back to M4, we learnt that P128's privates were bruised so badly that they turned black. We are not sure whether we were called by MAH first or whether we discovered the injury during a visit when P128 pulled down his trousers to show us. We were horrified. His privates were so badly bruised ... We spoke to H565 about the bruising to P128's privates. H565 asked whether P128 could have walked into something sharp or a bench to hurt his privates like that. We were very disappointed in H565 making such a suggestion and I, Doreen, told him that to his face. To this day,

⁶⁵ P29's Mother Transcript – 11/10/22 – Pages 16-17

⁶⁶ P57's Mother Transcript – 20/10/22 – Pages 16-18

I remember saying to H565 in his office, "I am not pointing the finger, but do you think P128 did this to himself or someone else did it? Tell me the truth now". H565 said that someone did it to him ... Nothing ever came of the police investigation and we were not told why. But P128 privates were completely black. The evidence was there to see that someone had really hurt him'.⁶⁷

Medication and oversedation

- 1.48 Many patients were admitted to MAH so that an assessment of their medication could be undertaken. However, many patients remained in MAH for significant parts of their lives. One issue frequently raised by relatives was the concern that the patient was being oversedated. It was not possible for the Panel to ascertain whether sedation was because of regularly prescribed drugs or drugs used 'pro re nata' (PRN) – that is, as needed – to control behaviour which is considered in more detail in Chapter 7 (Restrictive Practices). However, many families noticed a significant change in their loved one after admission, which they attributed to oversedation:

'I remember visiting P17 in the Hospital, and although the visits were in the afternoon and as late as 6:00 p.m., he seemed like he had been doped. He would have had a slight pause before answering or speaking and there was a slur to his speech. I think that when the staff could not be bothered with P17, they would give him another tablet. I am not sure whether this was because they were under-staffed or because they did not care'.⁶⁸

- 1.49 The Inquiry heard that the sedation was having a significant impact on the daily routines of some patients:

'My son was very quiet in Muckamore, I think he was too quiet, this was concerning to me because my son is normally quite vocal. My son told me that Muckamore were giving him diazepam and injections ... I think the injected medication tranquillisers was the reason why my son slept until 3:00 pm on one occasion that we visited. There is no way he would normally ever sleep to this time. His routine was like clockwork'.⁶⁹

[Counsel]: *'And in terms of his behaviour during that visit, did he pick up at all, or how did the conversation go, if there was any?*

[P24's Father]: *He was just, he was just very, he was very drowsy then, and we brought up crisps and some sweets for him and every time we was trying to talk to him, he'd just like -- he was trying to fall asleep all the time, you know'.⁷⁰*

⁶⁷ P128's Father Transcript – 25/09/23 – Pages 12-13

⁶⁸ P17's Brother Transcript – 12/10/22 – Page 11 – Line 14

⁶⁹ P24's Father Transcript – 26/09/22 – Pages 44-45

⁷⁰ P24's Father Transcript – 26/09/22 – Page 20 – Line 18

'They did -- in Cranfield 2, they did try to maybe get a drug that would suit him more, because they would try a drug and they think it would work okay but it didn't really change anything. Initially it just made him like a zombie with dribbling. You know, then I would have got calls to say that he had -- there had been an incident, he had fallen off a chair, he had missed the chair on the bedroom and he would have bruises. I thought, well, it's probably quite, you know ... Sometimes it would be another patient who had hit him. There was one who actually had a member of staff beside him the whole time. But, you know, then I thought, well, he is so heavily medicated maybe he got up to go to the bathroom. I can't believe anything now, anything that I remember that I've heard because, as I say, he just deteriorated'.⁷¹

'Every time we went to visit Maria at MAH, she looked zoned out, like she was doped up on medication. She looked like a zombie. Most of the time, she was in her wheelchair. Maria only walked to the visiting room with the staff on a couple of occasions when we visited. I cannot recall exactly how many times'.⁷²

Information about medication and the experience of raising concerns

1.50 Relatives felt they were not provided with the information they needed about the patient's medication regime.

1.51 P52 was admitted to MAH at various times between 2008 and 2015 and then again in 2016, but her mother was unable to see the records of frequency and dose of PRN sedation:

'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'.⁷³

'When P116 was at home I knew all of his medications. I know that he went on different medications in Muckamore but I do not know the details. They did not keep me fully informed so I did not know. P116 was so sick I could not tell if he was overmedicated. I believe that, given the level of emotion and pressure that I and many relatives were under, Muckamore staff should be careful to ensure that matters are carefully explained and, where appropriate, paperwork is provided so that we can properly understand'.⁷⁴

⁷¹ P101's Mother Transcript – 13/09/23 – Pages 64-65

⁷² P64's Father Transcript – 23/11/22 – Page 30 – Line 4

⁷³ P52's Mother Transcript – 19/10/22 – Page 109 – Line 4 (restricted)

⁷⁴ P116's Mother Transcript – 12/10/23 – Page 26 – Line 20

- 1.52 Parents felt sidelined or unable to raise concerns with the medical staff about the level of medication being delivered:

'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'.⁷⁵

- 1.53 When they were able to discuss prescriptions, some families still felt that their concerns were not taken as seriously as they should have been. The use of medication to control epilepsy is a complex issue and there are both risks and benefits but some parents were concerned that medication was being overused. P117's mother provided a detailed account of the use and monitoring of medication for her daughter, who had a diagnosis of epilepsy, learning disability and behavioural problems⁷⁶ during her time in Donegore:

'During P117's time in Donegore she was put on Clozapine which we were told was part of an attempt to reduce the cocktail of medication that P117 was taking. We were told that there was a risk to her heart from the Clozapine and that she would therefore need blood tests every month to manage this risk. We were also told there would be side effects at the beginning of the treatment and so she was started on a dosage of 25 milligrams a day. As part of the adjustments to P117's medication her Clozapine dosage was increased frequently. She was at times over medicated as she would be jerky and drooling which [was] not behaviour that she would usually have. I contacted the consultant Dr H614 directly about the medication P117 was on and the effect it was having on her. At this stage P117 was on over 200 milligram of Clozapine. We were worried that P117 was going to have a seizure because of the high medication level. I knew her medication levels as we had to give her medication to her when she came home at the weekends and so this information had to be shared with us. P117 had a grand mal tonic clonic seizure when her Clozapine medication was at 400 milligrams. I cannot recall the exact date this occurred but I was so worried that I contacted doctor H614 directly. She was on holiday at the time but assured us she would contact MAH about the level of Clozapine being given to P117. We can only assume that in response to this the prescription was slightly reduced. I remained worried about the possibility of P117's Clozapine medication being increased again and so I contacted everyone I could think of for help. On the 9th March 2015 I was due to attend a meeting at MAH about P117's Clozapine. Prior to that meeting, I had telephoned the Public Health Agency [PHA] for assistance and spoke to someone at the PHA ... I explained my concerns

⁷⁵ P52's Mother Transcript – 19/10/22 – Page 14 and Page 20 (restricted)

⁷⁶ P117's Mother Transcript – 10/10/23 – Page 10 – Line 22

about the level of P117's medication, including that P117 had a grand mal seizure following the increase of her Clozapine to 400 milligrams. The person from the PHA I spoke to agreed to contact MAH about this issue.

Both myself and P117's Father attended the meeting and were told that P117 had been re-graded from a detained patient to a voluntary patient. I was provided with a letter dated the 10th March 2015 from the Chief Executive of the Belfast Health and Social Care Trust, BHSCT, which stated: "I wish to inform you that from 9th March 2015 the above named has been assessed as no longer needing to be detained in hospital and is now a voluntary patient". I attach a copy of Mental Health Order discharge of 9th March 2015 at exhibit 15 and a copy of the letter dated 10th March 2015 at exhibit 16. We are suspicious of the motives of BHSCT sending such a letter at the time'.⁷⁷

1.54 P117's mother concluded:

'Neither myself nor my husband have any confidence in the way that P117's medication was managed by the clinician at MAH. We believe there was an overuse of medication because it was easy when other methods should and could have been explored. In or around February or March 2022, I wrote to Sarah Meekin, a consultant clinical psychologist at BHSCT about getting help for P117 who I believed was going downhill. Since April 2022, P117 has had assistance from Caroline Cafferty under the guidance of Sarah Meekin to help her manage her emotional state. This is a service that I had to work at to ensure that it is regularly provided to P117. Also, at the request of myself, Dr. Dors is helping to wean P117 off the Clozapine that had been prescribed and administered to her at MAH. All of these changes have made a considerable difference and I wonder about the difference for P117 if MAH had been prepared to adopt this approach, especially the provision of behavioural psychology'.⁷⁸

1.55 P96's father also expressed his disquiet about regular medications:

'I am also concerned about the use of Olanzapine. I am particularly concerned to establish whether P96 was subjected to any form of experimental drugs or drug regime while in MAH. Sometimes when I went to visit P96 his pupils were massively dilated. His medicines were stopped, chopped and changed but at the time my view was that P96 was in hospital, the doctors were the experts and I could not challenge them on this'.⁷⁹

1.56 When families queried why their loved one was so drowsy and why drugs were given, they were given a generalised explanation but without any concrete examples:

'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

⁷⁷ P117's Mother Transcript – 10/10/23 – Pages 16-18

⁷⁸ P117's Mother Transcript – 10/10/23 – Pages 19-20

⁷⁹ P96's Father Transcript – 11/10/23 – Page 29 – Line 20

*being drowsy would have been an allegation that P54 was “kicking off” and was administered PRN to calm him down’.*⁸⁰

[Counsel]: *‘At paragraph 23 of your statement you say that when you visited your son, he seemed heavily medicated, and you said in fact a couple of times in your statement. Are you able to say how often that would’ve happened that you would’ve observed him in a state where you felt he was heavily medicated? [P113’s Mother]: I couldn’t really recall how often, but I would say for quite a while. We were going up and P113 could hardly -- he would stumble; we would’ve been out in the grounds or I would’ve took him maybe further afield and P113 would’ve stumbled. There was times you knew that he was completely -- his eyes were glazed, he would’ve been dribbling, you know, he’d just have been in a trance really. But as I say, unless I asked -- I knew by just looking at him. And then, of course, once I took him back into the ward again I was saying, you know, “has P113 received PRN?” And then I would ask why this was. So it was me asking. There was maybe a few times I was told of incidents, but it was usually myself that would’ve been questioning why and when he was given the medication’.*⁸¹

*‘Within months of P77 being admitted to MAH in 2012, his brothers say he was “zombified”. He was expressionless and dull. I tried to discuss P77’s medication with [MAH medical staff] on a number of occasions but it was never reduced down. It was, and still is, difficult to get details of what medication P77 was on and doses of medication’.*⁸²

*‘I was also concerned about the overuse of PRN. My understanding was that PRN medication should have been used as a last resort, not as an easy and convenient intervention. I noticed there to be a pattern of increased use of PRN associated with a certain core of staff. I did raise this at one of the MDTMs’.*⁸³

1.57 Staff at times seemed irritated by questions about medication:

*‘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’.*⁸⁴

⁸⁰ P54’s Mother Transcript – 13/10/22 – Page 20 – Line 11 (restricted)

⁸¹ P113’s Mother Transcript – 26/09/23 – Page 81 – Line 1

⁸² P77’s Mother Transcript – 20/06/23 – Page 21 – Line 9

⁸³ P34’s Mother Transcript – 09/10/23 – Page 19 – Line 23

⁸⁴ P55’s Father Transcript – 18/10/22 – Page 29 – Line 2 (restricted)

- 1.58 Families had concerns about regular medicines and told the Inquiry that they were rarely involved in discussions about changes to medication. Sometimes they only found out about them when they brought their relative home for the weekend:

'I noticed after Kirsty went into MAH that she became more drowsy and sleepy. Kirsty said Mummy, they changed my meds. They did not inform me or consult me about changes in her meds as they said she was an adult. There was never any consultation with the family'.⁸⁵

'Doctors in MAH prescribed a drug called Melleril, which P12 then took from 1987 until the early 2000s when it was replaced by Largactil. Dosages were changed at various times but we have no hard record of when and by how much'.⁸⁶

'There has been a couple of occasions where medication, his medication has come home and I always have a system of setting his medication out and I've noticed there would have been a new medication, but I wasn't told about it. And usually what happens is then I Google to find out what it is and what is it for. But it has happened on a couple occasions, that there. And I did bring it up to [a doctor] that I was concerned that I wasn't - I didn't know what the medication was for and I should have been told'.⁸⁷

'The communication between my family and MAH as to exactly what medication P34 was being given and why was never good. However, it was particularly bad from 2018 onwards. In a 2018 medication review, it was clear that H50 had started P34 on Haloperidol on 23rd August 2018 as it had been increased to the maximum dosage within three months. These decisions had all been made without my family being notified'.⁸⁸

[Counsel]: *'And during P34's time period in Muckamore, did your family have regular contact with the prescribing clinicians about what medication P34 was on?*

[P34's Sister]: *My parents would have attended MDT meetings I think every six to eight weeks. I wouldn't have attended them with them in the earlier days and from what I am aware, I think some consultants were better than others at making them aware of what medication P34 was on, but I don't think they knew to the extent of what he was on. It might have been, like, the one main drug that he would have been on and not all the others that would have been given to him to counteract the side effects'.⁸⁹*

- 1.59 Several witnesses raised their concerns about the amount of drugs their relative was being given and the effect upon them, whether it was regularly prescribed drugs or drugs given PRN:

⁸⁵ P4's Mother Transcript – 28/06/22 – Pages 140-141

⁸⁶ P12's Brother-in-Law Transcript – 29/06/22 – Page 68 – Line 23

⁸⁷ P18's Mother Transcript – 21/09/22 – Pages 22-23

⁸⁸ P34's Sister Transcript – 09/10/23 – Page 59 – Line 21

⁸⁹ P34's Sister Transcript – 09/10/23 – Page 86 – Line 8

'We gradually noticed the longer P26 was in Muckamore and the longer that he was on the heavier medication that he became more tired looking and his speech became very slow. He didn't seem to be the same P26 that he was before he went into Muckamore. P26 would have been stubborn but full of fun. He wouldn't have been scared or afraid. However, after a while in Muckamore P26 totally changed in all those ways. It was like he became a totally different person. You would talk to him but there was no excitement about him. He was always in tracksuits and not dressed up. When he was in Muckamore, P26 always looked like someone who had slept in for too long that day ... We asked but could not get an explanation why P26 was on such heavy medication. He didn't pose a threat and my mum had been able to control him, so surely these professionals could have controlled him? I feel that if my mum had been a bit fitter he could have stayed at home and she would have been able to control him and he would not have needed to be in Muckamore. It didn't really take much to control P26'.⁹⁰

[P28's Mother]: *'I was frightened at the level of care they were giving him regarding medication. And I had a sense that, because I couldn't engage with P28, I felt at times he was overmedicated.*

[Counsel]: *What made you think that?*

[P28's Mother]: *It felt like he had a medical cosh because he -- he wasn't reacting the way that he normally would have at home. He wasn't responding to us in the way that you would normally expect him to. He wasn't engaging. He wasn't -- if you spoke to him, he, he would look at you with empty eyes. He would look at you through the top of his head. It was like -- it was like the lights were on and no one was at home'.⁹¹*

'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'.⁹²

- 1.60 Families also expressed reservations about the way PRN drugs with sedative effects were used. These are prescriptions that registered nurses (RNs) can decide to give when required, as opposed to the regular drugs, the frequency of which is determined by the prescribing doctor and that RNs have no discretion to increase or omit. P96's father told the Inquiry:

'I have concerns relating to the overuse of PRN medication as an early rather than last resort. I am unaware of whether there was any protocol in place for the use of PRN medications'.⁹³

⁹⁰ P26's Uncle Transcript – 26/09/22 – Pages 92-93

⁹¹ P28's Mother Transcript – 28/09/22 – Page 73 – Line 5

⁹² P54's Mother Transcript – 13/10/22 – Page 41 – Line 6 (restricted)

⁹³ P96's Father Transcript – 11/10/23 – Page 29 – Line 17

'On one occasion Alicia was given the maximum level of PRN, 4mg of Lorazepam, because she was so agitated even though she was already on 27mg Diazepam. When I went to visit Alicia at about 4:00 p.m. or 5:00 p.m. on the day, I found her lying in bed comatose. I spoke to the senior nurse and told her that was not how I expected Alicia to be treated, and it was unacceptable. I told the nurse that my understanding was that PRN was a method of the last resort. I was concerned that Alicia was at risk of an overdose. I complained to RQIA, but they did not consider that Alicia was at risk of an overdose'.⁹⁴

1.61 P76, an ex-patient at MAH, told the Inquiry:

'Overall, I felt that some patients had the right medication, but I felt that others were treated like guinea pigs and were given a lot of medication. This meant that patients were sometimes sleeping all the time, slurring their speech, unable to speak, with heavy eyes and generally drowsy. These patients would not have been aware of what was going on around them. I would have seen other patients walking around like zombies and I think this was because they were overmedicated. This annoyed me at times because some of the people who were overmedicated were not violent at all. I do not think that they needed the medication they were given'.⁹⁵

1.62 The response by the nurses to distressed behaviours was often PRN sedation, but families reported that PRN drugs were not required when their loved ones came home on leave:

'The medication, the PRN, is sent home with P18. I haven't had to use it. So that's the only ... I deal with all the rest of his medication that comes home with him, but I've never had to give him the PRN, because he's just, he's just, he's just a big ball of fluff, he really is, he's just gorgeous'.⁹⁶

1.63 P90 has been in MAH since 1988. His sister commented:

'It is my opinion that PRN was being used as a first response as opposed to the nurses using positive behaviour support. In Bryan's care plan it provided that positive behaviour support should be used before PRN. I had become vocal about the overuse of medication because Bryan had been very sleepy during the day. Staff had been using medication every time Bryan became agitated. I was advised on the 8th August 2022 by a member of staff during a telephone conversation that lazy staff on the ward were using PRN medications as a first line management of Bryan's agitation outbursts contrary to Bryan's care plan. This simply reinforced the concerns our family already had due to the number of times that we would go to visit Bryan to find him lying sleeping on a couch. This was the first real evidence we had received. This issue has been escalated to ASG [Adult Safeguarding]. Our family wondered at the time whether Bryan's apparent sleepiness was a result of his medication sedating him, together with a degree of boredom. As far as we could see the staff mainly

⁹⁴ P109's Mother Transcript – 21/09/23 – Pages 31-32

⁹⁵ P76's Transcript – 12/09/23 – Page 26 – Line 17

⁹⁶ P18's Mother Transcript – 21/09/22 – Page 22 – Line 20

sat in a corner observing Bryan, rarely interacting or doing anything stimulating with him'.⁹⁷

- 1.64 A former patient told the Inquiry that he was given PRN drugs if he did not do what the staff requested:

[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'.⁹⁸

- 1.65 P118 was verbal and told his sister what had been happening. His sister told the Inquiry:

'Whilst P118 was in MAH, I observed P118 demonstrating signs of being heavily medicated. For example, his eyes rolling in his head, slurred speech, falling asleep quickly and tripping over his own feet when trying to walk. I asked ward staff on numerous occasions why P118 was displaying these signs. I was always advised that P118's behaviour that day required further medication which I now know is called PRN treatment to manage the situation. When I enquired what P118 had done to require further administration of medication, the staff response was always negative towards P118's behaviour and presentation. For example, it was P118's own fault that he needed further medication because he was shouting or kicking out at staff. I never heard hospital staff being accountable for any of their own actions during any of these incidents. I would refer to this treatment type as chemical control and a highly inappropriate response to manage an unsettled moment in P118's life, bearing in mind the situation may have been triggered by a member of staff. P118 would have regularly disclosed to me what staff would upset him daily. P118 felt frightened. He said staff would laugh at him, shout at him, they swore at him and had punched him. P118 had explained to me that he had told staff that he was not a punching bag and to stop it. He told me that staff just laughed and walked away. If I questioned nursing staff, it was always dismissed with the explanation that incidents started with P118 and his presentation on that day. I was also advised that P118 fabricated stories to get staff into trouble. I know P118 and I know this to be untrue. P118 had also explained to me that staff would have taken his treasured radio away from him while sitting relaxing and listening to a favourite radio show. P118 uses a radio for sensory needs. He finds the radio a comforter and the music is a soother. P118 continues to enjoy this activity today. The staff at MAH would not have taken this on board. They would have taken P118 away from his radio to engage in some other activity, for example, saying that he had to watch TV. This would trigger P118 and they would then describe P118 as being aggressive'.⁹⁹

⁹⁷ P90's Sister Transcript – 11/10/23 – Pages 108-109

⁹⁸ P21 Transcript – 20/09/22 – Page 53 – Line 4 (restricted)

⁹⁹ P118's Sister Transcript – 09/10/23 – Pages 126-128

- 1.66 P117's father noted that the doctors seemed to find it easy to add medicines but much harder to decide to stop them:

*'With the medications, they are quick to put them on tablets, the medication, but trying to get them off them. They put them on them, they are on them for life, they don't reduce them unless you insist, that's what the problem is. Even today, you're still arguing with the doctor to try and get them reduced. But we've done that and we are afraid of taking her down, her behaviour might start. P117's Mother has proved them wrong by getting them to bring them down and there has been no issues with her behaviour, if you know what I mean'.*¹⁰⁰

- 1.67 Some parents felt they had no option but to accept the drug regime, as they had been told that the new drugs that might help their relative could not be tried in community settings:

*'I do strongly remember the meeting with the psychiatrist, who had stated she needed a secure unit - I think that was the issue, where Downshire wasn't a secure unit - to trial her on this medication, Clozapine. And if we didn't agree to it, then Downshire was the only option, but she would not [be] able to be trialed on this medication because it required a secure facility. The only money was in learning difficulties, so it would have to be Muckamore Abbey Hospital. That was the conclusion of the meeting'.*¹⁰¹

- 1.68 Relatives also expressed concerns about errors in medication:

*'I also found that there were frequent mistakes with P101's medication, including a failure to give him certain important medication. On one occasion when I was visiting P101, I noticed that his medication had changed. I told the young nurse that it was not correct. I told her that his dosage had changed. She went and checked and came back and said I was correct, and his medication had changed. This was concerning for me. Medication was never explained to me or P101. There was no family input. I feel that P101 was managed by medication rather than being given proper care by behavioural specialists. I always tried to stress the need for behavioural input, but I was invariably ignored. I was promised that a behaviour team would work with P101, but this was never followed up. P101 was prescribed medication for his unstable moods but it was tough on his liver. MAH were supposed to reduce the dosage but they did not reduce it for over week. They then suddenly reduced it by half, which I thought was potentially dangerous'.*¹⁰²

¹⁰⁰ P117's Father Transcript – 10/10/23 – Pages 22-23

¹⁰¹ P50's Sister Transcript – 19/10/22 – Pages 15-16

¹⁰² P101's Mother Transcript – 13/09/23 – Page 59 – Line 7

Personal care

1.69 Neglect of a patient can take many forms. Personal neglect might be in terms of general appearance, washing, or cleaning and care of teeth. Alternatively, there may be medical neglect where someone needs medical care and fails to get it, or the care offered is wholly inadequate.

1.70 A common theme in the evidence given to the Inquiry was the lack of attention to personal care by some (but not all) staff. This included lack of attention to personal appearance and a lack of consideration of the person's personal preferences:

'On one occasion Amanda's hair was cut really short like a boy's haircut. Her hair was usually long. I remember thinking that they did this so her hair would be more easily managed for the staff'.¹⁰³

'I recall going to MAH for an open day; I cannot recall the date. This open day was attended by the parents and families of patients, and there was a band and dogs. The open day was organised by MAH and I am not sure why it was organised. When I arrived, I was shocked to find that P100 was wearing a pair of trousers which had a broken zip. P100's privates were visible, and the soles of P100's shoes were hanging off. When I found P100 like this, I was devastated, I always provided P100 with new and clean clothes. P100 always would have had around 20 pairs of trousers in his wardrobe, which is why I could not understand why staff would have put faulty trousers on P100. I feel staff could not be bothered to change P100. I had to pull his coat down as far as I could so that it covered the zip area. I did this to respect P100's dignity'.¹⁰⁴

'Things began to get much worse and when we went to visit P28 he was more and more unkempt. When we were allowed on the ward we noticed more bruising. He wasn't as clean as he used to be. His hair was long and dirty. Alarm bells started ringing. He stank and smelt of strong body odour and urine. His beard was long and he was thin and gaunt. His trousers were falling off him'.¹⁰⁵

1.71 There were complaints of a lack of care as to what patients wore and whether it was appropriate:

'There were many occasions when P105 would be inappropriately dressed. This included being overdressed for warm weather in warm fleecy clothes. He would be literally sweating. I feel that it is pivotal to note that P105 was dressed by the staff. If he was inappropriately dressed, then I assume it was because the staff were not paying attention or did not care'.¹⁰⁶

¹⁰³ P2's Mother Transcript – 29/06/22 – Page 14 – Line 24

¹⁰⁴ P100's Mother Transcript – 14/09/23 – Page 16 – Line 10

¹⁰⁵ P28's Mother Transcript – 28/09/22 – Page 33 – Line 18

¹⁰⁶ P105's Mother Transcript – 14/09/23 – Page 49 – Line 1

1.72 P90's sister told the Inquiry:

'Bryan was left inside in his hot room during the heatwave without a fan or a fridge to keep cold drinks in or air conditioning. When I visited him during this time Bryan was clearly very uncomfortable and was visibly sweating. Aidan and I made repeated requests for things to change and for Bryan to be allowed a fan, a fridge and access to the outdoors. It took at least a week for accommodations to be made.

There were times when visiting that we had to wait for Bryan to be brought out of the visiting room. The reason given was mainly that Bryan had messed his clothes and needed changed. We accepted this as Bryan is a messy eater but were unaware of what state his clothes were in or what had caused them to be dirty. I also recall a time when Bryan was in Erne Ward, it would have been between 2016 to 2021 when I visited. Bryan was sitting on the couch in the common area and arose to walk across the room. He had jogging bottoms on which were loose and upon rising his trousers fell revealing that he did not have any underwear on. I spoke to the ward manager, H519, about this. She seemed unperturbed like this was not out of the ordinary and said she would speak to the staff. I never heard anything more about it. Sometimes Bryan's clothes were torn and on occasion he would be wearing someone else's clothes. Our family have always provided Bryan's clothes so I don't understand how that could happen. MAH did Bryan's laundry. Bryan is and always has been completely dependent upon carers for toileting and personal hygiene. I always hoped that this was being done correctly, but sometimes during visits I noticed faeces around Bryan's fingernails, and tips of his fingers. I have had to ask staff to wash Bryan's hands and cut his toenails'.¹⁰⁷

1.73 Unfortunately, the issues described above are not merely historic and seem to be continuing into more recent care at MAH. The Inquiry was told by one mother:

'I recall attending MAH on a pre-arranged visit to see P77 on Boxing Day 2021. I brought P77's brother Iain and Iain's girlfriend Jade. P77 was presented to us in such a poor state. His pad was clearly full and had not been changed in some time. He had not been given his medication and looked very neglected. I made a formal complaint by email'.¹⁰⁸

1.74 Families told the Inquiry that they had ensured their loved ones maintained personal hygiene routines when at home, but these were not maintained or supervised by MAH staff:

'P63's father and myself raised the concerns about P63 becoming more institutionalised, as we seen it, and losing the skills that he had had when he was at home, such as brushing his teeth, dressing and washing with help, helping in the kitchen, looking after himself'.¹⁰⁹

¹⁰⁷ P90's Sister Transcript – 11/10/23 – Pages 90-91

¹⁰⁸ P77's Mother Transcript – 20/06/23 – Page 74 – Line 1

¹⁰⁹ P63's Mother Transcript – 30/11/22 – Page 28 – Line 14

'Well, before P60 went into Muckamore, he had washed, bathed every day. He had taken great pride in his appearance and his dress sense. That all disappeared after he was admitted to Muckamore, after, like, so many months, to the point when I want to visit, or mum or dad went to visit, you could actually smell -- you know, the odour was on his clothes, and you noticed that his clothes were stained. You just said, "You know, P60" ... He lost all total pride within himself, even down to his toilet needs'.¹¹⁰

'P128 is dependent upon his carers to attend to his personal hygiene. In his resettlement place, gets a shower every morning. This was not the case in MAH. It was not clear how often P128 was washed in MAH. When the staff were asked, they would simply claim that he was washed regularly, but they provided no detail about frequency or what type of wash. It was clear his hygiene standard was not good at MAH, and this improved again after he moved out. We are convinced that the reason for P128's poor hygiene had nothing do with P128's behaviour, as became clear when he moved out. No issues have been raised in the resettlement place about washing and showering and his personal hygiene has improved significantly'.¹¹¹

'P34 has always required support with every aspect of his personal care. I recall during a family visit, I brought buns to the Cosy Corner. Whilst eating them, P34's Daddy noticed had [his hand] and was disgusted at the dirt in his nails. This appeared to be faeces. We returned right away to the ward and raised this discontent with a nurse called H591. I was very upset at her dismissive manner and when I mentioned that I was aware there had been several outbreaks of Norovirus, that P34 had been a victim to, she became very defensive. The member of staff that was supposedly caring for P34 that day was called H592. He was very curt with myself and my husband for around one year after we raised this issue. After this incident, I always carried a nail brush and scissors in my bag to cut P34's nails'.¹¹²

'I remember one time, but I am not sure when it was, that my mum and I went to visit P20. P20 was brought out to us, and he was covered in shit. We had to send him back to his room to get cleaned up. H71 was in charge on that day'.¹¹³

'On the occasions that I did get to see P77 when I visited, he would mainly just be out of the shower and I had to wait until he finished. I often thought, "why would they give P77 a shower just when I arrive". The staff presented P77 to me like he had just been given a special treat because he had just had a shower. The staff member would say smiling "P77 has just had a shower". I recall on one occasion, I visited P77 and he had not just had a shower. He looked filthy and his hair was greasy. He was led out to me by a female member of staff with black hair. I was devastated by P77's appearance and told the female member of staff that P77 needed a shower. She was reluctant but took P77 away and gave him a shower and brought him back to me ... I

¹¹⁰ P60's Sister Transcript – 20/09/23 – Page 58 – Line 13

¹¹¹ P128's Father Transcript – 25/09/23 – Page 14 – Line 10

¹¹² P34's Mother Transcript – 09/10/23 – Page 21 – Line 9

¹¹³ P20's Brother Transcript – 21/09/22 – Page 65 – Line 9

*did not complain about this because I did not know who to complain to and no one would care anyway’.*¹¹⁴

1.75 P124’s mother told the Inquiry:

*‘P124’s father and I were allowed into P124’s room when he was in Erne. At times we found that his bed had been made but there was a strong smell of urine. I checked the bed and it was soaking. This had been left for him to get back into that evening. There were also times when we collected P124, he would have human faeces on him’.*¹¹⁵

1.76 When asked why staff sometimes did not supervise patients in the maintenance of their own personal hygiene, it appeared that some staff did not believe this was their role. Staff told one parent:

*‘Muckamore is not a school, it’s a hospital’.*¹¹⁶

1.77 Plainly staff did provide personal care to patients and assisted them with daily tasks, but there were accounts that this care was not always delivered appropriately:

*‘The most concerning thing I can recall was morning time on the ward. It was like a scene from Annie. There would be several patients’ personal care being dealt with altogether. Seven or eight patients would all be brought to the bathrooms at the same time. Typically there would be only three or four Muckamore staff. Some of these patients, at least two or three, could do some of their personal care themselves but the rest could not. There would be one at the sink having their teeth brushed, one in the shower and one getting dried. The rest would be unattended. At least four patients would have been naked at the same time, others might have had a towel. There was a loss of dignity, or no attempt to preserve their dignity’.*¹¹⁷

Physical health

1.78 The Inquiry also heard concerns about the lack of attention paid to physical health. There was significant concern about the supervision of diet and weight. A number of families told the Inquiry about issues with weight management.

1.79 Many of the patients were on drugs known to be associated with weight gain; in some cases weight gain caused sleep apnoea¹¹⁸ and some people became

¹¹⁴ P77’s Mother Transcript – 20/06/23 – Pages 25-26

¹¹⁵ P124’s Mother Transcript – 20/09/23 – Page 117 – Line 14

¹¹⁶ P63’s Mother Transcript – 30/11/22 – Page 29 – Line 10

¹¹⁷ P57’s Brother Transcript – 21/09/23 – Pages 107-108

¹¹⁸ P64’s Father Transcript – 23/11/22 – Page 31 – Line 14

clinically obese. Some families talked about how they had managed weight at home through strict control of diet and ensuring some exercise was taken. However, at MAH weight gain for many people was dramatic and affected mobility:

'There was nothing for her to do - no recreation, no walks, no gym or exercise. When Kirsty went into MAH she was a size 10. I attach a photo taken of her around a week before she went into MAH ... when she left MAH she was a size 20'.¹¹⁹

- 1.80 Weight gain was for many compounded by limited physical activity. Despite some becoming clinically obese, the Inquiry heard that diet and weight were not always actively monitored on the wards in MAH and there was little attention to physical activity. Even for more able residents, Anne Laverty (then dietician) observed that exercise opportunities were limited:

[Counsel]: *'Was there anything put in place to try to assist patients with getting their exercise, like exercise classes or an exercise regime?*

[Ms Laverty]: *Yeah, well I think walking was about the best they could do really because, you know, there was no sort of exercise classes unless sometimes in the evenings I think some of the nursing staff might have encouraged some sort of exercise video or something.*

[Counsel]: *Did you see that happening?*

[Ms Laverty]: *No, I never saw that but getting them out to walk a bit more'.¹²⁰*

- 1.81 Others lost significant amounts of weight while in MAH, without clear care plan interventions:

'P28 needs support feeding for a lot of reasons. P28 has a visual problem, so if things aren't placed in front of him, he might not see them. P28 has cerebral palsy, so he may find it difficult to lift certain foods, especially foods that would spill - for example, yogurt or soup. P28 has epilepsy, so it's very important that he's monitored while he's eating in case, he may choke on something while having a fit. So, there's lots of reasons why P28 should be monitored and supervised while he is eating ... every time that we went, P28 seemed to have lost weight, lost condition'.¹²¹

- 1.82 One ex-patient explained how she did not like to eat in the dining room because there were too many people, which stressed her. She told the Inquiry:

'I went to school and I got a taxi there every day from MAH and a taxi back again to MAH. My school day was from 9:00 a.m. to 3:30 [p.m.]. I had my lunch in school but I starved in MAH. I ordered the food I wanted in the morning but the food that came was rarely what I ordered and most of the time there

¹¹⁹ P4's Mother Transcript – 28/06/22 – Pages 137-138

¹²⁰ Anne Laverty Transcript – 06/02/24 – Page 98 – Line 6

¹²¹ P28's Mother Transcript – 28/09/22 – Page 56 and Page 57

*was nothing brought to me at all. You were supposed to eat in the dining room but I did not like to be in there as there were too many people. The staff were supposed to bring my food to my room. I told my aunt that I was not being given food and she complained to the staff. I do not know who she complained to, but nothing happened. I would call my aunt on my mobile phone to order me a Chinese takeaway if my dinner did not come. The staff had to give me the Chinese food as if they did not, my aunt would come up to MAH. Sometimes I had no breakfast and no lunch, and I just had to wait until dinner to eat’.*¹²²

1.83 An ex-patient told the Inquiry:

*‘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’.*¹²³

1.84 Staff seemed to have little regard for the health aspects of food. There were frequent reports of takeaways and sweets given as ‘treats’. One mother of a person with a genetic predisposition to overeating felt that food was used to manage behaviour:

*‘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’.*¹²⁴

*‘The ward staff in MAH made me feel like a bad mother about being particular about what P77 had to eat. I was really concerned about his weight and the size of P77’s tummy because he was obese. I wanted him to have a balanced diet but I was made to feel like I was saying to the staff that P77 should not have any treats at all which was not the case. The ward staff would say to me that I was “insisting” on P77 having a good diet. I recall that the ward staff would say that they gave P77 a wee treat as if they were being nice to him and I was the bad mother who would not allow her son any treats. The ward staff would say “the mother does not allow P77 to have treats”’.*¹²⁵

¹²² P127’s Transcript – 20/09/23 – Page 139 – Line 11

¹²³ P21 Transcript – 20/09/22 – Page 29 – Line 5 (restricted)

¹²⁴ P5’s Mother Transcript – 29/09/22 – Page 25 (restricted)

¹²⁵ P77’s Mother Transcript – 20/06/23 – Pages 39-40

- 1.85 There were also examples of unhealthy behaviours, not seen at home, commencing on the wards of MAH:

'My son told me that he had been offered cigarettes, Red Bull and other energy drinks and alcohol. My son has never smoked and drank alcohol'.¹²⁶

'My family would always take Peter up sweets and treats when visiting. Peter became less interested in lemonade and sweets after he was introduced to cigarettes in MAH. We were all quite shocked that he could be introduced to smoking at MAH and that he was permitted to become totally addicted to cigarettes. Staff in MAH would give him a cigarette but then when he looked for another they would tell him he had to wait. It was a torture to Peter giving him a habit'.¹²⁷

- 1.86 The Inquiry heard that families had concerns that staff were not monitoring their relatives' physical state in a way that would be expected for very vulnerable people. Some noted that MAH did not routinely use body charts to monitor abrasions and bruises, making it hard to ascertain when unexplained injuries occurred or even how many occurred. Relatives also had concerns that there was a lack of care over personal issues that the patient could not have coped with themselves, such as their feet:

'There was also a lack of proper attention to P105's feet and toenails, which got into a terrible state. At one stage P105's feet were covered in blisters and his heels were cracked. His toenails were frighteningly long, he had a fungal nail infection and at one point he lost a toenail. I recall in and around May 2017, I had been out for a walk with P105 and he complained about his feet being sore. When we got back to MAH, I asked a nurse named H459 to look at P105's toes and feet. I phoned MAH that evening around 8:00 p.m. to find out the position but P105's feet had still not been looked at. P105 was unable to dress himself without help so I do not know how staff would not have seen the condition of P105's feet when they attended to his showering, personal hygiene and dressing. They must have known about it and decided not to deal with it'.¹²⁸

'I recall on another occasion, I had purchased nice shoes for P77 and the staff told me that he did not want to wear them as his toes were too cramped. I discovered to my horror when I went to give P77 a foot massage in and around April 2015, P77's toenails were so long that they grew over the top of his toe and curled to the back. It was not the shoes that were the problem it was his toenails. I remember being devastated about this at the time. I complained to H397 and told him that all of his staff including him are involved in changing

¹²⁶ P24's Father Transcript – 26/09/22 – Page 45 – Line 5

¹²⁷ P123's Sister Transcript – 28/09/23 – Page 42 – Line 18

¹²⁸ P105's Mother Transcript – 14/09/23 – Page 50 – Line 4

*and bathing P77 and they should have noticed. He did not have much of a response for me’.*¹²⁹

- 1.87 Families also told the Inquiry that continence was not managed at night as had been planned and patients were shamed for being incontinent:

*‘I recall P17 sitting on the side of the bed in his bedroom and crying. When I tried to console him and asked him what was wrong, he told me that he had wet his bed. P17 has had this problem for a long time. P17 said that he was supposed to have a nappy on to sleep but that the staff hadn’t put one on him that night. He woke in the middle of the night and found that he had wet the bed. He had used his buzzer and a member of staff had come to him. P17 said, “They were very cheeky to me”. P17 was very upset by this and I had to sit with him for a long time until he was able to calm down’.*¹³⁰

- 1.88 P17 was in MAH from around 2010 to 2017. His brother told the Inquiry of one occasion when he was very concerned about the state of his brother’s legs:

*‘The nurse came to see P17 and I got him to show the nurse his legs. She examined them. P17’s feet were hugely swollen, with three-quarters of his toes disappeared and black marks going up his legs. I think these black marks were from the swelling and not bruises. The nurse said that she would deal with it and get P17 treatment, and I took her at her word. I was very worried about these symptoms because our mother and our uncle, P17’s uncle, had both had swollen ankles and the same symptoms just before they died. I told the staff about this family history. Two weeks later when I was visiting, I asked P17 how his legs were. He said they were still sore but that the staff were putting cream on them. I was really worried and I complained to the nurse that P17’s legs were getting worse. She was very sharp with me, speaking only in short sentences to say that he was getting treatment. She had a very bad attitude’.*¹³¹

- 1.89 Some of the patients had specific aids for medical conditions but the families report that staff did not use them:

*‘He has to wear softer shoes because he has Raynaud’s Syndrome and he also has to take medication. We brought in a new pair of shoes and they didn’t put them on him. When my son came home, we saw that the labels were still on the shoes and that they had never been worn. This meant my son wore the same shoes the whole time he was there’.*¹³²

¹²⁹ P77’s Mother Transcript – 20/06/23 – Pages 35-36

¹³⁰ P17’s Brother Transcript – 12/10/22 – Page 15 – Line 11

¹³¹ P17’s Brother Transcript – 12/10/22 – Pages 14-15

¹³² P24’s Father Transcript – 26/09/22 – Page 46 – Line 5

- 1.90 Families reported that they were frequently not told about, or involved in decisions about, significant treatments issues. A number of parents found this very difficult as they had looked after their child's health since birth before admission to MAH:

'Following P97's discharge from MAH, when he was getting dental treatment, we discovered that he has had a lot of his back teeth removed. We were not consulted or informed by any MAH staff of any of P97's dental treatment while he was at MAH'.¹³³

- 1.91 P8's mother had power of attorney over P8 and was his next of kin. Nevertheless, she told the Inquiry of a lack of information from MAH about his health issues:

'For example, in the first year P8 was in Muckamore, he had a few health issues that I was not informed about until P8 told me weeks afterwards. P8 told me that he had bloods taken and that his bloods were too high. I do not know what this meant. P8 told me that there was something wrong with his liver. I recall P8 asked me if he was going to die, but I could not answer him, because I knew nothing about this. He told me he had been to the dentist and had a filling two weeks after he had had the appointment. I found out that P8 had been to the opticians only when he came out to me during one of my visits wearing a pair of glasses. P8 told me that he had a toenail removed by the podiatrist. I do not recall the specific dates of any of these events, but they were during his first year in Muckamore'.¹³⁴

- 1.92 The Inquiry heard frequent complaints about the lack of general healthcare and particularly the care of patient's teeth.

'When Eoin [admitted to MAH in 2006] was first placed in Mallow his teeth were inspected by a dentist who told me that his teeth were fine. In or around 2008/09, Eoin had to be referred to the Royal Dentistry Department. I asked for this referral but was told there was a three-year waiting list. I could tell that he was in pain as when he was eating he would lash out. We were seen by the dentist in RVH [Royal Victoria Hospital] who said that Eoin needed several fillings and that he had two impacted wisdom teeth which were infected. I could not understand how this had been allowed to happen, as the dentist in MAH said there was nothing wrong with his teeth ... I was generally and continuously concerned about the quality of medical care available at MAH. I believe this was of considerable significance for Eoin as infection can increase the frequency of seizures. Eoin's seizure activity increased in July and August 2007 when Eoin had nausea and was vomiting'.¹³⁵

'Right up to the present day, brushing his teeth has remained an issue. This was raised all the time at visits as it was clear P34 had not been getting support to brush his teeth. I brought a toothbrush and toothpaste with me to visits. Throughout his time at MAH, P34 had various dental procedures including two

¹³³ P97's Sister Transcript – 13/09/23 – Page 24 – Line 21

¹³⁴ P8's Mother Transcript – 26/09/23 – Page 16 – Line 13

¹³⁵ P115's Father Transcript – 27/09/23 – Pages 53-54

extractions and seven new fillings in May 2023, seven fillings in July 2021, as well as having other teeth extracted on other occasions. I recall another time during a visit when I spotted black in P34's teeth. That was decay and had to be removed. It was very clear to me that MAH staff were not regularly brushing P34's teeth. This was the level of basic care that was lacking'.¹³⁶

'The lack of personal hygiene support that P34 was provided in MAH was shameful. P34's dental record in May 2023 details how he had to have two teeth extracted and had to receive seven new fillings. I remember how past and present, I would have said [to] staff about supporting P34 in brushing his teeth. However, I felt they always used the excuse that he would not let them do it. P34 would have let my mother clean his teeth but I do believe some staff did not take the time and did not have the patience to do this for P34'.¹³⁷

'In and around 2018, I recall receiving a call from a dentist from the School of Dentistry at the Royal Victoria Hospital in Belfast. She was calling to ask my permission to do some work on P77's teeth. She advised me that P77's teeth had not been cleaned for years. This would confirm not only that the staff at MAH did not brush P77's teeth but also that he had not seen a dentist or brushed his teeth since he went into MAH in 2012. This is clearly neglect'.¹³⁸

'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'.¹³⁹

'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'.¹⁴⁰

Availability of medical care

- 1.93 Several relatives expressed concerns about the lack of access to primary care from a general practitioner (GP) and it seems in this respect patients at MAH were in a worse position than if they had been living in the community:

'There was no resident GP in MAH. Patients did not have proper access to a GP like everyone else. In my view, the patients only got to see the GP in an

¹³⁶ P34's Mother Transcript – 09/10/23 – Page 22 – Line 16

¹³⁷ P34's Sister Transcript – 09/10/23 – Page 55 – Line 20

¹³⁸ P77's Mother Transcript – 20/06/23 – Page 55 – Line 8

¹³⁹ P121's Sister Statement – 03/10/23 – Page 18 (restricted)

¹⁴⁰ P54's Mother Transcript – 13/10/22 – Page 65 - Line 8 (restricted)

*emergency which indicates that they were being treated as second-class citizens’.*¹⁴¹

1.94 In addition, the Inquiry was told that medical staff at MAH (particularly the doctors in training) failed to take responsibility for physical health and were slow to respond to emergency situations.

1.95 There was also concern about the lack of resident doctors overnight:

*‘Many of the patients engaged in swallowing inappropriate and often dangerous objects. This is something that P118 had not done before his admission to MAH. In or around 2010 when P118 was based in Cranfield 1, he swallowed two batteries, one of which he discharged but the other lodged itself in the bowel. Staff were not checking for the second battery to be passed. As a result, it remained in his bowel where it leaked and caused a large inflammatory abrasion with an accompanying abscess in his bowel. P118 became very unwell but the staff were very reluctant to have him seen by a doctor. I recall having to beg a night nurse to get P118 seen by a doctor or taken to Antrim Area Hospital. The nurse initially refused and told me that a doctor would be on shift later. I later learned that there was no doctor in MAH during night shifts at that time. The night nurse telephoned me in the morning to say that P118 was very unwell and he was on his way to the hospital. An x-ray taken in Antrim Area Hospital showed that P118 required surgery immediately. The surgeon telephoned me to inform me that he was going to have to remove part of P118’s bowel but he hoped he would not have to do a colostomy that would leave him with a colostomy bag for the rest of his life. The consultant telephoned me after he got out of theatre to inform me that the surgery had been successful, that he removed part of P118’s bowel but he had not had to carry out a colostomy’.*¹⁴²

1.96 There was further concern about the lack of attendance of a resident doctor during the day when needed:

‘In or around 2014 or 2015, I discovered that P118 appeared to be suffering from a chesty cold. I requested P118 be assessed by a doctor. I was promised that P118 would be seen the following morning. From my own nursing background, I recognised that P118 was becoming very [ill]. Despite assurances from staff when I returned the next evening, P118 still had not been visited by a doctor. I was again promised that he would be seen in the morning. The following evening, I found P118 extremely unwell and he still had not been seen by a doctor. I requested he be seen immediately and stated that I would not leave until this happened. The Staff Nurse was very hesitant in getting a doctor even though she was aware that P118 was very congested. I recall her saying to me that P118 only needed a drink of water and went and got a glass of water. I told the nurse that I would not be leaving P118 until he was assessed by a doctor. The nurse pulled a face and eventually went to get a doctor for P118. The doctor then requested P118’s observations to be taken

¹⁴¹ P105’s Mother Transcript – 14/09/23 – Page 51 – Line 25

¹⁴² P118’s Mother Transcript – 09/10/23 – Pages 105-106

and within minutes of her checking his observations, a doctor crashed through the door and came to P118's aid. It was like something you would see on television. The doctor diagnosed P118 with double pneumonia and proceeded to inform me that he was having him transferred to Antrim Hospital for admission and treatment as soon as possible. P118 was extremely ill for the next two weeks and had to be nursed for four days in the ICU unit[intensive care unit] in the hope of saving his life. Thankfully he recovered. An MAH staff member who had sat with P118 in Antrim Hospital told me that another patient, who was admitted a short time after P118, and while P118 was still an in-patient in Antrim Hospital, had also been diagnosed with pneumonia and sadly died. If I had not insisted that I wanted P118 to be seen by a doctor before I left on the third day, P118 would not be here with us today'.¹⁴³

'My mother told me that she visited P50 on the Thursday before she became very unwell. My mother noticed that P50 was unwell and asked a staff member if she would be seen by a doctor, as she was concerned. She was told that she would and that it was just a chest infection and there was nothing to worry about. My sister had wet herself and my mother had asked could she take her to her room to change her. She was told no and that a staff member would do it. My mother did not tell me the name of the staff member. The next day, my father received a call from MAH stating that P50 had been transferred to Antrim Area Hospital. I believe she was admitted to the intensive care unit I do not know who told my father, and he has since passed away. We were informed P50 had progressed to a critical condition on the second date of admission and was admitted to the intensive care unit and was critical. I was very concerned that P50 got to the point where she developed a critical condition from a chest infection. I believed that this was a result of lack of care. My parents were very upset. I sent a letter to the clinical psychiatrist when P50 was in hospital, saying that my parents and I did not feel that MAH was the right place for P50 in the first instance and certainly not now, after this incident'.¹⁴⁴

- 1.97 An issue was also raised as to the supervision of junior doctors by consultant psychiatrists. P109's mother told the Inquiry:

'I found out that [H338] had only been training for three years. During the meeting, I specifically asked who was overseeing him when H40 was away and that someone senior should have been. I referred to the risks associated with Lamotrigine including Stephens Johnson Syndrome, and considered H338 should have been properly advised about it. H50 apologised several times during the meeting and said that he should have been overseeing H338. H40 said that the learning from this would be that I was not listened to, but he did not apologise. However, I consider that an additional learning should have been that if there is a potentially very serious adverse reaction to medication, this should be highlighted so that any doctor looking after the patient can be aware of it and the symptoms to look out for. I think that also think that H40 had a responsibility to ensure this was done before leaving on holiday. I cannot understand how it was thought appropriate to warn me but not the doctor taking

¹⁴³ P118's Mother Transcript – 09/10/23 – Pages 108-110

¹⁴⁴ P50's Sister Transcript – 19/10/22 – Pages 11-12

care of Alicia in his absence. I received the letter from Belfast Trust dated 3rd June 2016 assuring me that there was appropriate supervision in place and that my experience would be shared at the doctors' monthly teaching session. It was also agreed that there would be an audit to identify and quantify the need for doctors in MAH to access outside specialists ... I have not seen any evidence that an audit was ever carried out and I would like the Inquiry to investigate whether such audits were carried out and whether a protocol or guidance was developed for MAH doctors to have access to specialist independent opinion, as they refused that for Alicia and instead went to another consultant psychiatrist employed by the Belfast Trust'.¹⁴⁵

1.98 Following this evidence the Inquiry wrote to the BHSCT to enquire about the results of any audit, but the response came back that it was unable to identify one.

1.99 P60's sister told the Inquiry that she noticed bad bruising to her brother's back in February 2019. She raised this with staff at MAH and a doctor did look at P60's back but said there was nothing to be concerned about. P60's sister told the Inquiry:

'My family continued to seek referral for the back pain. At this stage the police also became involved as staff refused to bring P60 to A&E. Eventually, P60 went to Antrim Area Hospital but only after the intervention of police. The doctor there said the injury would have happened a few days prior and drained 250ml of fluid from the injury. The doctor in Antrim Area Hospital said P60 was very lucky because there was a high chance of it getting infected and then it could have turned to sepsis'.¹⁴⁶

1.100 Concerns were also expressed about the lack of care for patients' general health:

'All the chasing and pressing for P116's medical care was done by us, P116's parents, and not by Muckamore. Tuberculosis was never mentioned or considered at this stage. I now realise P116 was developing symptoms of tuberculosis from at the very latest December 2016 but he was not diagnosed until August 2017 and they seemed to be looking for everything but tuberculosis. I did not feel Muckamore was interested in P116's physical health and his evident decline'.¹⁴⁷

And further:

'I wanted Muckamore to properly take control of P116's medical care. I was frustrated because I thought he was in a hospital and so there ought to be appropriate access to medical treatment'.¹⁴⁸

¹⁴⁵ P109's Mother Transcript – 21/09/23 – Pages 39-40

¹⁴⁶ P60's Sister Transcript – 20/09/23 – Page 31 – Line 16

¹⁴⁷ P116's Mother Transcript – 12/10/23 – Page 21 – Line 16

¹⁴⁸ P116's Mother Transcript – 12/10/23 – Page 23 – Line 3

Lack of activity

1.101 The lack of activities for patients became a recurring theme through the patient experience. Part of the role of the staff was, or should have been, to ensure that patients were engaged in meaningful activities.

1.102 P36 was admitted on a number of occasions between 2012 and 2018. His mother told the Inquiry:

'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'.¹⁴⁹

1.103 There was also concern expressed around the loss of social and other skills that patients had prior to their admission to MAH, due to the neglect in ensuring those skills were used and developed:

'P77's communication skills have deteriorated dramatically since he went into MAH. When he was in school he used PECS [Picture Exchange Communication System] cards as a form of communication. When P77 went into MAH in 2012, I asked if he was having speech therapy. The response I received from the ward staff is that P77 did not need it because he was non-verbal. But speech therapy is well beyond how someone speaks, it is about general communication. The staff have said from he went into MAH in 2012, right up to the current day, that the staff know P77 well and know what he wants and therefore they do not need to use PECS cards. But this does not help P77 communicate with strangers. What will P77 do when he leaves MAH and is in the community to communicate, if he ever will?'¹⁵⁰

Property, clothing and money

1.104 A significant issue for many families who spoke to the Inquiry was the issue of property, cash and clothing, and the apparent lackadaisical attitude to all three. This aspect of life at MAH is explored in more detail in Chapter 6 (Patients' Property and Finance) but here we will set out just some examples of the relatives' experience.

¹⁴⁹ P36's Mother Statement – 28/09/23 – Page 23 (restricted)

¹⁵⁰ P77's Mother Transcript – 20/06/23 – Pages 76-77

Finances and cash

- 1.105 A number of witnesses raised their concerns about the handling and use of cash brought in for patients:

'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'.¹⁵¹

'One time, a staff member at MAH asked me to pay them £300 to cover fuel costs from Shelley's benefits. Shelley told me that she was only travelling from MAH to Antrim Town but needed to pay MAH. I raised the additional cost at a meeting in MAH with [a staff member] who was a nurse at MAH, an occupational therapist, and a counsellor. They told me the money was to pay taxi fares. When I asked for receipts, they told me that Shelley lost them. This was the excuse given any time I raised questions about how much money MAH spent on behalf of Shelley each week. Generally, I did not want to rock the boat when Shelley was in MAH. I felt that our questions were not answered and we were fobbed off. At meetings with MAH staff, my husband and I felt very unwelcome, and felt that our questions and concerns were not important'.¹⁵²

'Prior to Mary being admitted to Muckamore, our family collected Mary's benefits. With this money, we provided her with clothing. After Mary was admitted to Muckamore, Muckamore or the Trust received Mary's benefits, which I understood should have been used to purchase clothing for Mary. However, when we visited, Mary would have been very poorly dressed and I found it very upsetting to see Mary looking a mess, as that was not how she was at home, where she had been properly dressed and had her hair done. We didn't have much, but we would have bought her clothes on a Sunday and dressed her'.¹⁵³

'During P77's time in PICU [Psychiatric Intensive Care Unit], I was constantly asked for money by the staff to purchase things for P77 such as toiletries, money for the Cosy Corner Cafe at MAH and takeaways. The staff stipulated to me that cash was preferable. I handed over cash every week to H397 or whatever nurse was on duty at the time. I was paying about a hundred pounds per week. I asked H397 on at least five occasions for receipts or an account of what the money had been spent on and each time he replied "absolutely" but I never received anything from him. I usually received a receipt from the ward for the money I paid in but I never received any receipts for the items that were allegedly purchased for P77'.¹⁵⁴

¹⁵¹ P5's Mother Transcript – 29/09/22 – Page 21 (restricted)

¹⁵² P29's Mother Transcript – 11/10/22 – Pages 17-18

¹⁵³ P22's Sister Transcript – 22/09/22 – Pages 17-18

¹⁵⁴ P77's Mother Transcript – 20/06/23 – Pages 33-34

However later P77's mother told the Inquiry:

'In the last year, I am now occasionally given receipts for P77's expenditure and I am given a statement on a monthly basis. The amount of money that I am asked for by MAH has reduced dramatically from when P77 was admitted to MAH in 2012. MAH has never provided me with a full account for all of the money which I gave in to the hospital for P77'.¹⁵⁵

- 1.106 P90's sister offered the following detailed reflections on how her brother's money had been managed over the years (from admission in 1988):

'Before our mother passed away in 2015 she looked after Bryan's money. The way it worked was that there was a float on the ward and Bryan got a personal allowance. His main account was controlled by the Belfast Trust. If he needed anything then MAH would tell our family who would provide it. A float of £100 was kept in Bryan's drawer on the ward for treats. Our mother would also send up extra money, usually around £300 every couple of months, just in case Bryan would need money for anything. Bryan also received £15 per week for going to day care. This would always be deposited into the finance office on site at MAH. The finance officer was H351.

When our family deposited money in MAH for Bryan's use we always ensured that we were given a receipt. However, we were never provided with receipts for the goods which the money was spent on. When my brother, Aidan, and I took over controllership for Bryan we requested expenditure receipts and for a very short time these were supplied. After a few months we were informed that MAH would no longer supply expenditure receipts and when we explained that we required these for the Court of Care and Protection, we were told that we should just give them the receipt provided for depositing the money to MAH. We therefore found it impossible to keep track of what Bryan's money was being used for. We felt that generally staff were truthful and honest but we had no way of knowing for sure.

Our family did have a concern with the ability to access and use Bryan's money. MAH staff might have bought things that were not for Bryan's benefit. A member of staff, whose name I do not recall, suggested to our brother, Aidan, that Bryan's money would need to be topped up as she had purchased an expensive aftershave for him costing around £80 and his money was running low. We did not see this staff member again after this incident, nor was there any evidence of it being purchased. I found the whole thing unusual as family always provided toiletries and clothing for Bryan.

My brother Aidan and I took over Bryan's financial affairs as financial controllers in 2014 when our mother became ill. I requested financial statements from the Belfast Trust up to and including the final closing statement for 2014. At that time Bryan's account with the Belfast Trust inexplicably had approximately £1,000 in it. The financial documents provided by the Belfast Trust included a transaction account kept by MAH. It was all recorded using codes so I could not see how his money was being spent. Aidan and I had the Belfast Trust account closed ... Since Aidan and I took over managing Bryan's finances he

¹⁵⁵ P77's Mother Transcript – 20/06/23 – Pages 54-55

has significantly more money in his account. This has made me concerned that Bryan's money was previously being used inappropriately by staff members'.¹⁵⁶

- 1.107 Relatives often told the Inquiry that they believed staff had been using the money for their own purposes:

'P60 had £40-£50 a week that he used for the Cosy Corner Café. I discovered that during his time in Muckamore, the staff were using P60's money to pay for taxis for trips as the hospital bus was out of operation. After P60's death, my family also found out that staff had been using P60's money to buy takeaway food for themselves'.¹⁵⁷

- 1.108 P76 was a patient at MAH from 1998 to 2011. He described how the staff kept control of money and valuables, how each patient had a drawer, which was in the staff area, and if a patient wanted anything they had to fill out a form that had to be countersigned by a member of staff:

'I recall money going missing from these drawers and disputes that patients had with staff members. I believe that this money was taken by staff members but they denied it ... I am of the belief that staff were dipping into the patient's money, taking what they wanted, as only staff were allowed in that area. I am also aware of issues around the signatures of patients being falsified, although I cannot recall specific dates or the names of patients or staff members involved. I do not think money went missing, I know money went missing'.¹⁵⁸

- 1.109 Whether or not P76 was correct in his serious allegation, his evidence speaks of a lack of trust and transparency over the safe keeping of money.

- 1.110 Relatives found it difficult to obtain reports on finances in respect of their own relatives who were patients in MAH:

'I had no problem in the first and second year when I requested these financial reports, I got them within a week. Then the third year I was stopped from getting them and was told I had to send a formal request to headquarters in Knockbracken for the financial report. I noticed that from that first incident and when I started querying and keeping an eye on John's finances, then his money in Muckamore went up and up each year. I tried to get financial reports for years prior to H351 being in charge of the finances, but I never received them. H351 was the financial controller for Muckamore. I couldn't believe this. I did not make a formal request for them as I thought I knew him well enough that they would be sent to me. I couldn't see why they wouldn't give them to me.

¹⁵⁶ P96's Sister Transcript – 11/10/23 – Pages 109-111

¹⁵⁷ P60's Sister Transcript – 20/09/23 – Pages 27-29

¹⁵⁸ P76's Transcript – 12/09/23 – Page 21 and Page 23

Any time I asked about them they would say they were too busy or that it would be looked into, but I never got them.

Belfast Trust gave John £28 a week whilst in Muckamore. I have no knowledge of how Muckamore accounted for John's money all the time he was a patient there or how carefully the accounts relating to the use of his money was scrutinized. I did not get reports nor did my mother. I was shocked when I got the first report to see that John had very little money accrued. I would have expected that a patient such as John would have had much more money in his account ... When John was in Muckamore, I did not get receipts about how money was spent, even when I became John's controller. I get this now that John has been resettled. I am required to provide a financial report to the Office of Care and Protection in November of each year. The Office of Care and Protection audit the financial report. I think that there is greater protection for John in every respect now that he has been resettled, compared to when he was in Muckamore'.¹⁵⁹

Clothing

- 1.111 As MAH was, for many patients, in effect the patient's home, the lack of care of the person and of personal appearance caused significant concern and suffering. There appeared for many to be a particular lack of attention to clean and suitable clothing. Patients would often be found to be wearing other patients' clothes or to be wearing wrongly sized clothing. Alternatively, we heard about patients being allowed to remain naked if they 'caused trouble'. The issues raised related to belongings, clothing and cash.
- 1.112 Historically patients wore communal hospital clothing, selected daily from a store cupboard.¹⁶⁰ This practice changed over time. Moreover, some patients were dressed in 'all-in-one suits' to prevent undressing.¹⁶¹ While personal clothing was later introduced, the transition was difficult for patients and staff as many patients had worn all-in-one suits for years.¹⁶²
- 1.113 There were frequent accounts of families finding that their loved one was not dressed in their own clothes, even when families took the clothes home to launder them and had labelled them. Some staff took the trouble to present patients well if they knew the family was visiting, but it was a different story if the family arrived unannounced:

¹⁵⁹ P107's Brother Transcript – 27/09/23 – Pages 111-112

¹⁶⁰ P122's Transcript – 28/09/23 – Page 9 – Line 10 (restricted)

¹⁶¹ Eilish Steele Statement – 23/05/24 – Pages 8-9; A12 – Statement – 28/03/24 – Page 23

¹⁶² A12 Statement – 28/03/24 – Page 23

'When we went on a planned visit, Ciaran had always been showered and looked clean. This was when the staff clearly knew we were coming. When we called to visit unexpectedly, Ciaran was not as clean and had other peoples' clothes on'.¹⁶³

'I also recall that from 2012 to 2017 every time I visited P77, he was wearing clothes that could only be described as rags. They did not belong to him. I bought P77 really nice clothes like Ulster Rugby shirts and Canterbury and Nike sportswear, but I never saw him wear them. The nurse on PICU ward advised me that if P77's pad leaked, his clothes needed to be boiled in "the sluice" which mostly destroyed the clothes, and they had to be put in the bin. P77 never wore the good clothes that I had bought him and she suggested to me that I should stop buying P77 good clothes'.¹⁶⁴

1.114 Dirty, missing and lost clothes were also a significant problem:

'When we visited Michael, without letting MAH know we were coming, we would find Michael wearing adult clothes that were four or six times too big for him. Michael's mother would tell the staff to take them off and put his own clothes on him. To make sure that Michael wore his own clothes, Michael's mother ensured name tags were put on to Michael's clothes. When we would collect Michael from MAH to bring him home, we would check the clothes he was wearing to make sure they were with his name tag on them. If the clothes he was wearing were not his, we would insist that they were changed. I remember one time he was wearing a very large green rugby-style t-shirt when we visited him. It was so big that it was down to his knees. Michael's mother told the staff to take it off them. This happened several times when he was in MAH'.¹⁶⁵

'Clothes also went missing. P124 was seen wearing children's clothes and other people's clothes. I then had to start doing P124's washing. I remember staff continuously putting dirty pyjamas that had been soiled with urine into the fresh bag of clothing that I had just washed. I had to throw out a lot of his clothes because the stench never went away. I raised this on many occasions and advised staff to keep the dirty and clean clothes separate but this was ignored'.¹⁶⁶

'I was concerned about the deterioration in P119's appearance. She was often untidy and unkempt. Sometimes P119's clothes were not put on her properly. This would have been the responsibility of the staff, as P119 required help with her personal hygiene and dressing. P119 looked like she had been thrown together. Whilst some staff helped to tidy her hair, others did not, and it pained me to see P119 looking such a mess'.¹⁶⁷

'When we went to visit Maria, she would often come to the visiting room in other peoples' clothes. When this happened, we asked a member of nursing staff

¹⁶³ P57's Mother Transcript – 20/10/22 – Page 12 – Line 20

¹⁶⁴ P77's Mother Transcript – 20/06/23 – Page 35 – Line 1

¹⁶⁵ P11's Father Transcript – 06/07/22 – Page 16 – Line 9

¹⁶⁶ P124's Mother Transcript – 20/09/23 – Page 119 – Line 19

¹⁶⁷ P119's Mother Transcript – 28/09/2023 – Page 16 – Line 18

why she was in someone else's clothes. I cannot recall the staff members' names that we asked about these incidents, and I do not recall if we reported this to anyone else at the time. I recall being told that there were clothes in her wardrobe, and us telling the member of nursing staff that the clothes she was wearing were not hers. We never got her own clothes back. We were just told by the nursing staff that Maria had ripped them and they had to be thrown out. We were not allowed to visit Maria in her room at MAH'.¹⁶⁸

1.115 P16 was in MAH from 2010. His mother told the Inquiry:

[Counsel]: 'And the clothes ripping, you explained that he does that when he's very agitated?

[P16's Mother]: Yes. He'll actually strip all his clothes off. It's like a "what are you going to do?", do you know?

[Counsel]: And did Muckamore staff discuss those behaviours with you?

[P16's Mother]: Well, I think some of them were letting him sit naked until another person, who was a Muckamore staff member, had said to me that she didn't think it was right that the staff were going in and out and letting my son sit naked. And that was the first I actually knew that that was going on'.¹⁶⁹

1.116 Another witness had seen patients running around naked and staff doing nothing:

'I recall during one of my visits to Muckamore, there were two patients running around outside naked while two nurses, whose names or appearance I cannot recall sat on deck chairs doing nothing. I could not believe what I was witnessing, but I did not speak to staff about this'.¹⁷⁰

1.117 P96's father, whose son was in MAH from 2017 to 2020, observed:

'During his time in MAH items of P96's property would have gone missing, for example I bought P96 a new coat for his birthday and it went missing almost immediately. I raised this with H397 but nothing seemed to be happening. My social worker advised me to bring a receipt for the coat into MAH. I did this and gave it to someone in PICU. Eventually I got the money back for the coat, but it took a long time. P96's grandmother also bought him an expensive cardigan with foxes on it and it went missing too. I also bought P96 a Gillette razor and blades but a couple of days later a nurse told me that P96 needed new blades as the blades which I had just bought had gone missing. When things were left in they should have been itemised but this did not happen in MAH, there were no records. I would like the Inquiry to investigate the whole way in which patient's money and other property has been handled over the years. I am aware of many families who provided money over the years in the belief that it was being used for extras to benefit their loved one, in addition to the benefits to which they were entitled, but who failed to receive any account of what was done with it. I would like the Inquiry to find out how management could fail to put in place a proper system of oversight to ensure not just the patient's money was handled properly and accounted for, but that their

¹⁶⁸ P64's Father Transcript – 23/11/22 – Pages 33-34

¹⁶⁹ P16's Mother Transcript – 20/09/22 – Page 56 – Line 14

¹⁷⁰ P69's Father Transcript – 23/11/22 – Page 123 – Line 5

possessions were treated with care. Clothing and other items were often gifts that needed to be respected'.¹⁷¹

1.118 Other relatives had similar experiences:

'I received a telephone call from a person who called themselves the coordinator on the ward. I do not recall her name or the date that this happened. The woman explained that she had been clearing out P17's wardrobe and that a lot of his clothes were done. I asked what I could do to help. She said that she needed to buy new clothes for P17 and asked that I bring up £300 and put it in an envelope and leave it on the ward. She said that she would go to town and she would buy P17 new clothes. I recall that this was shortly before P17's birthday, which is the 21st April, so I went out and bought four new shirts. When I brought these up to the hospital, I opened P17's wardrobe to put them in. I found that he had lots of good clothes. I wasn't sure what was going on, so I telephoned the social worker and asked if this was a new thing. I asked for a call back and for an explanation. I said that I have never been asked for this before. The social worker said that I should not have been asked for money and he said that he would deal with it. I also raised this with a nurse on the ward who I think was the charge nurse that day, and I also gave her my new telephone number'.¹⁷²

1.119 Clothing bought by families often appears to have gone missing without explanation:

'MAH staff would send patients' clothing to a dry cleaner on site. That meant that Shelley's clothes were put in a bag with her name on it so they could be returned to her. Some of her clothes did not come back from the laundry. I would buy Shelley new clothes Next or New Look, as she liked clothes from those stores. Each time I asked Shelley what happened to her clothes, she said that staff took them out of her room in bags. I asked staff at MAH where Shelley's clothes were. They told me that they checked the storeroom but the clothes could not be found. I believe staff took Shelley's clothes'.¹⁷³

'There are a few other things to mention about Roberta. Roberta was always well dressed, clean and tidy when she went to MAH. However, when I picked her up, she was very disheveled and hadn't been washed. I always sent her in with a bag filled with plenty of clothes, but when she came out she was never wearing her own clothes. I gave her enough clothes so that the staff didn't have to do any washing, but I never got her belongings back. She lost jumpers, leggings, trainers and other clothes. They just generally went missing. She came home in old clothes belonging to other people. They never fitted her. I didn't questioned the staff, I trusted them. I just bought her new clothes. She always had the best of everything'.¹⁷⁴

¹⁷¹ P96's Father Transcript – 11/10/23 – Pages 26-27

¹⁷² P17's Brother Transcript – 12/10/22 – Page 17 – Line 2

¹⁷³ P29's Mother Transcript – 11/10/22 – Page 20 – Line 1

¹⁷⁴ P23's Mother Transcript – 22/09/22 – Page 68 – Line 8

'Hardly a week went past without us bringing P128's clothes. We had money and we were determined that P128 would not go without. We found that he went through clothes so quickly. We had no idea where the clothes all went. When we visited P128 at MAH, he would have often had other people's clothes on him. This broke my, Doreen's, heart. We would have brought P128 new clothes and then the next week at MAH he would have been wearing someone else's clothes again. No answer was ever provided when the staff were asked about P128's clothes. They would provide excuses like "it was the only thing clean" and "would not happen again", but it still did. P128 had many clothes provided, so that washing turnaround was not an issue. However, this did not stop the wrong clothes being put on him. All his clothing was named, so there should have been no confusion'.¹⁷⁵

'There were issues with P113's clothes going missing in MAH. When I buy P113's clothes, they are sent to the laundry in MAH to be labelled. I put the clothes in a carrier bag and put a label on it with P113's name and a note to say that the clothes needed to be labelled. His grandmother brought P113 a new Adidas top that cost £45 and we noticed on a visit six months later that another resident was wearing it. This also happened to a top that one of P113's brothers gave to him. One day when we visited P113, we saw a resident who was much larger than him wearing his top. Some other clothes disappeared without explanation. When I raised these issues with H67 in MAH, I was told that staff did not know that the pyjamas and top were for P113 and they were labelled for another patient. I was also told that when clothes were sent to the laundry, sometimes they were returned to different wards. This is what they say every time clothing goes missing. As P113's pyjamas were new, H67 agreed that MAH would replace them'.¹⁷⁶

1.120 P116's mother noted:

'When P116 was losing weight I went and bought him new clothes. I took two bags of clothes up to Muckamore, all brand new with labels still on them. Subsequently when I queried why P116 was not wearing the clothes that I had bought for him, no-one could tell me why. They said that they had no record of it and that was that. There was nothing I could do. The same thing happened with some expensive aftershave that my sister bought for P116, it went missing and was never found. I would also have seen P116 wearing other people's clothes'.¹⁷⁷

1.121 Experiences at other facilities demonstrated to parents that the proper care of clothing was not an impossibility:

'Another staff member in MAH whose name we cannot recall told us not to let P128 go to the resettlement place. Thankfully, it has been the best decision to move P128. He has been there for about 16 years. He is very happy and the staff are very good to him. He is always supervised. P128 resides in a three-

¹⁷⁵ P128's Father Transcript – 25/09/23 – Page 15 – Line 11

¹⁷⁶ P113's Mother Transcript – 26/09/23 – Page 47 – Line 8

¹⁷⁷ P116's Mother Transcript – 12/10/23 – Page 27 – Line 2

bedroom bungalow. There are three clients in every bungalow. There is a communal lounge, a dining area and a kitchen. P128 has his own bedroom and wardrobe. If we do not label P128's things, the staff at the resettlement location label them. His drawers are always tidy. If he needs anything, they will buy him things and keep the receipts. We are kept informed. We never got anything like that from MAH'.¹⁷⁸

Other property

- 1.122 A number of families reported that property often went missing, causing distress to their loved ones:

'All the nice things that we bought P28 were gone. All his cars and toys, too. P28's Barney toy, which was so precious to him, was gone. We never got any explanation for this. I bought some expensive Tonka trucks that were supposedly indestructible, and they disappeared. We reported this to the nurse in charge, or the nurse who was on duty, but there was no explanation'.¹⁷⁹

'There were other items we bought for P34 over the years such as a CD player, radio, Wii, Play Station, and expensive aftershaves which went missing, or you would smell the aftershave on him once or twice and then it would be gone. Staff also never engaged with P34 in using any of these items and when we asked where they were, we were told they were broken or staff said they were not sure where they went, but we would never have seen them again. This is also why I would only leave in what P34 needed and when he needed it as I did not trust the staff'.¹⁸⁰

'We bought Maria new trainers on one occasion, a pair of Nike Airs. I cannot recall exactly how much they cost but the cost was significant to us. I do not recall when this was. When we went to visit Maria after buying the new trainers for her, she came to the visiting room in her old trainers. We asked a member of the nursing staff where her new trainers were. I do not recall the name of the member of staff. The member of staff told us that they would search Maria's room. The trainers were never found and were never seen again. When we complained to the nursing staff, they just searched her room and that seemed to be the end of it'.¹⁸¹

Lack of supervision

- 1.123 Some residents in MAH required very close supervision when eating, for example, because they were unable to feed themselves, or would otherwise ingest inedible material. This supervision was often lacking:

'Feeding him might have taken a period of an hour. You know, you had to be patient. He would run around and he would come back to it. So, we think now

¹⁷⁸ P128's Father Transcript – 25/09/23 – Pages 16-17

¹⁷⁹ P28's Father Transcript – 28/09/22 – Page 97 – Line 14

¹⁸⁰ P34's Mother Transcript – 09/10/23 – Page 25 – Line 6

¹⁸¹ P64's Father Transcript – 23/11/22 – Page 33 – Line 3

that wasn't happening. He was probably given a meal and, if he didn't eat it, he didn't eat it'.¹⁸²

'He moved into Conicar Ward in or around September 2000 when he was 16 and, when he moved in, he was a healthy weight. He had reached all normal height, normal weight and then within -- by the Christmas of being in Conicar Ward he had dropped to five stone, and we have pictures to show you'.¹⁸³

'Every time we had a meeting, there were issues about P101 not eating. P101 lost an atrocious amount of weight every time he went to MAH. It was clear that he was not eating. P101 would put weight on immediately when he was discharged from MAH. My partner and I brought food to MAH, trying to help him put on weight as at one point he was skin and bone. The staff would say they were monitoring this but nothing changed. I do not recall ever being shown a diet or nutrition plan for P101, or having it explained to me exactly what they were doing about his weight loss. P101 went down to 46 kilos, which is very skinny given that he is five foot eight'.¹⁸⁴

'P105 lost four stone in MAH in a two-month period. At times this was very concerning, and I believe that it was due to the bad diet P105 had in MAH. P105 left MAH with vitamin and mineral deficiencies. P105 had low B 12, low vitamin D and low folic acid. I recall P105 being seen by a dietician following my concerns. She recommended rice pudding for him to put on weight rather than good food. I raised the issues around diet with the staff and they said they would not increase his food intake as the dietician was off on leave. I believe that if a dietician is off, the staff should have permission to increase or decrease food intake as needed'.¹⁸⁵

'It was clear that P60 was losing a lot of weight and he told me that there were times when he was only given sandwiches for a meal. P60 would have enjoyed a large dinner when he was at home; that was part of the family home life. P60's personal hygiene and cleanliness had also become very poor. P60 required help with cleanliness after toileting but it was clear that this was not always being properly carried out'.¹⁸⁶

- 1.124 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,¹⁸⁷ possibly because there were not enough staff to manage the workload. Supervision of such patients is crucial to their welfare.

¹⁸² P1's Sister Transcript – 28/06/22 – Page 29 – Line 17

¹⁸³ P1's Sister Transcript – 28/06/22 – Page 28 – Line 13

¹⁸⁴ P101's Mother Transcript – 13/09/23 – Page 55 – Line 16

¹⁸⁵ P105's Mother Transcript – 14/09/24 – Page 51 – Line 11

¹⁸⁶ P60's Sister Transcript – 20/09/23 – Page 15 – Line 29

¹⁸⁷ P54's Mother Transcript – 13/10/22 – Pages 60-63; P52's Mother's Transcript – 19/10/22 – Page 27, Page 42 and Page 65 (restricted)

1.125 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.¹⁸⁸

1.126 P52 had pica, and her mother told the Inquiry:

*'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'.*¹⁸⁹

1.127 There were also failures to supervise patients who required assistance with eating, and for some there was a danger of choking. The Inquiry heard from P124's mother:

*'For example, P124's food should be chopped up into small pieces to reduce the risk of choking. There have been failures to cut up P124's food. On one occasion I attended a visit with P124 at dinner time and arrived just as his dinner was left out for him. The staff member just left the tray of food with P124 and me. This food had not been cut up and was not appropriate for him. I took a picture of the plate of food and I showed this to H223. H223 apologised and advised it would not happen again, yet it continued to happen. P124 requires constant supervision. On occasion when I would visit P124, I would find that he had been left alone in his room with the door locked. When challenged, staff would report that they had to go to the toilet. This happened a few times'.*¹⁹⁰

1.128 Sometimes the lack of supervision at mealtimes meant that other patients took a person's food, and patients asked their families for food when they visited:

'We always thought that Mavis was not getting enough to eat. There did not seem to be enough supervision at meal times, and patients would steal food from each other when the staff were not looking. Mavis was slow to eat. I once

¹⁸⁸ P68's Brother Transcript – 30/11/22 – Page 128 – Line 16 (restricted)

¹⁸⁹ P52's Mother Transcript – 19/10/22 – Page 65 – Line 10 (restricted)

¹⁹⁰ P124's Mother Transcript – 20/09/23 – Page 118 – Line 1

saw a patient try to steal her tea ... I thought to myself that this must be happening all the time. Mavis would go straight to our pockets looking for food, or my bag for sweets. She always seemed to be hungry. She does not have these behaviours where she lives now, Triangle Housing Association'.¹⁹¹

- 1.129 A number of families had concerns about how their loved one was monitored in their bedroom at night. One family had purchased a monitor that staff could observe from the nursing station and were alarmed that they were not notified for some time that it had stopped working:

'Mum had come on to the ward and a nurse had said, "Oh, the monitor's been broken for some time". And my Mum, "Sorry, what?". So my Mum was taken aback because this was the only thing -- like, this was one of the main things to keep Martin safe at night. So they just said "Oh, we just want to check we can take money out of Martin's money", and my Mum was like "There's a bigger issue here -- how long has the monitor been broken? Why has it not been replaced?"'.¹⁹²

Behaviour of staff

- 1.130 There was also direct evidence before the Inquiry of behaviour by staff that fell below what a relative might properly expect. P76, a patient at MAH from 1998 to 2011, told the Inquiry:

'I recall on the first night that I was put to bed at 5 p.m. I was so anxious that I did not sleep at all. I remember talking to one of the nurses on night duty ... I asked a question about why he had put me to bed so early and he did not answer me but he did say "you know why". H367 was very strict with us. I found out from H367 that he had put me to bed early because I had complained about the food. Over time, I noticed that H367 would pick on people who could not speak out'.¹⁹³

- 1.131 P116's mother told the Inquiry:

'It is my view the staff used intimidation. I felt very intimidated the day I went up to take P116 out to try and get some food into him as I was aware that he had not eaten for three days. I told staff that he had not eaten for three days and they replied to me, "he is an adult, if he doesn't want to eat he does not have to". I felt intimidated by the nurse I was dealing with. I felt that the whole atmosphere of the place was oppressive. It was not the type of place where parents of patients could easily meet one another as I had originally thought might happen to provide support. At the time I did not know about other parents' concerns and suspicions. I can recall a time when I took P116 to the Cosy Corner cafe, another patient came in with three nurses. This patient was given a can of Coke and left alone while the nurses were on their phones.

¹⁹¹ P30's Sister Transcript – 10/10/22 – Pages 12-13

¹⁹² P1's Sister Transcript – 28/06/22 – Pages 75-76

¹⁹³ P76 Transcript – 12/09/23 – Page 13 – Line 15

*Since he was clearly being ignored, I asked the wee fella if he wanted to come over and sit with me and P116. This was met with the nurse telling me to “mind my own fucking business”. I never complained because I knew at this stage there was no point’.*¹⁹⁴

- 1.132 P76 also told the Inquiry how he had witnessed directly members of staff mocking patients:

*‘I recall various members of staff mocking patients. This made me very angry as members of staff were deliberately trying to annoy patients, to get reactions from them. For example, I recall one patient ... who was generally calm, had difficulties with members of staff mocking him. Various members of staff would have said to him “good boy” and this annoyed him. He complained to the members of staff calling him “good boy”, that he was not a boy and that he was a man. He asked that they say “good man” but they did not do this. As a result of the members of staff calling him “good boy” and getting a reaction from him, patients began to call him this. This triggered the patient and he would become violent and he would try to bite people’.*¹⁹⁵

*‘I recall times when P100 would say things to me such as “I’ll hit you a slap” or “I’ll kick your bloody arse”. P100 began to curse a lot. P100 would not have said these words before he went into MAH and would not say these words at home. I feel P100 has heard these words in MAH and then he would repeat it. I do not hear P100 say these as much now but he would have said them a lot a number of years ago. I worry that P100 was not doing what he was told or what staff wanted him to do, and so staff members would have said these things to him’.*¹⁹⁶

- 1.133 P104 told the Inquiry:

*‘I was consistently pushed around in MAH by staff. I cannot recall their names. They abused me verbally almost daily and would also laugh at me. I recall being called things such as “an ugly fucker”. It was not just one member of staff; most of those I dealt with verbally abused me. Most of the abuse, verbal and physical, took place in my room’.*¹⁹⁷

- 1.134 The Inquiry heard that some nursing staff appeared to see their role as observation rather than active intervention, meaning that they spent most of the time at the nursing station or in the ward office, rather than engaging directly with the patients:

‘... “most of the staff”, I do mean the majority of staff, their attitude was out of sight/out of mind. They had the tendency just to let the inmates run riot, and they preferred to huddle in groups and talk in the back room and stuff like that.

¹⁹⁴ P116’s Mother Transcript – 12/10/23 – Page 25 – Line 19

¹⁹⁵ P76 Transcript – 12/09/23 – Pages 30-31

¹⁹⁶ P100’s Mother Transcript – 14/09/23 – Page 15 – Line 1

¹⁹⁷ P104 Transcript – 14/09/23 – Page 42 – Line 9

*And any time you asked them for something it was almost like you were interrupting them’.*¹⁹⁸

- 1.135 Some patients were uncomfortable with the ‘banter’ used by staff. They thought it was disrespectful to them and described it as the staff being ‘cheeky’:

[Counsel]: *‘You say in your statement “some nurses were nice, some were bullies”?’*

[P19]: *Yeah.*

[Counsel]: *Could you explain a little bit more what you mean by some were bullies?*

[P19]: *What I meant by bullies was they would yell or shout at you, or just yell or shout at you.*

[Counsel]: *Yes.*

[P19]: *And be cheeky with you’.*¹⁹⁹

- 1.136 P128 was admitted to MAH in 2000. His father told the Inquiry:

*‘On another occasion in Movilla B, I, Douglas saw P128 trying to walk past a staff member called H228 in the corridor, who blocked him. P128 tried to go to the left and he blocked him again. He tried to go to the right and he blocked him again. I went down the corridor and saw the staff member block P128 three times and asked him what he was doing. H228 said that he did not know where P128 was going. I spoke with the senior staff member on duty, H13, about it. H13 said that the staff member had only arrived, he was not fit for Movilla B and would be moved tomorrow morning’.*²⁰⁰

- 1.137 The Inquiry heard from former patients that, in the past, patients were directed by staff to undertake some care duties for other patients:

*‘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’.*²⁰¹

‘When I was in MAH I was told to look after another patient. I do not remember who told me to do this. The patient was older than me. She would take her clothes off. I was told that I had to try and stop her from taking her clothes off by taking out a game. Sometimes I stopped her and sometimes I did not. I did

¹⁹⁸ P28’s Father Transcript – 28/09/22 – Page 106 – Line 15

¹⁹⁹ P19 Transcript – 21/09/22 – Pages 86-87

²⁰⁰ P128’s Father Transcript – 25/09/23 – Page 11 – Line 11

²⁰¹ P27 Transcript – 11/10/22 – Page 31 – Line 8 (restricted)

not want to do this and it should not have been my job, as I was a patient. It was the nurse's job. I was told I had to do it'.²⁰²

- 1.138 P57's brother worked for the Positive Futures charity and spent part of his training at MAH in around 2008. His experience of staff attitudes was revealing:

'After roughly three months' training by Positive Futures, we were put straight into Muckamore. We were given a tour of the site before starting. I can recall the seclusion room and PICU during the tour of Muckamore. We were then put straight on to the ward. I only worked on one ward known either as Conicar or Six Mile. It was a big, open plan all-male ward. There were some single rooms for patients but mainly it was dormitory style where five or six shared. There was no proper introduction for us when we got onto the ward in Muckamore, although I think that one of the managers of Positive Futures may have been there on the first day. There were generally three of us from Positive Futures working on each shift. We were to follow the shift patterns of Muckamore staff. I understood my role was to simply observe and shadow the Muckamore staff.

My initial impression of Muckamore was horrible. The first couple of days at Muckamore were at times terrifying. I could sense a general standoffish atmosphere from both staff and patients. The staff did not inform us about the patient personalities or likes and dislikes. I recall about seven or eight patients on that ward had severe learning disabilities. My first impression that was Muckamore was very much an institution. The staff did not seem to like the Positive Futures staff being there. They looked at us as if we had not got a clue of what was in front of us, and they were right. There was no camaraderie between the Muckamore staff and those from Positive Futures, just as a sense of mistrust'.²⁰³

'In my opinion, most patients at Muckamore should not have been there. It seemed the patients were just bored out of their minds. There was very little to do and although there was a TV, it was rarely on and, if it was, it seemed it was on a channel for staff'.²⁰⁴

- 1.139 Even in death some relatives found that their loved one's passing was not properly observed and there was a lack of compassion shown to the family. P60 had lived in MAH from November 2008 until January 2022 when he choked on a piece of food, which led ultimately to his death. His sister told the Inquiry that no one from MAH had attended the funeral, no flowers or cards were sent. When she went to the hospital to collect P60's belongings they had been stuffed into black bin bags.²⁰⁵

²⁰² P6 Transcript – 05/07/22 – Page 51 – Line 10

²⁰³ P57's Brother (and support worker with Positive Futures) Transcript – 21/09/23 – Pages 104-105

²⁰⁴ P57's Brother (and support worker with Positive Futures) Transcript – 21/09/23 – Page 106 – Line 23

²⁰⁵ P60's Sister Transcript – 20/09/23 – Pages 46-47

Regret, guilt and trauma

- 1.140 Many parents and relatives unfortunately felt guilty about having put their loved one into MAH. Many were at a loss to know what to do to improve their loved one's life:

'We do not know the truth of everything that went on in MAH and it is upsetting for us to think about it. It is totally for us to look back and think about what happened when we were not there and did not know what was going on. P128 could not have told us anything that was done to him. And he was so vulnerable there. We have to live with this regret'.²⁰⁶

'I have found the whole experience very difficult, mentally traumatic, and I believe that I have lost 10 years of being a mother because of the culture that existed in MAH, and P119 has suffered unimaginable levels of abuse and neglect, not simply from the staff on the floor, but from those higher up, who really had a duty of care to protect her. I hope that other children and parents never experience what we have gone through as a family'.²⁰⁷

'P34 has been under the care and treatment of the psychiatric hospital for a period of 16 years and during that time, he has significantly regressed. By way of example, P34 is now using flash cards for communication whereas previously it would have been possible to explain to him what was going to happen and he would have understood this well. Also, P34 is now largely double incontinent, his whole presentation is different. P34 is unable to fully communicate the impact on him of his MAH experience. I am concerned that without specialist assistance, no-one will ever know the exact the effects MAH has had on him or what should be done now to best help him. My family would like P34 to be independently assessed as we have no confidence in the diagnosis and treatment he received in MAH. My family have been left heartbroken because P34 was put into MAH with the belief that he would [be] helped, only to find that in fact he has been significantly hurt and damaged by his experience. It is impossible now to give him back the life he would have had if he was properly looked after'.²⁰⁸

'We, as Bryan's family, and advocates, feel totally let down on his behalf by the length of unnecessary time he has had to spend in MAH and then to discover that he has been exposed to abusive and inhumane treatment by some of those who came across as the most kind and caring individuals is the worst kind of betrayal. No one, and nothing, will ever be able to make up for the many years of Bryan's life which have been lost in this terrible system and the most devastating part of it all is the fact that we now have discovered that some of those who appeared to be the most caring and wanting to do good for Bryan, have now been charged with abuse.

I do not know if my brother is safe. Going on recent events I do not think he will be safe. The CCTV in MAH has not been able to provide an explanation for some of the injuries Bryan sustained. I think it is obvious that if a staff member wishes to harm a patient, then there are well-known and obvious areas that are

²⁰⁶ P128's Father Transcript – 25/09/23 – Page 18 – Line 14

²⁰⁷ P119's Mother Transcript – 28/09/23 – Page 33 – Line 5

²⁰⁸ P34's Sister Transcript – 09/10/23 – Page 70 – Line 4

not captured by CCTV. Even with draconian measures, such as placing staff in his bedroom overnight and keeping the light on, he was nonetheless able to be injured and staff were unable or unwilling to explain it.

*Bryan appears to have very little quality of life in MAH and given that we have no control over when he will ultimately be discharged, I find it very distressing’.*²⁰⁹

*‘I cannot adequately express the distress, trauma and damage which these events have caused to patients and their families. It is grossly unfair that some families have been forgotten about. Also, because a patient was not in a ward covered by this investigation, their abuse seems to be treated as less important and forgotten about’.*²¹⁰

*‘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’.*²¹¹

- 1.141 In January 2020 P34 was moved to what was termed a ‘pod’, which consisted of a bedroom, a living room with a window and a bathroom, with a single entrance with a small window in the entrance door. There was a small television behind a Perspex screen. As a result of Covid restrictions, P34’s family were not able to see where he was living until 2022. The walls were described as blank and colourless. P34 spent a significant part of his time living and eating his meals in the pod.²¹² P34’s mother told the Inquiry:

*‘My biggest regret is the day that I ever let P34 walk through the gates of MAH. I feel he is not, nor will he ever be, the same person after what he has endured in MAH. His daddy and I honestly believed that he would be going in for a few weeks of assessment, but how wrong we were. We feel it is a life that has been lost and we now want to make this up to P34. We hope he can get the best possible life going forward in his new home in the community. This has been one of the longest and hardest roads for P34 and my family and I just hope no other vulnerable person suffers similar maltreatment and that life would be kinder to people with a learning difficulty in the future’.*²¹³

²⁰⁹ P90’s Sister Transcript – 11/10/23 – Pages 120-121

²¹⁰ P90’s Sister Transcript – 11/10/23 – Page 123 – Line 3

²¹¹ P121’s Sister Statement – 03/10/23 – Page 17 (restricted)

²¹² P34’s Sister Transcript – 09/10/23 – Page 45 – Line 5

²¹³ P34’S Mother Transcript – 09/10/23 – Pages 40-41

Good care and good practice

- 1.142 It is important to acknowledge in this report that there were examples of good practice at MAH. Public inquiries naturally attract those with criticisms of the institution under investigation, and as such, there will be bias in favour of reporting poor practice. While the Inquiry Panel made clear, through pre-evidence sessions and media communications, that it welcomed accounts of both good and bad care, the majority of evidence inevitably focused on the latter.
- 1.143 This section of the report highlights some of the expressions of good care shared with the Inquiry and reflects on what distinguished these examples from poor practice.
- 1.144 Despite serious concerns, including those revealed through CCTV footage, some relatives who came forward primarily to speak about poor care also recognised instances of good practice:

'The care he received in the intensive care unit at Cranfield was quite good and Ciaran improved dramatically. He stayed there for one year. H12 was the nurse in charge of Cranfield at the time and was very good ... Now, there was a nurse there that was absolutely brilliant and took Ciaran under her wings, and she looked after Ciaran very well and would have took him out of the ward as much as she could'.²¹⁴

'I felt that some frontline staff were caring and supportive, and I felt they appeared to be doing their best within a very restrictive culture led by management'.²¹⁵

'I feel that MAH is a good place, but the staff levels are much diminished over the past two to three years, with a lot of the staff leaving'.²¹⁶

- 1.145 While few patients gave evidence directly to the Inquiry, one individual expressed clear satisfaction with the care received:

'At MAH, we used to carry on and have banter with the nurses, doctors and carers. The staff bent over backwards for me and the management in the three wards that I was in was excellent'.²¹⁷

²¹⁴ P57's Mother Transcript – 20/10/22 – Page 23 and Page 32

²¹⁵ Witness in relation to P71, Transcript – 23/11/22 – Page 108 – Line 14

²¹⁶ P100's Mother Transcript – 14/09/23 – Page 19 – Line 19

²¹⁷ P7 Transcript – 30/06/22 – Page 34 – Line 25

1.146 It is also important to acknowledge the dedication of many staff members who continued working under extremely challenging circumstances following the CCTV revelations. Numerous staff were suspended, some for direct actions or omissions that harmed or put patients at risk of harm, and others for failing to intervene. These suspensions led to a reliance on agency staff, many of whom lacked experience in supporting individuals with learning disabilities. The pressure on the remaining staff must have been considerable.

1.147 Inevitably some of the accounts provided a mixed picture of care. One patient described contrasting experiences:

[Counsel]: *'You say in your statement "some nurses were nice, some were bullies"?*

[P19]: *Yeah.*

[Counsel]: *Could you explain a little bit more what you mean by some were bullies?*

[P19]: *What I meant by bullies was they would yell or shout at you, or just yell or shout at you.*

[Counsel]: *Yes.*

[P19]: *And be cheeky with you'.²¹⁸*

1.148 Other accounts highlighted moments of exceptional care. One witness described the positive impact of one-to-one support for P36:

'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'.²¹⁹

1.149 However, the same witness also raised serious concerns:

'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'.²²⁰

²¹⁸ P19 Transcript – 21/09/22 – Page 86 – Line 23

²¹⁹ P36's Mother's Transcript – 10/10/23 – Page 105 (restricted)

²²⁰ P36's Mother's Transcript – 10/10/23 – Page 123 (restricted)

- 1.150 Some witnesses spoke positively about individual staff members who provided consistent and compassionate support, even when these witnesses were recalling distressing events involving other staff:

'I had a good relationship with H48, our community nurse. He was great, and if I had any problems, I went to him. If I needed something for Roberta, he brought it up to MAH for me. He went to appointments with me. H48 previously worked in MAH and then became a community nurse. H48 always offered to take stuff up'.²²¹

- 1.151 Evidence of good practice was sometimes found in relation to the range of activities available, both on and off the ward:

'The ward is good'.

'I get on well with my named nurse'.

'There are lots of things for me to do, I go to the gym and I go horse riding'.

'I like going to Moyola (day-care)'.

'We go out at the weekends'.

'I am frustrated that there is nowhere for me to go to in the community'.

'Being here has helped me but I am fed up waiting on a place in community'.²²²

- 1.152 The Regulation and Quality Improvement Authority (RQIA) also identified examples of good practice. A 2015 RQIA report noted:

'Although patients spoke highly about the care and treatment on the ward they expressed their continued frustration that their discharge was delayed. This meant that patients remained in a restricted environment which potentially had an impact on their human rights'.²²³

- 1.153 A separate RQIA report highlighted strong patient involvement on Donegore Ward:

'All of the patients interviewed stated they had been involved in their care and support. Patients knew who their named nurse was and informed the inspector their named nurse had discussed their care plans with them. The patients all stated they were offered the opportunity to attend their multidisciplinary meetings. Patients informed the inspector that prior to the multidisciplinary meetings the named nurse will explain the content of the meeting and asks the patients what they would like discussed at the meetings. If a patient chooses not to attend patients stated they are informed of the outcomes of the meeting ... All of the patients interviewed stated they were happy with the care and treatment they received on the ward. Two patients indicated they had a good relationship with their named nurses. Patients described the care as "good" "staff were nice" and one patient stated "I really love it here".²²⁴

²²¹ P23's Mother Transcript – 22/09/22 – Page 64 – Line 24

²²² Patient experience evidence, multiple sources

²²³ RQIA - Mental Health Inpatient Inspection Report, Cranfield Ward 2 – 28/11/16 – 30/11/16

²²⁴ RQIA - Mental Health and Learning Disability, Patient Experience Interviews Report, Donegore Ward – 06/05/14

1.154 Another RQIA report from 2014 praised Donegore Ward:

'Care records reviewed by inspectors showed evidence that each patient had an individualised assessment of needs and person-centred care plan completed. Risk assessments and care plans were reviewed and updated six monthly or sooner if required by the multidisciplinary team. The multidisciplinary template was completed by all staff and signatures of the patients and patients' relatives were consistently recorded. It was positive to note in daily care records reviewed that patients had been consistently consulted with in relation to their care ... Easy read information was available for patients in relation to: the patient's charter; complaints; independent advocacy services; keeping healthy including dentist and venepuncture; deprivation of liberty; capacity; and consent'.²²⁵

1.155 An RQIA report on Oldstone Ward also found patients generally satisfied with their care, though they worried about being discharged:

*'Pretty much happy with my treatment and care here';
'... o.k. I get treated well';
'... cares very good';
'Staffs trying their best to help me ... they always do help when you need them';
'Treatment in Oldstone is very good';
'I don't want to move';
'Really going to miss Oldstone ... very bad';
'Don't close the place'.²²⁶*

1.156 One of the consistent features of positive reports was when witnesses could point to activities patients had enjoyed and benefited from:

'In around 2008, we set up a car wash at MAH. MAH patients and MAH staff worked as a team to wash cars and received a payment in return. I felt that this was an important part of normalisation. It helped MAH patients understand that, in return for doing a task, they received a reward. The money that was earned from car washing was kept in a jar and the patients decided what they would spend it on. They would have selected things like ten pin bowling, a cinema trip or go to McDonalds'.²²⁷

1.157 Another witness described efforts to engage:

'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'.²²⁸

²²⁵ RQIA - Mental Health and Learning Disability, Unannounced Inspection, Donegore Ward -18/11/14 & 19/11/14

²²⁶ RQIA - Mental Health and Learning Disability, Patient Experience Interviews Report, Oldstone Ward – 07/05/14

²²⁷ Christine Keenan Transcript – 13/11/23 – Page 31 – Line 5

²²⁸ P36's Father's Transcript – 10/10/23 – Page 84 (restricted)

1.158 The importance of skilled behavioural support was also highlighted:

'In the past there were activities organised for P34 and he had good behavioural support, mainly from H593 who was a behavioural nurse working in Cranfield 1 and PICU. This was a critical element in P34's improved behaviour. In 2018 when PICU closed and P34 was moved to Cranfield 1, he lost the benefit of H593's skills and level of care, as she was moved to work in Cranfield 2. Until around mid-2018, just prior to P34's move to Cranfield 1 and having been prescribed Haloperidol, P34 was at his best behaviourally. This was after a considerable amount of attention and work with H593. I have provided two photographs at 'Exhibit 11' to show as a comparison how P34 appeared during that period in 2018 and how he appears now'.²²⁹

1.159 Medication management was another area where some staff made a difference:

'I would get calls from staff at MAH regarding P96's medication. Staff did manage to get P96 off sleeping medication whilst he was in MAH and managed to control his ADHD'.²³⁰

1.160 The 'Way to Go Report' in 2018 highlighted the ongoing provision of compassionate care at MAH:

'Families want it to be known that there are some Hospital staff who conscientiously provide compassionate care and treatment: kept my son alive// grade 3 staff go the full hog to meet needs// staff are fantastic ... Activities were valued when they were available, and one person acknowledged the help he had received to prevent self-harming'.²³¹

1.161 Kilead Ward was commended for its emphasis on enjoyable, self-directed activities:

'This women's admission ward draws attention to the pleasures of being able to choose what to do. They are assisted by staff who understand the importance of providing the kinds of opportunities and routines which are valued by all of us. The initiative of a ward manager to document an approach characterised by conflict resolution merits particular attention. It could have invoked a safeguarding investigation, yet the approach adopted acknowledged and documented the felt and expressed harm. The relations of power at the Hospital are complex and subtle. The ward manager sought to explore a solution which changed the relationships of the two men concerned. The Review Team commends this approach because the resolution of conflict hinges on the art of facilitating an appropriate process for those in dispute to problem-solve together and, through the process, to reconstruct their relationship'.²³²

²²⁹ P34's Sister Transcript – 09/10/23 – Page 54 – Line 12

²³⁰ P96's Father Transcript – 11/10/23 – Page 14 – Line 11

²³¹ Margaret Flynn Statement – 24/04/23 – Page 21 (Exhibit MF/1) - A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, published in November 2018

²³² Margaret Flynn Statement – 24/04/23 – Page 34 (Exhibit MF/1) - A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, published in November 2018

1.162 A patient's own words captured both appreciation and frustration:

*'Being here has helped me a lot but I'm fed up waiting on a place in the community (Cranfield 2017).'*²³³

1.163 Of the staff who gave evidence, some were proud of their achievements, offering specific examples of good care. H903, who worked at MAH as a bank healthcare support worker (1998-2006) and later as a registered learning disability nurse (2006-2016), primarily cared for children in Conicar and Iveagh wards. She described her approach as patient-centred, incorporating therapeutic activities tailored to individual needs and preferences:

*'I recall playing games with patients, taking patients, both those mobile or in wheelchairs, out on walks and helped teach them new skills, for example, how to brush their teeth. I enjoyed taking patients swimming within the hospital which was a preferred activity for many ... Teams tried proactively to meet patients' needs and help support them. Patients were assessed and nursed in the ward most suitable for their needs at the time and this could change.'*²³⁴

1.164 She also spoke of MAH as a community:

*'MAH was a community where service users had access to everything on site, to include discos, a swimming pool, a cafe, transport and walks around the grounds. A lot of patients were able to have the independence to socialise and go places within MAH on their own unsupervised. This included going to work skills, to the shop or to the disco. This helped them build confidence and boosted their self-esteem. This may not have been achievable within community settings due to their vulnerability and the higher risks posed. Patients regularly engaged in community activities and trips out ... Staff on each ward I worked on treated patients like family. Some patients did not have family to go home to at Christmas for example, so staff who cared for them often volunteered to work over the Christmas period to support them. Staff made Christmas fun and festive for patients by supporting them when they were missing particular people.'*²³⁵

1.165 H112 also described how structured activities were incorporated in care plans. When asked by Dr Maxwell about typical ward-based activities, she responded:

*'It would have been like tabletop activities, like jigsaws, board games. Fintona North, I suppose because it was a female ward, there would have been lots of hairdressing, make-up, nails, there would have been – there were young girls with learning disability, and that would have formed very much part of their social needs, and they would have enjoyed that. Foot spas, out of memory, would have been very popular.'*²³⁶

²³³ Margaret Flynn Statement – 24/04/23 – Page 36 (Exhibit MF/1) - A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, published in November 2018

²³⁴ H903 Statement – 17/05/24 – Page 3

²³⁵ H903 Statement – 17/05/24 – Page 5

²³⁶ H112 Transcript – 10/09/24 – Page 12 – Line 6

1.166 Listening to these accounts, it was evident that when patients and their relatives spoke positively about the care received or praised staff, several themes emerged:

- A patient-centred focus by staff;
- Genuine kindness, interest and compassion shown by individual staff to patients;
- A commitment to treating each patient as a unique individual, with their wellbeing placed at the forefront of care delivery;
- Provision of meaningful activities to prevent boredom and promote engagement.

1.167 Some of the families who gave evidence to the Inquiry reported that there were some excellent staff, giving good care in difficult circumstances:

'The care he received in the intensive care unit at Cranfield was quite good and Ciaran improved dramatically. He stayed there for one year. H12 was the nurse in charge of Cranfield at the time and was very good. Now, there was a nurse there that was absolutely brilliant and took Ciaran under her wings, and she looked after Ciaran very well and would have took him out of the ward as much as she could'.²³⁷

'I felt that some frontline staff were caring and supportive, and I felt they appeared to be doing their best within a very restrictive culture led by management'.²³⁸

1.168 P31's father had nothing but praise for the care his daughter received at MAH. P31 was born in 1984 and had severe learning disabilities. She can indicate her needs but would struggle to build a conversation. P31's mother worked at MAH as a seamstress for 16 years until 2017 when she retired. From the time P31 was 15 she was a fairly regular visitor to MAH and spend varying amounts of time there between 2000 and 2018.²³⁹ Her father described how two nurses provided fantastic care to his daughter while she was on Fintona Ward:

'As P31 got older, she started attending the Antrim adult centre. The staff at MAH were happy for me to collect P31 in the morning, bring her to the Antrim adult centre and bring her back to MAH later that day. P31 never appeared to become upset when being brought back to MAH after a weekend or day trip away. My wife was very particular about P31's clothing and laundry and did not want this to be washed along with other washing in the hospital. The MAH staff went out of their way to ensure P31's laundry was separated from other

²³⁷ P57's Mother Transcript – 20/10/22 – Page 23 – Line 1

²³⁸ P71's Foster Mother's Sister Transcript – 23/11/22 – Page 108 – Line 14

²³⁹ P31's Father Transcript – 21/09/22 – Page 49 – Line 19

laundry so that my wife could wash and iron P31's laundry herself ... At some point during P31's time at MAH, a new ward was assembled which was known as Cranfield. P31 was moved to the Cranfield Ward. The Cranfield Ward had a more clinical setting and was less homely than the Fintona South Ward. That said, P31 never appeared to be unhappy in the Cranfield Ward. P31 was cared for by a senior nurse in the Cranfield Ward called H163. H163 was in charge of the female patients in Cranfield Ward and took very good care of P31 and other patients. I understand that H163 is now retired'.²⁴⁰

'Had MAH not stopped admitting patients, my wife and I would have been happy for P31 to continue her treatment there. The last four years without the support of MAH have been difficult. [Doctor named] previously indicated to me that if MAH had been available, she would have recommended that P31 be admitted to MAH again'.²⁴¹

- 1.169 Shelley was admitted to MAH between 2016 and 2018 when she moved to a residential home where she settled:

'Although Shelley had bad experiences in MAH, some staff were good to her. There was a nurse called H157, who went out of her way to help my family when we came to visit Shelley. Shelley communicates well and usually says what she thinks and feels. Shelley is very vocal. She would not talk behind your back. When she talks about her time at MAH, she describes it as "a hell hole"'.²⁴²

- 1.170 P109 was in MAH from November 2008 to July 2018. Her mother had very frequent contact with staff at MAH looking after her daughter. She told the Inquiry:

'I do, however, want to make it clear that I am aware of good caring staff, not just in the community but in MAH. In my view having interacted with staff in relation to Alicia over a number of years, these good staff need to be properly valued and helped with better training and improved terms and conditions. They also need to be encouraged to be part of improving the system whether it is in MAH or in the community. With the appropriate training and support, staff can be part of ensuring that procedures are followed and those who are not conducting themselves properly are made accountable. My experience is that not only do some staff not know how to properly raise concerns but many who do may be afraid to do so'.²⁴³

- 1.171 P96's father acknowledged:

'There were some individuals who properly cared for P96 and I feel that it is important to also recognise this'.²⁴⁴

²⁴⁰ P31's Father Transcript – 21/09/22 – Pages 53-54

²⁴¹ P31's Father Transcript – 21/09/22 – Page 55 – Line 11

²⁴² P29's Mother Transcript – 11/10/22 – Page 23 – Line 15

²⁴³ P109's Mother Transcript – 21/09/23 – Page 51 – Line 14

²⁴⁴ P96's Father Transcript – 11/10/23 – Page 23 – Line 11

- 1.172 P96's father made an interesting observation about provision for adults with a learning disability as distinct from provisions for children. He put this pithily as follows:

'And the common theme, which we didn't appreciate at the time, was while he is a child there will be provision, there will be respite, there will be all these different things for him. But once you become an adult, it just drops off a cliff'.²⁴⁵

'I think it is important, sometimes in a scandal the negative press takes pre-eminence and I have no doubt, in that letter, if you have seen it, I make it quite plain it would be a hard paper round coming into work every day, staff were working long hours to maintain safe staffing levels, et cetera. Some staff were providing very good care. Some of them moved from Muckamore to his facility to transition him, especially his favourites. I am very grateful for the ones that went the extra mile and especially one that I mention in a senior position. For instance once it was obvious I was on the war path and I was so prominent with Action for Muckamore, anything that happened, she would tell me. If I came up on a visit, I want to let you know there is an elderly visitor came in, opened the door and P96 charged out the door and got out, right, okay. I was happy enough as long as I was being informed and how far did he get? So she would tell me if anything adverse had happened, P96 has been assaulted by patient A, right, fair enough. So it was good to know when that individual was on and she was held in high regard by the management of the Trust because certain things never happened if she was on duty, which I thought, that would be appropriate, that would be my assessment of her too. So, yes, there was ones I named were very good with P96 and worthy of the accolade'.²⁴⁶

- 1.173 P90's sister commented favourably on H30's care for patients (emphasis added):

'During Bryan's time in MAH he has had quite a few different consultants. One who stands out in my mind is Dr. H30. During the time Dr. H30 cared for Bryan I was able to form a good relationship with her, and we often had informal chats about both our lives. I recall one day while visiting Bryan, Dr. H30 came in while I was in the visiting room. I don't recall the specific date, but it was in Erne Ward and before 2017 when the abuse was discovered. I think it would have been around 2016. Dr. H30 started talking but seemed upset. I asked her what the matter was and she told me she was leaving MAH. I was shocked as I had not expected this, and probably selfishly started to think of the future uncertainty of who would come to take her place. I had always been very pleased with Dr. H30 as she seemed to be a very good doctor who was conscientious and cared for her patients. I asked her why and she told me that she could not take it anymore. Dr. H30 then left MAH and took up a post elsewhere. At the time I thought she was maybe having a bad time as I was aware that she had problems at work before this. With hindsight I now feel that Dr. H30 had become aware of the ill-treatment and neglect which was

²⁴⁵ P96's Father Transcript – 11/10/23 – Page 35 – Line 22

²⁴⁶ P96's Father Transcript – 11/10/23 – Page 62 – Line 2

happening to the patients. I have only spoken to her once since she left MAH. I asked her how she was getting on and she told me she was doing much better as she was now working in a place where they cared what happened to the patients'.²⁴⁷

Although later she told the Inquiry:

'At one stage Bryan's consultant, Dr. H223, was off on long-term sick leave. We were unaware of this until someone mentioned it during an MDT meeting. When I asked why the family had not been told and made aware of who would be covering for Dr. H223, I was more or less accused of interfering in staff's private business and told there was no reason why we should be given this information. I tried to explain that I did not want to know anything private but as Dr. H223 was Bryan's consultant I felt the family should have been told that he would not be present for a protracted period and told who would be responsible for Bryan's care during this period'.²⁴⁸

1.174 P90's brother also highlighted the good care that he had received:

'I think it is important to mention that there were some brilliant nurses in MAH. Many of the nurses did their best. The nurses who are still there are a credit to their profession. The difficulty I have with staff is the management. They had the power and could set the culture. I do not know how the nurses who inflicted the abuse were allowed to continue with their abuse for so long. I feel that management spent too much time either refusing to properly manage a place where abuse could easily occur or trying to avoid blame'.²⁴⁹

1.175 P36 was admitted to MAH for what turned out to be a two-month admission in May of 2012 at the age of 22 years old. His mother told the Inquiry:

'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'.²⁵⁰

1.176 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.²⁵¹

²⁴⁷ P90's Sister Transcript – 11/10/23 – Pages 80-81

²⁴⁸ P90's Sister Transcript – 11/10/23 – Page 113 – Line 1

²⁴⁹ P90's Brother Transcript – 11/10/23 – Page 144 – Line 15

²⁵⁰ P36's Mother Statement – 28/09/23 – Page 8 (restricted)

²⁵¹ P36's Mother Statement – 28/09/23 – Page 12 (restricted)

1.177 P7 was a former patient of MAH admitted in 2006 at the age of 46. He had only good things to say about his care at MAH, describing how members of staff bent over backwards for him and he enjoyed the banter.

1.178 However, some families thought the bantering might be a way of distracting patients from sharing their experience:

'It appeared on this one occasion that P18 was about to tell us something about the bruises when this staff member stopped him by bantering with P18. The staff would always have bantered with P18'.²⁵²

1.179 Although poor care and abuse has and will be the focus of this report, many staff working at MAH deserve praise and admiration for working in what for many, and possibly all, will have been a difficult and challenging environment.

Conclusions

1.180 The Inquiry heard from over 90 family and patient witnesses, either by direct evidence or via statements being read, giving their accounts of how they saw the patient experience at MAH covering the period of our Terms of Reference. The accounts in this chapter are a small but representative selection of the evidence as a whole from this important group of witnesses.

1.181 The Panel concluded that injuries such as bruises and marks were not isolated or incidental; they were visible indicators of systemic failure. As we will explore later in this report, dealing with each incident individually resulted in the inability of the organisation to recognise patterns, escalate concerns and protect patients, and allowed physical abuse and neglect to continue unchecked, causing lasting harm to patients and profound distress to their families.

1.182 The patient experience evidence provided the Panel with material leading to several themes that were further explored in the evidence and are looked at in more detail elsewhere in this report. These themes included:

- The misuse of restrictive practices, including physical restraint, sedation and seclusion;

²⁵² P18's Mother Transcript – 21/09/22 – Page 14 – Line 12

- A lack of personal care, including significant weight gain and weight loss and physical neglect;
- The lack of available primary care;
- Poor accounting, control and security of cash and personal property;
- A lack of supervision where supervision was needed;
- Poor communication to families in all of the areas listed above.

1.183 The evidence from the patient experience has been used throughout this report where appropriate, but where possible we have avoided repetition, although inevitably we have not been entirely successful. The Panel appreciates that for all of the witnesses who provided evidence to the Inquiry, despite every effort the Inquiry staff could make, the preparation for giving evidence and the task of giving evidence to the Panel must have been a difficult but necessary duty.

1.184 Having spoken to the great majority of the witnesses both before and sometimes after their evidence, I have good reason to believe that almost all were pleased they had undertaken the task and satisfied with the account they gave. The Panel is grateful to each and every one of them.

(This page is intentionally left blank)

Do you see me?

'Well, we took him out to the pub. His idea was -- he learned very quickly to order a Scotch and white with ice for me and vodka and white, for someone else, with ice, but he had "a coke with a slice of lemon and no ice, please", and he was not shy about telling barmen that that's what he wanted, but he did that, you know, quite regularly. So it was the fact, not so much drinking, it was being there in company was what he was looking at all the time, and he enjoyed himself with all the things -- he actually got his own membership of the Boat Club, so he was able to get in and out of the place himself and sort of drink -- he had a very -- how can I put it? -- he had a very interesting way of paying for drinks: he ordered them and asked me for money and then put the change in his pocket.'

'My daughter is very family orientated. She loves her brothers and sisters. She idolises me and calls me Super Mummy. She loves playing chess and attends a chess club. She loves shopping and eating out and her favourite thing to do is to go to the cinema to watch scary movies. She has a great sense of humour.'

Chapter 2

Admission of Patients to MAH

Introduction

- 2.1 This chapter examines how the experience of admission to the hospital evolved over time, with a particular focus on our Terms of Reference (ToR) period from 1999 to 2021. During these years, MAH underwent significant change: from a long-term care and living facility to an assessment and treatment model.
- 2.2 Much of MAH's institutional history and development is comprehensively documented in 'From Special Care to Specialist Treatment A History of Muckamore Abbey Hospital' by Ian Montgomery and Joe Armstrong.¹ We draw on this work throughout this chapter and gratefully acknowledge the authors' contribution. Although we do not replicate their detailed account, we highlight key changes that shaped the purpose and experience of patient admissions to MAH over time.
- 2.3 Former residents and families gave evidence, some recalling experiences as far back as the 1970s. Their accounts give insight into how conditions at MAH changed, and how those changes affected the lives of those admitted.

From long-term living and care to an assessment and treatment model

- 2.4 MAH admitted its first patient in 1949 and then rapidly expanded. The 1960s 'villas' Moylena, Rathmore, Conicar, Moyola, Finglass, Movilla and Fintona were built also for long-stay residents.
- 2.5 These original 'villas', designed to support MAH's role as a long-stay facility, had fallen into disrepair by the 1990s. They were described as cold and impersonal, with patients sleeping in shared dormitories rather than in private rooms.²

¹ I. Montgomery and J. Armstrong (2009) From Special Care to Specialist Treatment: A History of Muckamore Abbey Hospital. Ulster Historical Foundation, Belfast (ISBN:978-1-903688-41-0) – <https://ulsterhistoricalfoundation.com/library/from-special-care-to-specialist-treatment-a-history-of-muckamore-abbey-hospital>

² From Special Care to Specialist Treatment (Montgomery and Armstrong) – Pages 107 & 125

By 1993, when the hospital still housed over 550 patients, serious concerns were being raised about the condition of the buildings, particularly the villas. Outdated boilers left many wards without adequate heating, prompting public outcry and leading to targeted investment in upgrades. This included improvements to the Moylena and Fairview villas.³

2.6 Despite these issues, proposals to close the hospital in 1995 were met with strong resistance, notably from the Society of Patients and Friends of Muckamore Abbey Hospital (SPFM), reflecting the deep ties many families had to the institution.⁴

2.7 A 1991 survey revealed that nearly half of MAH's residents had been there for more than 20 years, many admitted before the age of 20.⁵ The Inquiry heard evidence of individuals admitted as young as six years old, who moved through different wards as they aged, spending much of their lives within the hospital. Some were transferred to other facilities but returned to MAH when resettlement failed; others stayed only briefly. For many, MAH was not just a hospital, it was home.

2.8 Early on, MAH often served as a place for when families could no longer cope and either respite care or longer institutional care was needed, including for young children with learning disabilities when families struggled:

'Greg was first admitted to MAH in November 1980 at the age of 9 years old. My mum cared for Greg at home but found that she could not cope with him on a full-time basis'.⁶

2.9 Commonly, individuals were admitted during adolescence, sometimes after a difficult early family life and due to emerging mental health issues:

'My connection with Muckamore is that I am a relative of a patient who was at Muckamore. My brother, Joe, was a patient there. The relevant time period that I can speak about is between 1972 and the early 2000s ... We weren't a close family ... We lived with our parents and grandparents ... There was one bedroom upstairs and a living room downstairs. Joe was bigger and rougher than me. When I was about three or four and Joe was about five or six, we were put into a care home. Two of my sisters and another brother were in one

³ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Pages 122-128

⁴ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 128

⁵ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Pages 121-122

⁶ P13's Sister Transcript – 05/07/22 – Page 58 – Line 8

part of the care home. Joe was in the care home until he was around 12. ... When Joe was 17 or 18, he ended up in a prison for the same things, mischief and house-breaking. When Joe was about 20, he put his hand through a window to try to commit suicide. I didn't know that this had happened until afterwards. This was the reason why he was put into Muckamore. My mum told me that Joe had been put in Muckamore and took me down there'.⁷

2.10 Over time, MAH evolved into a more specialist facility. It came to be seen not just as a long-stay facility but as a hospital offering assessment and treatment. We discussed in Chapter 1 (The Patient Experience) how families were often told their loved ones were being admitted for therapeutic purposes. This typically involved medication adjustments, intended to take place over a six-week period but often taking much longer.

2.11 Many families were told that MAH was the only option, and admission to MAH was initially welcomed. Families were often told that their loved ones would receive a brief period of assessment, typically lasting six weeks. However, they later learned that treatment would extend beyond medication to include behavioural interventions:

'Martin's disability became apparent at the age of around two years old. Initially, he went to a local special education school. He then went to MAH at the age of six. We were told that he would have to be resident in MAH for an initial six-week period for assessment. This was insisted upon, even though it caused Martin distress, given his age and disability. We were told after the initial six weeks that he had to attend the Behavioural Therapy Unit as an inpatient'.⁸

2.12 Even into the 2000s, some of the wards were described as unhomely and depressing. Laura (now deceased) was admitted to MAH at the age 13 when she went into Conicar Ward. At around the age of 19, in 2004, she was moved to Ardmore Ward. Her mother told the Inquiry that the family dreaded it:

'Well, the environment that she was in was totally not -- you know, there was nothing -- it was an institution. It was just like One Flew Over the Cuckoo's Nest where you watched all these people aimlessly going around, doing really nothing. Bare walls in a lot of the wards. No softness, no furnishings, no love, no nothing, no caring. Now I can't say that about all the wards because obviously I wasn't in them all'.⁹

⁷ P9's Brother Transcript – 30/06/22 – Page 10 – Page 12

⁸ P1's Sister Transcript – 28/06/22 – Page 17 – Line 9

⁹ P51's Mother Transcript – 12/10/22 – Page 110 – Line 23

- 2.13 Before 2006, admission often meant a long-term placement, effectively a new home. Some individuals remained in MAH for decades, and some still reside there. Families frequently described a culture in which they were told that they should 'get on' with their life without their loved one. This was particularly difficult, and often unacceptable, for parents of children:

'As I recall, it was a -- it was almost like "Why -- he can just stay in". It was almost like "Why would you want to do anything different?" It was, you know, they didn't seem to be cognisant of the fact that he was six years old and that this was not a proper place for a six-year-old to be attending full-time'.¹⁰
(Patient admitted 1990)

'My mother brought P90 to the doctor and was told that P90 would never be any better than he was at that time. The doctor told my mother that she should put P90 in an institution and forget about him'.¹¹ (Patient admitted 1988)

- 2.14 However, as early as the 1980s, the deteriorating physical environment at MAH, coupled with growing public concern and shifting attitudes towards institutional care, had laid the groundwork for a move away from long-term residential placements. The 1987-1992 Northern Ireland Regional Strategy for the Health and Personal Social Services (HPSS) gave a commitment that rather than live in long-term facilities like MAH, people with 'mental handicap' should be enabled to live in the community. The ambition behind the strategy was to reduce the number of people in long-stay hospitals by at least 20 percent. All subsequent Department of Health, Social Services and Public Safety (DHSSPS) and Department of Health (DoH) strategies reaffirmed this vision. This transition was eventually formally initiated by the DoH's Priorities for Action (2000). This tasked the North and West Belfast Health and Social Services Trust (NWBHSST), the body responsible for MAH, with developing a capital business case for a new core hospital. Initially planned for 115 beds, later reduced to 87, the new facility was intended to support a future model of care centred on community-based living.¹² The policy also included moving all children (under-18s) out of MAH.

- 2.15 The experience of long-term placement at MAH was shaped not only by policy and institutional culture but also by the physical environment. Between 1999 and 2006

¹⁰ P1's Sister Transcript – 28/06/22 – Page 42 – Line 12

¹¹ P90's Sister Transcript – 11/10/23 – Page 75 – Line 23

¹² Oscar Donnelly Statement (Organisational Modules) – 28/06/24 – Page 7

the plan was for MAH to undergo a significant transformation. This was from a long-stay facility that was housed in deteriorating buildings to a modern, clinical centre for short-term assessment and treatment, which eventually opened in 2006. This shift in infrastructure mirrored a broader change in the ambition of the hospital's purpose and the nature of admissions, but this plan, which would involve a significant reduction in beds, was not achieved in practice for many years. In 2005 MAH had 318 beds¹³ and in 2014 still had over 140 beds.

- 2.16 The change in policy for people with learning disabilities, involving resettlement into the community, out of long-term care, began with the 1987-1992 strategy, and was followed by the Bamford Review and particularly the Equal Lives report published in 2005. Nevertheless, in practice, many individuals remained at MAH for extended periods. In 2005 'Equal Lives' estimated that the average length of stay was 20 years.¹⁴
- 2.17 This policy direction marked a significant departure from MAH's historical role as a permanent home for individuals. It also preceded the Equal Lives report (2005), part of the Bamford Review, which strongly advocated for the resettlement of all patients with learning disabilities into the community.¹⁵ The ideological shift was clear: MAH was no longer to be a place to live indefinitely, but rather a facility for short-term treatment and transition.
- 2.18 In May 2001, NWBHSST (then responsible for MAH) approved the phased closure of seven resettlement wards.¹⁶ At the time, MAH still accommodated 366 patients across 16 wards, spread over a 30-hectare estate. The hospital's infrastructure reflected its legacy as a long-stay facility. Its provision included not only clinical wards but also a rehabilitation unit, day-care services, administrative offices, a leisure centre, a community hub and a swimming pool.¹⁷

¹³ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 176

¹⁴ Equal Lives Report – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Equal%20Lives%20Report.pdf>

¹⁵ Equal Lives Report – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Equal%20Lives%20Report.pdf>

¹⁶ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 162

¹⁷ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 155

2.19 Meanwhile, families increasingly shouldered the burden of care at home. Some struggled in silence, reluctant to seek help due to fear or stigma, or a sense of personal responsibility. The sister of P72 described how her parents coped in 2004-2005:

'I worked with Paul Mills [community learning disability nurse] ... and I was a behaviour support teacher, and I often said to Paul "mummy and daddy are getting to crisis point but they're not telling anybody". Because I think it was their generation, you know, "we'll deal with this at home, I don't want people knowing that my child's attacking me and we can't cope". And I think she was maybe afraid of him being taken away from her, or maybe, you know, she was afraid of something like this happening'.¹⁸

2.20 The opening of the new 'core hospital' in October 2006 was intended to mark a pivotal moment in MAH's transformation.¹⁹ Cranfield Ward, a 35-bed mixed-sex unit with divided areas, and Sixmile Ward, a unit with 23 beds, were designed to support short-term assessment and treatment. These facilities represented a move toward modern, clinical care environments.

2.21 Dr Damien Hughes (then consultant psychiatrist) described the opening of Cranfield as an 'exciting time' for the hospital:

[Counsel]: *'Why it was an exciting time for the hospital?*

[Dr Hughes]: *A number of reasons really. The main one, I suppose, was it was a time when it was obvious to all of us who worked in the hospital or around the hospital that it was no longer fit for purpose in terms of the buildings and the surroundings. So, the development of brand new carefully designed wards in which we could better meet the needs of our patients was an exciting development. Time was taken to engage with a number of stakeholders, but most reassuringly with patients and families around what this "new hospital", in inverted commas, would look like. I think from memory it was the first time that patients had single rooms, and not either shared rooms or even dormitory style accommodation, but from a professional perspective it was a time when we were able to I suppose separate in a lot of ways acute hospital services from longer stay or continuing care, and we were excited by the prospect of that, that we would have a dynamic ward that patients flowed in and out of. Patients came in unwell, recovered and went home. And there were I think a number of very senior staff who, as I say, were excited and looking forward to the prospect of being able to do that'.²⁰*

¹⁸ P72's Sister Transcript – 24/11/22 – Page 30 – Line 3

¹⁹ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 164

²⁰ Damien Hughes Transcript – 24/09/24 – Page 9 – Line 29

- 2.22 But the new wards were described by families as clinical, very clean but lacking in comforting or homely features. Despite policy momentum, progress was uneven. By 30 January 2005, MAH still accommodated: 10 children in Conicar Ward (out of a total of 15 beds available), 170 patients in nine treatment wards (out of a total of 182 beds available), 19 in the delayed discharge ward (Finglass) (out of a total of 20 beds available) and 86 patients in four resettlement wards (out of a total of 100 beds available).²¹ Despite the push for resettlement, MAH still had around 150 patients in 2015, underscoring the gap between policy ambition and practical delivery.²²
- 2.23 Concerns about the physical environment persisted for a considerable length of time. P16 was admitted to MAH just after his 18th birthday in 2016:
- [Counsel]: *'But you then described attending Muckamore the next day and you do recall attending.*
- [P16's Mother]: *A horrific place.*
- [Counsel]: *The Moyola Ward?*
- [P16's Mother]: *Yeah ... When you walked into it, there was a hallway with a small hallway and then a door. But once you went in the door, it was just an old, very old building with, like, dirty carpets, and there was papers on the wall, but I think they looked like leaflets that had been up years. And then I had to walk along this deserted part and up steps and then along another deserted corridor where I seen the patient just crawling about, he was an older man. And I just couldn't believe that. I couldn't believe what I was seeing. And then when I went to the end, they had P16 in a room that looked like a small gym'.²³*
- 2.24 This perception was echoed by professionals. Damien Hughes told the Inquiry:
- '... I did for brief periods have responsibility for some of the continuing care wards, and the environment in some of them, if not all of them, was pretty stark. You know, you did have very little space where patients could be by themselves or take part in activities that interested them, and only them, so there was a sense that it was, you know, a group of people brought together and had to share some quite dilapidated surroundings, and the impact of that on people's lives was significant'.²⁴*
- 2.25 Issues with inappropriate admissions to MAH resulting from the lack of alternative available respite care were not only historic but continued long after the change in approach at MAH, leading to admission to MAH. P55, diagnosed as autistic with

²¹ MAH bed occupancy 2005 data provided to Inquiry by BHSC

²² Esther Rafferty Transcript – 15/10/24 – Page 43 – Line 16

²³ P16's Mother Transcript – 20/09/22 – Page 51 – Line 22

²⁴ Damien Hughes Transcript – 24/09/24 – Page 10 – Line 25

severe learning difficulties, was non-verbal. He would need assistance to eat but could use a spoon. He exhibited challenging behaviours, which increased during his teenage years. He also developed epilepsy and had seizures. Even in 2016, P55's family were unable to access sufficient respite care in the community, so had to resort to MAH:

'[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'.²⁵

- 2.26 P28 was a twin, born prematurely in 1987. Both brothers had disabilities as a result of the problems at birth. P28 had cerebral palsy and severe learning disabilities. After difficult experiences elsewhere and his parents' health challenges, he was sectioned and admitted to MAH in 2017 at age 29:

'We were told that he would be at MAH for at least six to eight weeks. We felt we can deal with the six to eight weeks. In the end, he was there for two whole years. It was a prison sentence'.²⁶

- 2.27 The move toward bed reduction and short-term care was predicated on the timely resettlement of long-stay patients into community placements. Yet MAH retained a significant number of long-stay patients well into 2021 and beyond. This disconnect between planning assumptions and the lived reality of patients is reflected in testimony from families. For those who had lived in MAH for many years, the shift from a homely, albeit deteriorating, environment to a clinical hospital was deeply unsettling. Many were not resettled for a significant time, and the hospital, once considered home, became a place of transition and uncertainty.

The effect on patients of the change to the new core hospital

- 2.28 The move from the old MAH wards to the new core hospital marked a significant shift in both physical environment and institutional ethos. While the older wards

²⁵ P55's Father Transcript – 18/10/22 – Page 20 – Line 2 and Line 14 (restricted)

²⁶ P28's Mother Transcript – 28/09/22 – Page 29 – Line 7

were in poor repair, some families described them as more homely. In contrast, the new wards, though modern and clean, were perceived as clinical, impersonal and emotionally sterile. For many long-term residents, this change felt less like progress and more like a loss of comfort and identity.

- 2.29 Beyond the physical environment, the shift in care philosophy also appeared to affect staff attitudes. Testimony from a social worker described a growing divide between hospital staff and community learning disability teams, with nurses becoming more clinical and less collaborative:

'I began to notice a change in the approach taken by MAH towards Social Workers following the appointment of H507 Service Manager in and around 2012. I describe it as a rift as the nurses no longer worked well with the community teams. Their attitude changed towards Social Workers and the nursing staff acted as if they were "experts"; they treated the community team as if we did not know what we doing. The community LD teams supported over 1,700 users with complex needs and are very experienced social workers, nurses and AHPs [allied health professionals]; only a tiny percentage of service users were in MAH. I found that the nurses became more professional and lacked warmth. Some patients had been at MAH for a long time and considered it like their home. There was a notable shift in the approach taken by staff at MAH when dealing with patients. The new approach was that patients could not stay long term at MAH as it is a hospital and, although this is quite right, the patients' bedrooms where they had their personal possessions were stripped and the environment became more sterile'.²⁷

- 2.30 Reluctance to return to MAH after home leave was a recurring theme in the Inquiry, suggesting that the environment was not experienced as safe, comforting or pleasant by some patients. Compounding these issues was a freeze in staff recruitment from 2012, which exacerbated the lack of day-care and support services, which had been increasingly apparent from 2010. A senior nurse described the staffing crisis:

'In the last few years prior to my retirement in 2016, I was responsible for managing staff absences and managing sickness. Staffing resources were frequently an issue. There were many factors which impacted staff levels such as staff being off sick due to stress; injury; long term chronic illness; extended maternity leave; requests from staff to reduce working hours for various reasons including returning from maternity leave; reduction in working hours during a "phased return" following injury/trauma/serious illness; introduction of paternity leave; releasing staff for mandatory training; volume of work needed to close/secure closed wards; increase in annual leave entitlement for staff in

²⁷ A4 Transcript – 14/11/23 – Page 12 – Line 15

*service more than ten years and staff requesting career breaks which could be any time period up to five years. There was a three-year period between 2012 and 2015 when we were only permitted to offer temporary contracts as we were told that the hospital would be retracting and eventually closing. Opportunities were lost during this time to employ newly qualified younger staff’.*²⁸

- 2.31 As the resettlement agenda progressed and bed numbers were reduced, patients were frequently moved between wards, often without consultation. Some families expressed concerns that their loved ones were on wards with people who had very challenging behaviour, and the environment was not calm and conducive to recovery. This was particularly distressing for autistic people, for whom routine and stability are essential:

*‘He was moved about between different wards. He moved between Movilla A, Erne and Killead ... I remember on one occasion when he was moved, we were not told and neither was he. He was moved one night without any prior communication’.*²⁹

*‘It was around this time [2013] that Muckamore began to close down certain wards, and a lot of patients with difficult behaviours were placed on her ward’.*³⁰

Managing medication

- 2.32 From 2005 onwards, almost without exception, families reported that the primary reason they were given for their loved one’s admission to MAH was to manage medication for a set period of time. This was typically said to be six weeks but was often much longer. In the hospital, patients were often prescribed new or different dosages of drugs to control their behaviours. Maria’s family recalled her 2021 admission to MAH:

*‘We were told by Dr Carey that Maria was only going to MAH to get her medication tweaked for a couple of months. We were supportive of this at the time, as Maria was so difficult to manage. We thought it would be a good idea to get her medication adjusted and to get her back to herself again to be more manageable’.*³¹

Lack of community support

- 2.33 Despite efforts to care for loved ones at home, many families found themselves with no viable alternative but to seek admission to MAH, often in crisis. Some tried

²⁸ Eileen McLarnon Transcript – 06/02/24 – Page 27 – Line 2

²⁹ P100’s Mother Transcript – 14/09/23 – Page 11 – Line 9

³⁰ P30’s Sister Transcript – 10/10/22 – Page 10 – Line 11

³¹ P64’s Father Transcript – 23/11/22 – Page 29 – Line 9

to access community support, only to be turned away or told to wait. P24's mother described the events leading to his 2017 admission:

'I actually took him on the Saturday to get him a mental health check-up, but they told me they couldn't do nothing until Monday, because I was wanting the medication changed. I knew he needed a mental health check-up like because he was getting lots of new behaviours and stuff ... I had actually took him on the Saturday at 3:00 o'clock to the doctor's in Newtownards and he had the big tantrum with the neighbour about 6:00 o'clock that same day'.³²

2.34 P96's father told the Inquiry:

'On the day P96 had originally been due to be admitted, H580 came to our family home and advised that P96 had been assessed as dangerous but that they had no place ready for him at MAH. She told us we would have to wait for a few more days. The doctor in attendance asked me what my plan was to manage risks posed by P96. This did not inspire me with much confidence as I thought had he was something they should have provided guidance and assistance to us about, the plan should have come from them'.³³

2.35 Marie Heaney (then Director of Adult and Social Primary Care) acknowledged that even after the 2017 CCTV footage, inappropriate admissions to MAH continued due to a lack of community alternatives:

'Admissions to Muckamore Abbey Hospital were consistently high. The data showed that most admissions were at weekends or out of hours. There was a widely held view within the hospital that most admissions did not meet the hospital's clinical criteria and that the hospital was historically used as a behaviour management backstop. Further there was evidence of repeat admissions. This practice reflected the lack of adequate community infrastructure in assessment and treatment and long-term living options that could meet complex needs, including episodes of behaviours that community services could not effectively address. Adult Mental Health inpatient units did not accept admissions, even for those with a mild learning disability'.

[Counsel]: 'So you then go on [in the statement] to say that there was no regionally agreed admission criteria or out-of-hours regional pathway for admission - this is just at paragraph 170. But ultimately you say: The Trust provided leadership in securing regional agreement regarding admission criteria for in-patient learning disability units. When was that regional agreement?'

[Ms Heaney]: It would have been 2019'.³⁴

³² P24's Mother Transcript – 26/09/22 – Page 59 – Line 20

³³ P96's Father Transcript – 11/10/23 – Page 13 – Line 3

³⁴ Marie Heaney Transcript – 26/09/24 – Page 62 – Line 23

2.36 John Veitch (then Co-Director of Learning Disability) echoed this:

[Counsel]: *'Would it be fair to say in your experience that there were admissions to Muckamore that occurred because of a lack of community support and infrastructure, rather than meeting the clinical admission criteria?*

[Mr Veitch]: *Most of the admissions to Muckamore occurred when a patient presented risk to themselves or to others. I think I've got to just refer back to my answer a few moments ago, that there were admissions to Muckamore continuing to occur at the time of my retirement which could have been prevented through community treatment and crisis intervention services being much further developed, and community treatment would have been by far the preferred option for a high proportion. Now that's not to say there wasn't a significant number of appropriate admissions which continued throughout my time in post, but there was a high proportion which in an ideal world, with a fully developed community crisis and treatment services, would have negated the need for an institutional admission'.*³⁵

2.37 Barry Mills (then Clinical and Therapeutic Services Manager) described how young people were admitted simply because insufficient community support was available:

*'But from 2014, the atmosphere in MAH changed due to the decisions being made in work force planning, delayed discharges for patients and a change in patient profile. We were getting young people of around 18 and 19 years' old admissions, as these patients had previously been supported in school but were then admitted to MAH for the wrong reasons and the patients ended up being stuck there. The community resources did not support them as it could have been a year before the community package was ready. We had complex admissions which was only worsened when patients should not have been admitted at all. For example, patients admitted from the Iveagh Centre. H50 and I opposed this as these patients were delayed discharge, but were admitted to MAH as no resettlement was available. So they built "apartments" for these patients but they were nothing other than dormitories divided. These "apartments" were scattered throughout the hospital and they were staffed with one or 2 nursing assistants. They were inappropriately placed and I cannot imagine the trauma this would have caused the patients. There were at least 4 patients who fell into this category'.*³⁶

2.38 Damien Hughes confirmed that crisis admissions were far more common than planned admissions between 2006 and 2009, and that this was largely down to a lack of community services:

'I wish it was better today, but I'm not sure services have developed much in the last 15 or 20 years with regards to community. My role in the community sector between 2006 and 2009 isn't particularly different to what my role has

³⁵ John Veitch Transcript – 19/09/24 – Page 27 – Line 29

³⁶ Barry Mills Transcript – 26/06/24 – Page 87 – Line 1

been since 2018 since I became a community psychiatrist again, a lot of it is crisis management'.³⁷

2.39 There was continuing admission of young people to adult wards by 2010. When community alternatives were unavailable, admission to MAH became unavoidable. This was often due to dysregulated behaviour during adolescence. A 2013 Regulation and Quality Improvement Authority (RQIA) overview report into the safeguarding of children and vulnerable adults confirmed that such admissions were still occurring in 2010. During the period from November 2010 to November 2011 there were 71 admissions of young people under 18 to adult mental health and learning disability wards (ward type unspecified) reported by the five Northern Ireland Health and Social Care Trusts (HSCTs), despite efforts to minimise them. These incidents were classified as serious adverse incidents (SAIs), reflecting their severity and the failure of community provision.³⁸

2.40 The situation worsened after MAH closed to new admissions following the 2017 CCTV revelations. With no alternative inpatient facility, families were left with community support options:

'In or around 2018 we met with P31's consultant, to enquire as to whether P31 could be admitted to MAH while changes were made to her medication. We were advised that as a result of the investigation into MAH staff, P31 could not be admitted to MAH at this time. Had MAH not stopped admitting patients, my wife and I would have been happy for P31 to continue her treatment there. The last four years without the support of MAH have been difficult. [The doctor] previously indicated to me that if MAH had been available, she would have recommended that P31 be admitted to MAH again'.³⁹

Admission to MAH and the use of the Mental Health Order

2.41 Admission to MAH occurred through a range of pathways, often shaped by complex and often distressing circumstances. Some were state mandated and involuntary, including admissions through the criminal justice system into forensic care wards. These patients often had different experiences of care, shaped by both clinical need and legal circumstances.

³⁷ Damien Hughes Transcript – 24/09/24 – Page 14 – Line 22

³⁸ RQIA - Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report – February 2013

³⁹ P31's Father Transcript – 21/09/22 – Page 55 – Line 6

- 2.42 The legal framework governing admissions to MAH, particularly the Mental Health (Northern Ireland) Order 1986 (MHO) and other legislation relating to the admission of patients with learning disabilities or mental health problems is discussed in detail in Chapter 18 (Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty). Here, we focus on how patients and families experienced the use of the MHO and the information they were given at the time.⁴⁰
- 2.43 Under the MHO, individuals can be detained for assessment and treatment if they are deemed to pose a serious risk to themselves or others due to a mental disorder or disability. This decision must be made by an approved medical practitioner. The legislation also makes provision for an application by a patient or nearest relative to the Review Tribunal, which has power to direct discharge in defined circumstances.⁴¹ These rights are explored in further detail in Chapter 18.
- 2.44 The Inquiry heard repeated accounts of admissions triggered by a crisis, often with police involved, and use of the MHO. Families reported confusion about the criteria for detention, especially when they had already agreed that admission was in the patient's best interest. In one case, the MHO appeared to be used to ensure that a bed would be available promptly, rather than because of the patient's mental health and risk to themselves or the community:
- 'On some occasions P31 was detained and admitted to MAH. On such occasions I recall the applications for P31's detention being made in order to expedite P31's admission to MAH'.⁴²*
- 2.45 Some families were told that the MHO would be used without family consent. While legally accurate, this left families feeling powerless and excluded:
- 'Social workers and doctors attended the family home. The social worker advised that P96 should be detained under the Mental Health Order. We were really concerned about this as we knew P96 would struggle to deal with it and so we did not agree to section P96 at that time. The Social Worker returned to advise that detaining P96 was something they were going to pursue, with or without family approval. She explained to us that if we did not agree, then they would have P96 sectioned, which would have to involve the police removing*

⁴⁰ The Mental Health (Northern Ireland) Order 1986 – <https://www.legislation.gov.uk/nisi/1986/595>

⁴¹ The basis on which the power to discharge may be exercised is set out in Article 77 of the Mental Health (NI) Order 1986 – <https://www.legislation.gov.uk/nisi/1986/595/article/77>

⁴² P31's Father Transcript – 21/09/22 – Page 50 – Line 16

him to MAH. We were told social services would succeed in sectioning him, even if we contested it, and then P96 would be taken by the police to any available mental health unit, which could be Londonderry, Armagh, or MAH'.⁴³

'It was our understanding that the purpose of admitting P96 to MAH was for him to be assessed and treated. H580 indicated that the process would take between four to six weeks. She showed us pictures of MAH and described it as being like a holiday village. She said that MAH had been subject to so many investigations it was a very safe place to go. She also said there were cameras everywhere and that it was the most highly staffed and highly trained unit, it was the jewel in the crown'.⁴⁴

2.46 P12's brother-in-law told the Inquiry:

'We did not want P12 to go back to MAH. We were told by the Disability Services Manager that if we did not agree to admit P12 voluntarily to MAH, that two social workers would section him. We felt pushed, bullied and intimidated into agreeing to him being admitted'.⁴⁵

2.47 P96's father told the Inquiry:

'I was not provided with any meaningful information about the facilities or what we could expect'.⁴⁶

And he later told the Inquiry:

'I also have concerns about P96's detention status whilst in MAH. During the first five or six weeks the staff would have commented how P96 was very good and had no adverse behaviour. However, after a while our family were told that he did have some behaviours and that he had been sectioned. Subsequently Dr. H30 told me that they had lifted the section as they had decided P96 did not have the ability to escape. P96 clearly did have the ability to escape given what happened when they moved P96 from PICU to Cranfield 2'.⁴⁷

'A couple of months later Dr. H30 then told me that P96 was to be sectioned again. This was, she said, because it did not sit well with her to use force or seclusion on a voluntary patient. At the time I did not appreciate the significance of P96 being voluntary or detained. When P96 was sectioned I thought this was the procedure for getting him the treatment he needed. In hindsight for me, the reality is that when P96 was sectioned I lost total control, MAH made all of the calls'.⁴⁸

'P34 was admitted at about 3:00am to Cranfield 1, which is a male ward. It was explained that this was because there were no beds available in the children's ward. I was unaware of the arrangements that were made for P34

⁴³ P96's Father Transcript – 11/10/23 – Page 11 – Line 6

⁴⁴ P96's Father Transcript – 11/10/23 – Page 11 – Line 22

⁴⁵ P12's Brother-in-law Transcript – 29/06/22 – Page 72 – Line 14

⁴⁶ P96's Father Transcript – 11/10/23 – Page 13 – Line 18

⁴⁷ P96's Father Transcript – 11/10/23 – Page 24 – Line 11

⁴⁸ P96's Father Transcript – 11/10/23 – Page 24 – Line 23

in recognition that he was only fourteen years old and being placed on an adult ward. I do believe that Dr. H40 was of the opinion P34 required one-to-one care whilst in the adult ward and this was provided. P34 was formally detained under the Mental Health Order by a doctor at MAH. This was not explained to me at the time but I did understand that this meant P34 could not leave MAH ... After about three or four weeks, a bed was available in Mallow. Mallow was a children's ward and I felt this was an appropriate transfer'.⁴⁹

'In 2010, P34 was transferred to the Iveagh Centre. Iveagh opened on 26th March 2010 as a specialist facility for the diagnosis of children with mental health issues and disabilities. Mallow had closed and P34 was transferred to Iveagh when it opened. I cannot recall being shown any risk assessment for P34's transfer to Iveagh or any transitioning work being done with him. There was no gradual transition. It was just a matter of moving the children to Iveagh to get them away from Sixmile which was a forensic ward. That is what the manager at the time told me'.⁵⁰

2.48 The use of the MHO also had legal implications for families. It removed legal responsibility for their loved one's care from families to the state. Many families described feeling excluded from care planning and decision-making as a result.

2.49 The Inquiry heard that many families were not informed of their rights when their loved one was subject to the MHO. Some struggled to understand what the MHO meant, how long it would last or what options were available to challenge it:

'We didn't know our rights or anything about Muckamore; nobody told us. It was just felt that Ciaran was taken off us and we had no rights whatsoever over him'.⁵¹

'Because when we got the phone call to say that she was going, I offered to come and get her and bring her home, because we knew how to settle her and how things would settle down without escalating it, putting her in Muckamore, getting police escorts. And I was told, no, that she was now an adult and that I had no control over it.

[Counsel]: *And did anyone explain what the purpose of the detention was?*

[P23's Mother]: *They just says when they got her in that they would look -- they would review her medication to see if maybe there was something else they could give her to stop her lashing out at people.*

[Counsel]: *Was it ever explained to you how long the detention was likely to last?*

[P23's Mother]: *No.*

[Counsel]: *During the period of detention, were you ever told that you could -- was it ever mentioned to you, a mental health review tribunal or commission, were you ever told that you could try and get Roberta home?*

⁴⁹ P34's Mother Transcript – 09/10/23 – Pages 11-12

⁵⁰ P34's Mother Transcript – 09/10/23 – Page 14 – Line 10

⁵¹ P57's Mother Transcript – 20/10/22 – Page 29 – Line 7

[P23's Mother]: *No.*

[Counsel]: *I wanted to ask you about visiting her. You said that you couldn't get in to see her for four weeks?*

[P23's Mother]: *Mm-hmm.*

[Counsel]: *And I think you said you had been trying to get in?*

[P23's Mother]: *Yes. Yeah'.⁵²*

2.50 Another witness said that they were given no explanation at all when their son was 'sectioned' (compulsorily detained under the MHO).⁵³ They had no understanding of what it meant and were given no information by the hospital.⁵⁴

2.51 Families described feeling very vulnerable and unsure of what to do. Many felt they had no choice but to trust professionals and to go along with what they recommended. In the light of later CCTV revelations at MAH, this has become a source of guilt:

'We were given an information leaflet. I felt confused. I felt overwhelmed, I didn't know what way to turn. I didn't know what to do that was best for P28. I didn't know what was best for anyone. I just wanted my child fixed. I didn't know how to get my child fixed. I trusted them. I trusted them. It's the worst thing I could have done. I trusted them with my child'.⁵⁵

The experience of patients and their relatives in admission and discharge

2.52 The Inquiry heard repeated accounts of families being poorly informed about the nature, purpose and implications of admission to MAH. This led to families feeling excluded and disempowered from the outset. Families were told not to visit in the initial days (and sometimes weeks) of admission, on the basis of allowing the patient to 'settle':

'The male nurse recommended that we did not visit for a few days to allow Ashley to settle. I wanted to come in with her, but the male nurse stated that it was not safe for me on the ICU Ward. I remember saying to him, if it is not safe for me, how is it safe for Ashley?'⁵⁶

'When John was first admitted to Muckamore, myself and family were told by staff, I cannot recall who, that we were not allowed to visit John for a period of time to allow him to settle'.⁵⁷

⁵² P23's Mother Transcript – 22/09/22 – Pages 76–77

⁵³ P24's Mother Transcript – 26/09/22 – Pages 79–80

⁵⁴ P24's Mother Transcript – 26/09/22 – Pages 79–80

⁵⁵ P28's Mother Transcript – 28/09/22 – Page 84 – Line 2

⁵⁶ P114's Mother Transcript – 27/09/23 – Page 14 – Line 28

⁵⁷ P72's Sister Transcript – 24/11/22 – Page 11 – Line 27

'P110 was readmitted to MAH from 2014 - 2019. I was told that I would not be able to see P110 for an initial period. I believe a period of eight weeks was required to allow P110 to settle in. I had no communication from MAH during this period on how P110 was getting on. I was not allowed to phone or to visit. This was horrific for me. P110 is my whole life. Not being able to speak to him was mental torture for us both'.⁵⁸

- 2.53 P117's mother explained to the Inquiry that P117 was readmitted to MAH in 2001 under the MHO (having earlier been admitted for respite for a few days a week between 1998 and 2001):

'We did not have any experience of detention before this. We were told that P117 would remain in MAH for a period of six weeks for assessment. We were also told that we could not visit P117 during this time which we found that very difficult. I would telephone MAH to ask how P117 was and to try and speak to her but the staff we spoke to would not let P117 talk to us on the telephone. After the six week assessment period had ended myself and P117's Father visited P117. We felt what P117 was okay but we thought what she had to remain in MAH as we were told that it was the best place for her to receive the proper treatment she required and to have her medications adjusted appropriately. At no stage were we told that P117's detention in MAH would be long term. We believed after treatment she would come home again full-time'.⁵⁹

- 2.54 She later commented:

[P117's Mother]: 'We didn't actually realise at the start that she was being detained, we didn't actually because we didn't know all the ins and outs, we didn't realise at that time that she was a detained patient. We just thought she went up for six weeks for treatment.'

[Counsel]: Was that not explained to you at that time?

[P117's Mother]: No, because you weren't told anything, no, you were very much just the mummy and daddy, you weren't told anything.

[Counsel]: So at the time that she was admitted in 2001 you weren't aware that she was admitted specifically under the Mental Health Order as such?

[P117's Mother]: No, I wasn't aware of that, no'.⁶⁰

- 2.55 The Inquiry heard from a number of witnesses that families were also discouraged from entering wards, particularly the Psychiatric Intensive Care Unit (PICU). They instead saw their loved ones in visiting rooms outside the main ward area:

'Things had started off okay at MAH. Initially, Bob and I were accepted into the ward and could see P28's room. At the beginning when we visited P28 it was more welcoming and the staff let us sit in the dayroom with him. There, we were able to let him have his music and play with his toys, and we had a level

⁵⁸ P110's Mother Transcript – 28/09/23 – Page 73 – Line 9

⁵⁹ P117's Mother Transcript – 10/10/23 – Page 14 – Line 23

⁶⁰ P117's Mother Transcript – 10/10/23 – Page 26 – Line 23

of interaction. We would encourage him to eat and we could even walk him to his room. We would change him or arrange his things in his room. I tried to make the room homely, but it was impossible ... We got to know that if there was one particular member of staff on duty there was always a reason why we couldn't get on to the ward. I cannot recall her name ... As the weeks and months went on, things began to change. Things were going the same way as Facility A [the previous resettlement facility, which failed]. I was living it all over again. It was a long and tiring drive from -- your home. Often when we would get to MAH only to be told we were not allowed on to the ward or we couldn't visit P28. It felt like they simply didn't want us there. They would bring P28 out to the visitors' room. The visitors' room was totally inappropriate as there were only seats in there. P28 had toys in his room and we could engage with him, which made for a better family visit'.⁶¹

- 2.56 P116 was admitted to MAH Cranfield Ward just before Christmas 2015. His mother described the distress of being separated from her son over this period:

'We were not provided with any adequate information about what was happening and what we could expect of Muckamore. My husband and I went up the day after P116's admission to try and see him. We were told that we could not see him for a few days until staff got him settled. This again was massively distressing for us. Both my husband and I cried our eyes out in the car park. P116 could not see his family over Christmas, which was the first Christmas that our family had not been together'.⁶²

- 2.57 Some families reported that, although they saw staff on wards during their visits, it was often unclear who they should speak to. The absence of a designated key worker left them feeling adrift:

'There was no one. I mean there was just a person, we went in -- we went in, like we went into a room, a person brought him in and then she went out again, or he went out, and that was it. We had a half an hour, or maybe 20 minutes, and then we left. There was no one I knew we could talk to about it'.⁶³

- 2.58 A recurring theme was the perceived power imbalance between staff and families. Some felt that raising a concern or complaint could jeopardise future admission and access to care at MAH:

'When I was raising concerns regarding P105's admission to MAH, he said I wouldn't be making any complaints. You're lucky we had a bed for him. We might not have a bed for him next time'.⁶⁴

⁶¹ P28's Mother Transcript – 28/09/22 – Pages 29-31

⁶² P116's Mother Transcript – 12/10/23 – Page 13 – Line 23

⁶³ P24's Father Transcript – 26/09/22 – Page 21 – Line 8

⁶⁴ P105's Mother Transcript – 14/09/23 – Page 49 – Line 28

2.59 Upon admission, families often expected to work in partnership with health and social care staff at MAH to plan care and make decisions. The Inquiry heard that many families found that this did not happen in practice which is explored in more detail in Chapter 3 (Care and Treatment at MAH):

'I received no adequate information from Muckamore staff as to Mary's care, treatment or medication. I was never provided with any brochures or leaflets dealing with admission, patients' and family's rights, care and services provided by Muckamore or resettlement from Muckamore. I never saw Mary's bedroom in Muckamore. I was not aware of Mary ever being provided with meaningful leisure or other activities in Muckamore'.⁶⁵

2.60 Following the 2010 relocation of children's services to the Iveagh Centre, a failure to plan properly for resettlement in the community meant that these patients were often admitted to MAH on turning 18. These transitions were often abrupt and distressing, with little prior communication with families:

'P77 was discharged from the Iveagh Centre on 28th September 2012, which was the day after his 18th birthday. When P77 was being moved from the Iveagh Centre to Muckamore, I was not allowed to be involved. He was transferred to Muckamore. I received a call from the deputy manager in the Iveagh Centre - I do not recall her name - on 20th September 2012 to advise me that the transition had occurred but that Muckamore advised that we were not allowed to visit P77 at Muckamore for a while to allow him to settle in. The female who called me from the Iveagh Centre seemed a bit weird on the phone. It sounded like she was going to tell me some more information on the transition but then decided against it. She told me she was not happy with staff at Muckamore as she wanted to stay with P77 to assist with the transition but the staff at Muckamore would not allow it'.⁶⁶

2.61 Families were typically told that admissions would last six to eight weeks. However, discharge criteria and care goals were rarely explained to, or discussed with, families. For some patients, short-term stays extended into months or years without any clear explanation to families. Families were told that it was not safe for their loved one to be discharged. Although efforts were made to resettle patients, the potential for long-term harm caused by institutionalisation from long stays at MAH was not sufficiently acknowledged.

2.62 There appeared to be an assumption that people would be discharged from MAH to 'supported living' rather than return home to their families. However, limited

⁶⁵ P22's Sister Transcript – 22/09/22 – Page 28 – Line 8

⁶⁶ P77's Mother Transcript – 20/06/23 – Page 18 – Line 29

availability of appropriate supported living placements caused prolonged delays in discharge. In some cases, this led to inappropriate placements (often against the families' wishes) that quickly failed, resulting in readmission to MAH.

- 2.63 The Inquiry heard from several families who successfully fought to access direct payments. This was a budget that families could use to organise bespoke care support at home:

'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'.⁶⁷

- 2.64 However, this was the exception rather than the rule in evidence received by the Inquiry.
- 2.65 Issues with a lack of support for people in crisis continue. The Inquiry heard that the current closure of MAH to new admissions is causing problems as no alternative inpatient facility is available.

Conclusions

- 2.66 MAH was built as a long-term placement facility and remained so for many years after changes in policy in the UK.
- 2.67 When the policy did change in Northern Ireland in 1987-1992 it was not implemented effectively.
- 2.68 The opening of the core hospital in 2006, which was part of the implementation of the policy, did not fundamentally alter large parts of the hospital. However, on the

⁶⁷ P55's Father Transcript – 18/10/22 – Page 91 – Line 19 (restricted)

assessment and treatment wards there was a new clinical environment, and the experience of the patients altered.

- 2.69 The assessment and treatment wards were designed to be short stay but in practice became long-term placements. We discuss this further in Chapter 15 (Resettlement).
- 2.70 Transitions of children, once they became adults, from Iveagh to MAH were badly planned and poorly communicated.
- 2.71 Such a transition to MAH would not have been necessary if it had not been for the failure to adequately plan and implement the vision from the 1987-1992 and later Bamford Review policies.

Recommendations

R4	Prior to the decision to move a service user to a different facility there must be discussion with the staff regularly caring for them, the relevant multidisciplinary team (MDT), the person's family where practicable and the person themselves where possible, to consult with them about the potential move.
R5	Any service user with a learning disability should have a named person (a key individual) responsible for their care plans and this person should be involved in and record the discussion with the family and the discussion with any relevant MDT and sign off the final decision. (And see Recommendation 99).
R6	The named person responsible for the care plan must both review and approve the preparation of anyone with a learning disability transferring to a new environment within or external to the Trust in which they are cared for. This approval must be recorded in the healthcare notes.

Patients are people first

'Yeah, and when he could walk, he loved to dance and he loves music and he loves movement. And, as I say, he tries to join in a conversation and he loves -- he hugs himself when babies are around or small children, he just loves them. And, yeah, he loves driving in the car, he'd drive around all day in the car. And he used to love the swing. And when he was younger, he was the most agile child you would ever see. He used to be able to run up stairs without -- he never fell over, he was just -- but, yeah, he's a -- he always, you know, always smiling. But then he had his issues as well, unfortunately'

'Since my son was discharged from Muckamore, he flourished. He mows the lawns and cleans the cars of our neighbours. He is learning to drive. He is very good at home and looks after me.'

'My son had a therapy dog who was trained to anticipate his seizures. This dog was called Ciara and would have stayed with my son when he had seizures. He was not allowed to have his dog in Muckamore and all the time he was in Muckamore he really missed his dog'

Chapter 3

Care and Treatment at MAH

Introduction

- 3.1 Chapter 3 explores the nature of care and treatment provided at MAH, highlighting limitations in the provision of clinical care. It also considers how the social and developmental needs of patients were provided for and how provision, or lack of provision, affected the wellbeing of those patients admitted.

Treatment with medication

- 3.2 Approaches to care provision vary, depending on the model underpinning them. Traditionally the dominant model of care in all settings has been the medical model, which focuses on identifying and categorising a deficit or impairment within an individual person. Assessment and diagnosis of this is central, leading to a plan to correct or compensate for the impairment. In physical health, the corrections may, for example, include surgery. In learning disabilities, the compensation for an individual's impairment has historically involved withdrawing them from mainstream settings and putting them into special schools or long-stay residential facilities, and/or using medication to control behaviours.
- 3.3 The social model focuses on the environment rather than any deficits in an individual. It looks at the ways society is organised and how this prevents people of different abilities from living a full life. The model focuses on changing environments and helping people find personal strategies for managing situations that they find challenging. There is an emphasis on inclusion and participation and promoting dignity and autonomy, together with psychological interventions that allow the individual to manage their own behaviours.
- 3.4 As the philosophy of care changed, with the ambition that no one should call a hospital their home, the medical model of diagnosing and correcting or compensating for an impairment remained, with an increased use of medication to manage the impairment. This was intended to allow the person to be able to live successfully in the hospital, with little attention being paid to how they would

manage in the community when resettled. After 2006, MAH was supposed to have moved from a long-stay setting to an assessment and treatment centre, but both before and after 2006, care at MAH was planned around a medical model, with little psychological input and few social or educational activities. There was little evidence that these activities, even when delivered, had been devised as therapeutic interventions to increase the patients' autonomy. However, after the changes in 2006, many social activities appeared to stop.

3.5 Almost without exception, after the change in 2006 families reported that the reason they were given for their loved one's admission to MAH was to manage their medication.

3.6 P55 was admitted to MAH between February 2016 and September 2017:

'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'.¹

3.7 In the hospital, patients were given new or different dosages of drugs to control their behaviours.

3.8 P34, diagnosed with autism at age 10, was first admitted to MAH at age 11 in 2005. P34's mother gave evidence to the Inquiry:

'Dr H40 felt P34 just had a learning disability and was a bit hyperactive. He considered the most suitable treatment was via medication. I cannot recall whether P34 was on Ritalin at that time. In any event I think Dr H40 prescribed either Risperidone or Seroquel. I recall Dr H40 advising that if we got P34 into MAH for assessment for a couple of weeks then he could get back to school. This led to P34's first admission to MAH in and around March 2005. When P34 went into MAH he was aged 11 years old. P34 was placed in Conicar, which was a children's ward ... P34 was aged 12 years when he was discharged to home. He returned to [named] School'.²

3.9 Medication sometimes included the use of 'pro re nata' (PRN). Chapter 7 (Restrictive Practices) examines PRN as a restrictive practice. Many families told

¹ P55's Father Transcript – 18/10/22 – Page 20 – Line 10 (restricted)

² P34's Mother Transcript – 09/10/23 – Page 10 – Line 24

us that they thought that their family member was overmedicated, sometimes describing them as ‘zombified’. Many examples of this have already been related in Chapter 1 (The Patient Experience), so just a few follow:

*‘Within months of P77 being admitted to Muckamore in 2012, his brothers say he was zombified; he was expressionless and dull. I tried to discuss P77’s medication with Dr. H40 and Dr. H30 on a number of occasions but it was never reduced down. It was and still is difficult to get details of what medication P77 was on and the doses of medication’.*³

*‘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’.*⁴

*‘There was one occasion when P10 was admitted to MAH ... My parents made a formal complaint about her treatment ... They were not happy with her treatment. She was being given so many drugs and was extremely drowsy. She was not her normal self. My parents and I were very concerned about her ... days, weeks and months passed she got worse and worse until she could not walk, her speech was slurred, slobbers leaking from her mouth, eyes rolling in her head, head nodding, unable to feed herself. Indeed, she became a danger to herself as she did not appear to be able to swallow and was choking on her food’.*⁵

- 3.10 While patients subject to the Mental Health (Northern Ireland) Order 1986 (MHO) must have their medication regularly reviewed by the Regulation and Quality Improvement Authority (RQIA), and formerly by the Mental Health Commission (MHC), there appeared to be no formal monitoring of medication for voluntary patients beyond the prescribing clinician.
- 3.11 The use of medication as a restrictive practice is examined in more detail in Chapter 7.

Psychological treatment

- 3.12 During the time period covered by our Terms of Reference (ToR), MAH operated as a medical and nurse-led environment, with very limited psychological input. According to data provided by BHSCT to the Inquiry, there was at most only one psychologist employed at the hospital at any given time between 2011 and 2020

³ P77’s Mother Transcript – 20/06/23 – Page 21 – Line 9

⁴ P55’s Father Transcript – 18/10/22 – Page 22 – Line 11 (restricted)

⁵ P10’s Sister Transcript – 05/07/22 - Page 34

notwithstanding the large number of patients. As a result, challenging behaviour was poorly understood and was treated largely with medication under a medical model.

- 3.13 Dr Clare Byrne (a specialist forensic psychologist), who worked on Sixmile Ward in 2017 and 2018, told the Inquiry:

[Counsel] *'Great, thank you. At paragraph 37, you describe Muckamore as "a medically orientated institution". I wonder can you explain what you mean by that?*

[Ms Byrne] *Yeah. So, I think that was in response to a specific question that I was asked when I was giving my statement. I supposed, I think probably just reflects more broadly the services in Northern Ireland as it is, which, you know, where there is a kind of fairly medical – a medical model of understanding mental health, mental illness, so focusing on thinking about, when things go wrong, you know, it's an illness and something's imbalanced, and understanding it from that point of view, and obviously, then, medication being an important part of treatment'.⁶*

- 3.14 A consultant psychiatrist told us:

[Chairman:] *'Thinking about the NICE [National Institute for Health and Care Excellence] Guidelines regarding challenging behaviour specifically, that they say that anti-psychotic medication shouldn't be used alone for the treatment of challenging behaviour, was practice falling short of those guidelines during the periods that there were no psychologists or occupational therapists?*

[Dr Hughes:] *Yes. Yes. Undoubtedly, that's exactly what I referred to, Chair, that there were times of feast and times of relative famine, and it was very noticeable in terms of the difference between the two'.⁷*

Families rarely reported meeting psychologists, and many patients received no psychological therapy or even a positive behaviour support plan. One psychologist, employed at MAH from 2015 to 2021, commented:

'As MAH was a hospital setting, treatment was largely influenced by a medical model'.⁸

When questioned further, she explained:

[Counsel]: *'... You describe how Muckamore was a hospital, obviously a hospital setting, treatment was largely influenced by a medical model. Was that the predominant model for treatment within the hospital?*

[H291]: *Well, we were aware we did have psychologists and even, you know, behaviour nurse therapists would have been delivering psychological*

⁶ Clare Byrne Transcript – 08/05/24 – Page 36 – Line 23

⁷ Damien Hughes Transcript 24/09/24 – Page 48 – Line 9

⁸ H291 Statement – 20/05/24 – Page 5

interventions. But I suppose it was just commenting on the fact at the end of the day it was a hospital setting.

[Counsel]: The fact of that influence, of the medical model, can you tell us about whether or not that informed approaches to the use of medication?

[H291]: Well, yes. I mean, I suppose medical model, that is a core part of treatment then, you know, is medication'.⁹

- 3.15 At times a psychologist did work at MAH on specific wards, for example Clare Byrne. She did not attend multidisciplinary team (MDT) meetings on the wards or contribute to electronic patient record notes, instead keeping separate records and feeding back on individual patients to ward staff. Her work focused on group dialectical behaviour therapy (DBT), a third-wave form of cognitive behavioural therapy (CBT) for patients with borderline personality disorder (BPD). She also observed:

'The administering of medication was not within my job role. However, as an observer, medication was a key part of how MAH staff managed patients. The institution was what I would describe as "medically orientated". I do not have medical input as I am not sufficiently educated in this area, but I can see how some patient's relatives may have described the patients as over-medicated. I did not feel that the patients I worked with were "zombified" but I only worked with more able patients who were able to engage with DBT therapy. Therefore, it is possible that the more challenging patients, who may have been more heavily medicated, did not attend the DBT therapy sessions. I was informed of patients being managed by medication, for example, that patients would request PRN medication when becoming distressed, through informal interactions with the ward staff. I cannot recall specific staff names'.¹⁰

- 3.16 Psychologists who gave evidence described their work as trauma-informed and tailored to individual needs. For example:

'Primary therapeutic treatments from a psychological perspective were delivered within a trauma-informed framework and included Positive Behavioural Support [PBS], and Dialectical Behaviour Therapy. Within these broad approaches other specific individual or group psychological interventions were delivered as appropriate to individual client need. For example, trauma specific interventions such as Eye Movement Desensitisation Reprocessing [EMDR] Therapy, Cognitive Behavioural Therapy, Compassion Focused Therapy [CFT], forensic specific interventions and systemic approaches'.¹¹

- 3.17 Despite the range of interventions available in one or two wards, in some years, very few psychologists were employed at MAH. Forensic patients in Sixmile Ward

⁹ H291 Transcript – 05/06/24 – Page 18 – Line 2

¹⁰ Clare Byrne Statement – 28/03/24 – Page 10

¹¹ H291 Statement – 20/05/24 – Page 7

benefited most, receiving structured group therapy, such as motivation enhancement, good thinking skills and adapted sex offender treatment, as well as some individualised one-to-one offence-focused interventions for anger, violence and fire-setting.¹² However, the vast majority of residents in MAH received no psychological input whatsoever, likely the result of the very small numbers of clinical psychologists in post.

- 3.18 Northern Ireland's clinical psychology training is delivered through Queen's University Belfast (QUB). Dr Pauline Adair (Clinical and Health Psychologist and Interim Head of Psychology, QUB) told the Inquiry that between 2002 and 2021, between 5 and 13 clinical psychologists graduated annually (average number 9.7 per year). Most remained in Northern Ireland after qualifying, but only around one per year chose to specialise in learning disabilities, usually going into community settings. When asked whether any steps had been taken to ensure hospital setting were adequately staffed, Dr Adair stated:

'There has been no specific work undertaken between QUB and [Belfast Health and Social Care Trust] BHSCT to ensure certain clinical psychology posts are filled'.¹³

Other therapies

- 3.19 There were also relatively few other therapists available at MAH. Very few families spoke of occupational therapists (OTs), speech therapists or physiotherapists, dieticians or podiatrists. Data provided to the Inquiry by BHSCT showed that there were between zero and one qualified OTs between 2009 and 2013, rising to two or three between 2014 and 2017, and three to five from 2018 to 2021. Similarly, there were two or fewer qualified speech and language therapists (SALTs) between 2009 and 2021, and two or fewer qualified physiotherapists between 2009 and 2019.¹⁴

¹² Clare Byrne 2nd Statement – 15/08/24 – Page 1

¹³ Pauline Adair 1st Statement (Organisational Modules) – 17/04/24 – Page 5

¹⁴ MAHI – Additional Materials Referenced Bundle – Page 301 (AHP and Psychologists WTE (2009 – 2021))

Occupational therapists

3.20 There were MAH-based OTs reintroduced in 2012, with non-recurrent funding,¹⁵ solely to support resettlement, but they did not work on the assessment and treatment wards.¹⁶ Between 2012 and 2015, the management team at MAH made a number of unsuccessful bids for additional psychiatry, psychology, social work and occupational therapy posts as well as nursing and 2 (HCA) hours.¹⁷

3.21 Dr Shelley Crawford (then an occupational therapist), was seconded with a colleague (H726) from community services in 2012 to support resettlement, and described a challenging environment:

*'When I first moved to MAH in December 2012, I was taken aback by the culture. H726 and I started in the Ennis ward. H726 looked at me and said "what do we do here?" The staff mentality seemed to be that we were there to take their jobs. This was not the case as our intervention was time limited and only focused on the resettlement process. Occupational therapy had not been a service that MAH had offered for a very long time and there had been no OTs for approximately 30 years prior to the appointment of H726 and I. I felt that the staff at MAH had a very sceptical attitude towards the resettlement process'.*¹⁸

3.22 Shelley Crawford further noted:

*'MAH was a strange set up, although it was part of the BHSCT it was in a remote location and was very isolated from the rest of the Trust. I met many employees at MAH who seemed to have only worked at MAH and they appeared to be institutionalised, i.e. resistant to change with limited experience of employment outside of this setting. A lot of them had trained there and had never been beyond MAH. There was a lot of resistance towards us initially and it was not the easiest of jobs to begin with. A lot of the staff simply didn't know what benefits OTs could offer'.*¹⁹

3.23 Shelley Crawford also raised concerns about the lack of specialist training for physiotherapists at MAH, particularly in wheelchair and seating assessments:

'There was input from a physiotherapy service, however they had little or no access to specialised wheelchair training that was available and commissioned regionally for OTs. This was because across the region, OTs would provide this type of assessment and equipment with the exception of MAH. The physiotherapists at MAH could not access the OT specific training around

¹⁵ John Veitch Statement (Organisation Modules) – 31/05/24 – Page 163 (Exhibit T12.01) – Note of Hospital Modernisation Meeting held on Friday 9 January 2015 (Staffing and Skill Mix Required for Modern Hospital)

¹⁶ Shelley Crawford Transcript – 14/11/23 – Pages 86-87

¹⁷ John Veitch Statement (Organisation Modules) – 31/05/24 – Page 23, Page 174, Page 176 and Page 189

¹⁸ Shelley Crawford Transcript – 14/11/23 – Page 82 – Line 24

¹⁹ Shelley Crawford Transcript – 14/11/23 – Page 84 – Line 18

*specialist seating and it is unclear if they knew how to access the resources associated with the wide array of wheelchairs and custom moulded seating available at that time. It was evident that the majority of service users with highly complex and destructive postures were in inappropriate wheelchairs and static chairs. For example, standard transit and self-propelling wheelchairs when their needs would have been better met with individual custom contoured seating or highly modular seating options’.*²⁰

Speech therapists

3.24 Communication difficulties are a core feature of learning disabilities and autism, ranging from individuals who are completely non-verbal to those who have challenges expressing emotions and needs. SALTs have driven major advances in communication support, including simplified sign languages (such as Makaton) and pictorial communication systems such as Talking Mats.

3.25 The Inquiry heard from Suzanne Smith, a SALT at MAH from 1994 to 2022. Like the OTs, she worked part-time at MAH, spending only two days per week there, with the rest of her working time spent with community-based clients. Her referrals came mainly from ward and day-care staff, focusing on eating, drinking and communication difficulties. Early in her role, she worked primarily in day care:

*‘In the earlier parts of my time at MAH, I worked with patients while they were at day care in the day care area. I did this as there were fewer patients in each room, there were more opportunities to promote communication, and it was generally more spacious so I could do group work with patients’.*²¹

3.26 She also worked on the wards and described generally positive engagement:

*‘Staff generally treated me with respect and valued my advice and adhered to advice given by me regarding eating and drinking difficulties. Staff did their best to carry out work on any therapy goals I had requested’.*²²

3.27 As a SALT, Ms Smith would have prepared plans for those patients referred to her. She shared examples of this, including:

- Personalised placemats at mealtimes with dietary requirements;
- Use of Talking Mats to support communication on issues like mental capacity;
- Social stories and Easy Read materials, especially around resettlement.

²⁰ Shelley Crawford Transcript – 14/11/23 – Page 83 – Line 9

²¹ Suzanne Smith Transcript – 12/09/24 – Page 62 – Line 12

²² Suzanne Smith Transcript – 12/09/24 – Page 63 – Line 26

- 3.28 While SALT plans would have been prepared for individual patients, the responsibility for using them lay with the ward staff; the Inquiry heard this did not always happen. Furthermore, the provision of SALT services was severely limited. One part-time SALT, supported by an unqualified assistant, was inadequate for a hospital serving hundreds of residents. No doubt much excellent work was done with individual patients. As Ms Smith explained:

'I feel that our resources within SALT were limited and time in MAH was limited. I and other staff were unable to always do as much as we would have liked. Our resourcing wasn't what we wanted it to be. If I could have been at more review meetings, that would have been better for patient care. I had three day centres [in the community] and was part-time, so I had to prioritise my time by seeing patients'.²³

Dieticians

- 3.29 The Inquiry heard from Anne Lavery (a former dietician), who worked part-time at MAH from 1995 until 2004. Prior to her appointment, MAH had no dedicated site-based dietetic provision. As the sole dietician, she managed a substantial caseload:

'... I remember the caseload, I think there was about, what, probably about 350 patients in Muckamore at the time and I would have had probably about 80 on the caseload at one stage'.²⁴

- 3.30 Referrals to the dietician could come from nursing staff and/or doctors from any ward. However, on the whole, Ms Lavery supported patients with complex needs in the wards for more disabled residents, some of whom had very specific needs, such as tube feeding. Her work involved advising on tube feeding and collaborating with SALTs to develop diets that mitigated choking risks. Together they provided tailored dietary plans with written instructions for nursing staff. Due to the numbers of residents in MAH and the number of referrals they received, they were only occasionally able to watch mealtimes on the wards.

- 3.31 Ms Lavery felt that health professionals were well respected in MAH:

[Counsel] 'Okay and when we think about all those AHPs [allied health professionals] and the various different professions that were there at

²³ Suzanne Smith Transcript – 12/09/24 – Page 67 – Line 14

²⁴ Anne Lavery Transcript – 06/02/24 – Page 92 – Line 11

Muckamore, did you feel that all the different types of professionals were well respected and equally valued in Muckamore?

[Ms Laverty] Yes I think so, yeah, we all had a role to play.

[Counsel] And you also say in your statement that you felt you could speak up or report anything about which you were uncomfortable and you give some examples of that, and I will come to one of those in a second. Can you recall having to ever speak up about anything or report anything related to patient care, patient safety?

[Ms Laverty] Em, I can't think of anything, quite honestly'.²⁵

- 3.32 Families occasionally requested to understand their relative's dietary plan and were signposted to the dietician:

'I do not recall when this was but Dr H50 referred me to the dietician. I asked him why did he refer me to the dietician, surely he should be referring to the nurses on the ward to the dietician as they are looking after P77. He replied, "No, you" and pointed at his finger at me. I did meet the dietician, I cannot remember when this was. I do not remember her name but I recall that she presented as being very defensive at the beginning of the meeting. I think she thought that I was going to be difficult. However, she relaxed when she realised that I had no issue with the diet plan prescribed for P77, it was the fact that the diet plan clearly was not being followed by the nursing staff on the ward. P77 would not have been the size he was if it was being followed'.²⁶

Feet and nail care

- 3.33 Some families also felt that their sons or daughters had problems with their feet that were not well cared for. This is reflected in Chapter 1. Patients unable to look after their own care would have required regular checking of their toenails and feet. If they needed to see a podiatrist this proved difficult. P77's mother told the Inquiry:

'I recall on another occasion I had purchased nice shoes for P77, and the staff told me that he did not want to wear them as his toes were too cramped. I discovered to my horror when I went to give P77 a foot massage in around April 2015 that P77's toenails were so long that they grew over the top of his toe and curled at the back. It was not the shoes that were the problem, it was his toenails. I remember being devastated about this at the time. I complained to H397 and told him that all of the staff, including him, are involved in changing and bathing P77 and they should have noticed ... eventually I was told that the podiatrist did call but he was too busy to see P77 ... P77 did see the podiatrist eventually, which was several weeks from I raised the issue regarding P77's toenails'.²⁷

²⁵ Anne Laverty's Transcript – 06/02/24 – Pages 106-107

²⁶ P77's Mother Transcript – 20/06/23 – Page 38 – Line 19

²⁷ P77's Mother Transcript – 20/06/23 – Pages 35-36

- 3.34 P105, who had learning disabilities, autism and bipolar disorder, was admitted to MAH in 2017, when he was 27 years old:

'There was also a lack of proper attention to P105's feet and toenails, which got into a terrible state. At one stage P105's feet were covered in blisters and his heels were cracked. His toenails were frighteningly long, he had a fungal nail infection and at one point he had lost a toenail ... I asked MAH to call the GP to look at P105's feet, which took a considerable time to organise. I was present when the GP, H314, attended P105. H314 told me that "toenails are just cosmetic" and I believed she was angry at being called for blisters and cracked heels. As a result of my complaint, P105 was referred to a podiatrist, but this referral should have been done long before they got so bad. I was told that staff could not cut P105's nails and that a podiatrist was off on annual leave. I think that there should have been some kind of procedure in place to ensure that P105's personal hygiene was looked after. If they had have told me that his nails needed cut, I would have done this for him'.²⁸

Activities and day-care

- 3.35 A key disadvantage of hospital care for people with learning disabilities and autistic people is the provision of 'hotel services'. Residents are not expected to clean their rooms, do laundry, shop or cook. As a result, it is common for hospital residents to lose these everyday skills and yet, for people with learning disabilities and autistic people, these may be precisely the very skills they need to develop. The lack of meaningful activity often leaves residents unoccupied for long periods.
- 3.36 Ward staff did sometimes take patients shopping or have weekly cooking sessions, when staffing levels permitted. These did not necessarily involve the resident properly in the activity. According to OT Shelley Crawford:

'By way of example, the patients were often passive observers in situations. Shopping was an activity that staff members claimed to do with patients. Patients would attend with the staff member to go shopping but they were never taught how to even use the self-scanner et cetera. The staff members would carry out these activities rather than actively engaging in the activity with the patient. We would often have six-week independent living programmes where the patients learned the skills to be independent such as cooking, budgeting, et cetera. We found that staff would suggest to us that the patient was able to cook as they would cook a fry every Friday morning. It would then transpire that the ward staff cooked the fry and sat with the patients to eat this. This made it very difficult to assess when you were not being given the entirety of the facts. The staff members' interpretation of the patients' functional ability was very different to what OT assessed'.²⁹

²⁸ P105's Mother Transcript – 14/09/23 – Page 50

²⁹ Shelley Crawford Transcript – 14/11/23 – Page 98 – Line 1

3.37 Involving people with learning disabilities and autistic people in everyday tasks is a recognised skill in community settings, supported by staff training in 'active support'.³⁰ This was acknowledged in the 2018 MAH day service review.³¹ However, we heard no evidence that the assessment of the numbers of staff required on the wards took into account the additional time required to support a person with activities of daily living, nor of such training being provided to MAH staff.

3.38 MAH did offer scheduled day activities outside of the wards. Early on, Portmore and Portview units catered for more physically disabled residents, alongside a work skills unit. Due to limited community services, in the early days some individuals were brought into MAH for day-care and training. Day-care worker H471 (1980-2015) described gender-segregated workshops:

'The male workshop had five separate rooms: printing, tailoring, woodwork, shoe repairs and a room for contract work. In the contract work room, the patients packed fruit for a local supplier, printed blood transfusion labels, and constructed calendars for Ulster Weavers. I was based within the woodwork room making stools and doing some contract work. The female workshops had three rooms where they packed clinical sterile dressings for Belfast City Hospital, combs and rollers for Denman Plastics and cardboard dividers for Tunnock's tea cakes for a company called Box Pack'.³²

3.39 A 1980s review led to the creation of the day-care department in Moyola, with a more recreational focus, including horticulture, discos, swimming, arts and crafts, cookery and football. Work skills training still took place for more able residents, including contract work (for example, packing dog biscuits for a local firm called Favour). Residents were typically allocated five half-day sessions per week, excluding weekends, without formal assessment, and both patients and families were often positive about the day care in the early days, especially about outings to the lough or to football matches. However, the day-care staff included day-care workers and HCAs, and in later years, from 2013, frequent staff shortages meant that HCAs were often redeployed to wards, resulting in cancelled sessions:

³⁰ British Institute of Learning Disabilities (Bild) What is Active Support? Bild, London – <https://www.bild.org.uk/course-subjects/about-active-support/>

³¹ MAHI – Day Care Supplementary Bundle – Muckamore Abbey Hospital Day Care Review 2018

³² H471 Statement – 12/03/24 – Page 2

*'The number of patients reduced and there were staff shortages from 2013. Nursing assistants were taken out of day care to be sent to the wards and this left the Day Care Department short-staffed.'*³³

- 3.40 Philip Ward (a former day-care worker), who worked in Moyola from 2008 to 2010, estimated that around 50 residents attended daily, divided into rooms of up to 10. He told the Inquiry:

*'My normal working day was structured and activities were set out on a timetable. Activities included taking patients to the swimming pool, playing and learning in the recreation hall, themed events and outings. During the activities I assessed if the patient required further assistance with their learning and development. If I identified a need, I added this to the daily report so it could be considered by those responsible for the patient's care plan. I had access to the daycare notes but I did not have access to ward notes. I tried to make the activities fun for the patients.'*³⁴

- 3.41 Day-care workers received verbal handovers about each patient from ward staff, but there were no clear guidelines on what information should be shared. Occasionally incidents occurred, and patients were sometimes returned to the ward. Mr Ward reported that he was discouraged by another more senior member of staff from reporting incidents involving violence by patients on other patients or on staff. He was told that at MAH they were 'at the end of the road' for those with challenging behaviours and it was expected that patients would hit or injure each other or members of staff. He was told to stop completing incident forms.³⁵ Elsewhere in this report we address the broader impact of a culture of non-reporting of incidents, which fostered the belief that 'this is how things are done around here'.

- 3.42 Day-care workers recorded daily progress notes in day-care files but did not write in hospital case notes or on the Paris electronic patient record system. Instead, short quarterly reports were written:

'As part of my role, I completed a quarterly report that was issued to senior members of staff. This was a short report to management in Moyola and ward staff. The report was general and included details of patient engagement in activities and any issues flagged. The report would be reviewed by medical-led staff to include consultants, nurses and ward managers. The report included details of activities the patient was involved in, whether any

³³ H471 Transcript – 08/05/2024 – Page 68 – Line 5

³⁴ Philip Ward Transcript – 15/11/23 – Page 9 – Line 9

³⁵ Philip Ward Transcript – 15/11/23 – Page 11 – Line 9

*behavioural support was required when attending day care, for example, help with speech and language’.*³⁶

- 3.43 Mr Ward felt unsupported by Moyola’s senior staff and expressed concern about the lack of external oversight, noting that he did not ever see the RQIA inspecting Moyola:³⁷

*‘I am not aware of any inspections taking place during my time at Moyola. I was not aware of any oversight or inspections from representatives from the Belfast Trust. If any reviews or inspections of Moyola were carried out, they were done by the management staff in the day care centre, usually H722 and H77. This meant that the reviews were not independent. I cannot recall an auditor carrying out a walk around inspection or speaking to staff’.*³⁸

Nevertheless, the RQIA say that it examined day-care and day-care schedules for patients when it inspected wards.

- 3.44 In 1998, Barry Mills (then a permanent charge nurse in MAH) became Manager of Behavioural, Vocational and Therapeutic Services at MAH. Though Mr Mills had considerable experience as a nurse, he had no specific training in day services or behavioural care. There were approximately 28 day-care workers and 16 healthcare support workers at that time (reduced to around 30 in total by 2017). Services ran on weekdays from 9am to 4pm. Early on, provision included external work experience and attendance at college outside MAH:

*‘The day care services in MAH provided work skills training and this was for the low dependency patients who participated in work experience at local factories, recycling plants and some patients worked for the local council. This was in addition to placements for patients within hotel services, portering and catering within MAH. We had an educational programme and worked closely with the Belfast Metropolitan College, Belfast and the Northern Regional College, Antrim. They provided a wide range of certified adult learning programmes for the patients’.*³⁹

- 3.45 Mr Mills highlighted the significance of the recreational hall and swimming pool at MAH (which were open to the local community) until the early 2000s, when the hall was demolished as it was felt not to be appropriate for a hospital setting:

‘For example, the recreational hall which served as a community centre and kept us in touch with our community. People would say this building was an

³⁶ Philip Ward Transcript – 15/11/23 – Page 14 – Line 1

³⁷ MAHI – Day Care Supplementary Bundle – Muckamore Abbey Hospital Day Care Review 2018 – Page 19

³⁸ Philip Ward Transcript – 15/11/23 – Page 21 – Line 22

³⁹ Barry Mills Statement – 04/06/24 – Page 5

institutional thing but it was heart of MAH. It was felt this gave the wrong image for new MAH. Previously, people from the Antrim community came on to MAH even for walks on grounds. Members of the local community used the MAH swimming pool and lots of voluntary groups used the recreational hall. The patients' lives were diminished when this was closed'.⁴⁰

- 3.46 Christine Keenan (a former behavioural nurse therapist), also spoke about the loss of the recreational hall, which she described as 'the heart of Muckamore' where pantomimes and drama groups had taken place 'and everything was going on there'. She said that by the time she left MAH in 2016 many of the activities had stopped. She told the Inquiry that apart from some small activities in day care many of the other amenities had been removed:

[Counsel:] 'Was there anything left for patients by way of recreational activity? [Ms Keenan:] Because they were seen as patients in a hospital, and patients don't play snooker, patients don't do this, it was said if you want to play snooker go out to the community and do it, so all of those activities are gone'.⁴¹

She also described how during her time at MAH physical intervention training became increasingly prevalent in the training and development of staff. This was due, she said, to the increased aggression of patients and lack of opportunities for patients created by policy changes at government level.⁴²

'They were just termed now it was a specialist hospital and they were patients and there were to be treated as patients'.⁴³

- 3.47 One patient's brother told of his experience in 2008. He was a care worker who spent some of his training at MAH. He told the Inquiry:

'I never seen any activities or outings. I recall on occasion one patient may have been taken out on a Sunday and one or two possibly went to day care. I recall there was a church services on a Sunday and the Catholic service was held at the top of the room and the Protestant service was held at the bottom. I observed next to no stimulation on the ward. I have no idea what any of the patients would wake up and look forward to in the morning. The ward was dreary and uninviting'.⁴⁴

- 3.48 According to H471, who was by then a senior day-care worker, major changes to day-care occurred later in around 2013:

⁴⁰ Barry Mills Statement – 04/06/24 – Page 8

⁴¹ Christine Keenan Transcript – 13/11/23 – Page 73 – Line 12

⁴² Christine Keenan Statement – 03/11/23 – Page 10

⁴³ Christine Keenan Transcript – 13/11/23 – Page 74 – Line 7

⁴⁴ P57's Brother Transcript – 21/09/23 – Page 107 – Line 8

*'I felt there was a clear cultural change towards the end of my time in MAH. The number of patients reduced and there were staff shortages from 2012. Nursing assistants were taken out of day care to be sent to the wards and this left the Day Care Department short-staffed. With new management in place, staff morale was low. I cannot recall who said this but I remember a quote where someone said this is a "hospital not a holiday camp". Obviously, they did not think that MAH was the patients' home and was just a hospital. A lot of changes happened, which, in my personal opinion, were unnecessary. These changes included; stopping the evening activities such as the disco, the evening clubs run by volunteers and stopping the Sky television (a subscription in the wards which patients had paid for themselves). The Helping Hands Club volunteers had been running the club for over forty years and had to close'.*⁴⁵

- 3.49 Mr Mills (then Clinical and Therapeutic Services Manager) described the impact of staffing pressures around 2014:

*'The other things that concerned me were staff shortages and relocating staff to wards that were short staffed. I had to close areas of day care services and staff were re-deployed to different wards, on a daily basis, with the knock-on effect was day care closing'.*⁴⁶

When questioned by Counsel, Mr Mills expanded on this:

[Counsel]: *'At [paragraph] 43 you then say you "had to reduce senior day care workers from four to one, as one retired and one moved to behavioural services. No recruitment and therefore already no entertainment activities. The staff themselves were very frustrated by this". How were you made aware of that, that sense of staff frustration?*

[Mr Mills]: *I was speaking to the people.*

[Counsel]: *Yes*

[Mr Mills]: *This was budget led [to] do this. We were doing -- I was expected to do this and we hadn't the patients discharged. This was all part of a resettlement programme that would have allowed patients to have moved on'.*⁴⁷

- 3.50 Mr Mills continued, describing how the plan was for there to be a much smaller 'core' hospital with short-term active assessment and treatment:

*'Staff wanted to get into working on the core hospital wards and to be involved in assessment and treatment. The plan was that we would not need large day care service or the entertainment services to the extent that we had because patients were to be admitted for short periods for assessment and then discharged and treatment continued in the community. It didn't happen in practice'.*⁴⁸

⁴⁵ H471 Transcript – 08/05/24 – Page 68 – Line 4

⁴⁶ Barry Mills Statement – 04/06/24 – Page 20

⁴⁷ Barry Mills Transcript – 26/06/24 – Page 77 – Line 23

⁴⁸ Barry Mills Transcript – 26/06/24 – Page 85 – Line 10

- 3.51 Mairead Mitchell (then Head of Learning Disability Services at BHSCT) also had a number of concerns; for example, she was shocked at the lack of activity for patients left in Muckamore:

'When I then had the managerial role in 2016, I was slightly shocked that there wasn't people coming in or patients going out for day care, it was very insular. Ehm, many patients didn't go off the wards for day care because staffing issues, or the day care was closed because of staffing. So, when I walked the wards, you know, patients would just be sitting and very little activity'.⁴⁹

- 3.52 Upon Mr Mills' retirement in 2017, Bert Lewis (then a charge nurse at MAH) became Day Services Manager (2017-2020). He described his responsibilities:

'I had responsibility for Moyola Day Services (Group Rooms), several areas of Portmore Building (mainly used to support patients in bespoke activities as they were unable to participate in group activities), Horticultural Department and the MAH swimming pool. There were approximately thirty-five staff, made up predominantly of day-care workers, approximately eight healthcare workers and three swimming pool attendants ... Day services staff worked closely with colleagues in behavioural services, Occupational Therapy, and Speech and Language Therapy. The service had approximately six hours of music therapy per week and four days of access to an artist in residence'.⁵⁰

- 3.53 A 2018 review aimed to align day services with the modernised hospital model focused on short-term admissions and assessment and treatment (87 beds). It noted:

'Direct Day Care Services are available between the hours of 9.15am to 4pm, Monday to Friday. On average patients will have 5 sessions in Day Care per week, with sessions varying in length from 10 minutes to 3 hours per day'.⁵¹

- 3.54 Despite this, day-care provisions had remained largely unchanged for years. The review found a Moyola service for 40 residents daily, while 10 a day went to horticulture, six a day had aromatherapy or on-ward or Portmore sessions, and around 10 a day went swimming. However, over a third of MAH residents had no day-care provision at all, due to a lack of referral to day-care services.⁵² Stakeholder interviews indicated a need for more skill-building opportunities. Day-care:

⁴⁹ Mairead Mitchell Transcript – 16/09/24 – Page 107 – Line 22

⁵⁰ Bert Lewis Statement – 10/07/24 – Page 19

⁵¹ MAHI – Day Care Supplementary Bundle – Muckamore Abbey Hospital Day Care Review 2018 – Page 5

⁵² MAHI – Day Care Supplementary Bundle – Muckamore Abbey Hospital Day Care Review 2018 – Page 7

'was seen as more diversional or recreational as opposed to making a significant therapeutic contribution to a patient's journey through Muckamore'.⁵³

3.55 Interviews with service users and carers as part of the day-care review led to calls for:

- More community-based activities;
- Increased sport and exercise;
- Greater involvement with discharge planning.

The ambition was to reposition day care at MAH:

'... must evolve from being perceived primarily as a diversional intervention to being that of a dynamic therapeutic service that provides a key contribution to a person's admission'.⁵⁴

3.56 The review produced 13 core recommendations, including that day-care should be seven days a week, including evenings and weekends, that it should be person-centred, that it should become more multidisciplinary, linking better with OT, SALT and psychology, that accredited qualifications should be available for more able residents, that there should be more links to, for example, community-based football groups, and there should be more gym equipment across the site and better transport into the community. In addition, more involvement of day-care staff in ward rounds and in discharge planning, and more involvement of families, was recommended. A further 16 staffing-related recommendations were also made.

3.57 Bert Lewis oversaw implementation of these major changes to the day services following the review:

'I led a team that implemented huge changes following a review of services which dramatically improved the range and quality of activities that were available to patients. I was supported in this change by a commitment from management with additional resources, including funding of these activities. These included a move to community based activities such as ... outreach programmes to community day centres, "Extern" resource and an educational centre for patients with a forensic history ... Daytime Opportunities both off site in a resource centre at Mallusk and education classes internally at Moyola ...

⁵³ MAHI – Day Care Supplementary Bundle – Muckamore Abbey Hospital Day Care Review 2018 – Page 13

⁵⁴ MAHI – Day Care Supplementary Bundle – Muckamore Abbey Hospital Day Care Review 2018 – Page 16

*Introduction of “open” art, swimming, gardening and fitness sessions, whereby patients were given more choice of when and how often they attended activities. Another focus was to move to a seven-day service, a major move from a traditional “nine to five” service” with day services available to eight o’clock each evening and from nine o’clock in the morning to five o’clock in the evening at weekends’.*⁵⁵

- 3.58 These changes were evaluated in the Feedback and Measuring Outcomes Day Care Review (January 2020). The vast majority of recommended improvements had been implemented. Staff surveys, resident interviews and family feedback were overwhelmingly positive.

Conclusions

- 3.59 Relatives often had a misunderstanding of the nature and duration of care at MAH, reflecting a lack of clarity and transparency in communication between hospital staff and families.
- 3.60 Families were often told that the purpose of admission was to adjust and regularise the patient’s medication over a few weeks. However, overmedication and very lengthy stays were a recurrent concern expressed by many relatives.
- 3.61 There was a chronic shortage of suitably qualified professionals, including psychologists, behavioural specialists, OTs, SALTs, physiotherapists, dieticians and podiatrists. Their increased presence may have mitigated the medical model approach.
- 3.62 MAH’s character and purpose evolved significantly over time. Following the 2005 Equal Lives Review report, a strategic shift aimed to reduce the hospital size and resettle residents in the community.
- 3.63 This shift in approach to assessment and treatment, coupled with budget cuts as a result of the anticipated resettlement of patients (which did not occur), led to the regrettable closure of a number of activities likely to be enjoyed by the patients

⁵⁵ Bert Lewis Statement – 10/07/24 – Page 6

and to have alleviated boredom. These included the recreational hall, the occasional discotheque, evening clubs and access to Sky television.

- 3.64 AHPs were still in very short supply after 2006, and they were poorly integrated with the ward staff generally and not embedded in the routine care of patients.
- 3.65 One of the consequences of the medical model, and the lack of an 'active support' philosophy, for the care of patients with learning disabilities and/or autism was the loss of everyday skills and social skills, which would have affected the likelihood of successful resettlement.
- 3.66 There was a failure to have in place an adequate process to ensure that MAH staff supported patients to retain the daily living skills they had upon admission, or to work to improve them. This was a persistent theme throughout the patient experience evidence.
- 3.67 Although some staff did take patients shopping and for cooking sessions, patients were not always encouraged to take an active part. This may have been the result of a lack of training of the staff involved in 'active support'.
- 3.68 Staff shortages frequently disrupted access to day care services. However, a 2018 review led to the reinstitution of day-care and community-based activities.
- 3.69 The Panel considers that the reduction of day-care services and activities would inevitably have had a significant impact on patient boredom and, consequently, behaviour. The withdrawal of activities, based on the assumption that patients would soon be resettled (see Chapter 15 (Resettlement)), was, in the Panel's view, poorly conceived and detrimental to the daily lives of those who remained. In reality, resettlement took many years longer than anticipated.

Recommendations

R7	While patients remain in hospital pending resettlement, there should be a focus on enhancing their independent living skills, tailored to their physical and mental capacity.
R8	Medication should never be used simply to subdue people in the absence of other forms of treatment and good quality care. DoH should issue a regional audit pro forma to measure compliance with National Institute for Health and Care Excellence (NICE) guidelines and Trusts should conduct quarterly audits. These audits should be part of an RQIA review as well as an agenda item at the accountability meetings with the Permanent Secretary of Health.
R9	Each facility or service should have an integrated workforce plan that includes all allied health professionals (AHPs) and all staff involved in patient care. This should be based upon the assessed needs of the service user and must include protected time for staff to consult with each other.
R10	It is critical for the wellbeing of people with learning disabilities and autistic people that they are well supported by, and have access to, AHPs including psychologists, speech and language therapists (SALTs), occupational therapists (OTs), podiatrists and dieticians. These AHPs need to be well integrated into daily life in service users' homes and their recommendations, including positive behaviour support plans, need to form part of care plans.
R11	Like anyone else, people with learning disabilities and autistic people require a variety of meaningful activities on a daily basis to enhance their quality of life. Every person should have an individualised activity schedule, including leisure activities and skill-building activities, and staff should be trained in 'active support' so that they can deliver this.

Do you see me?

'I would say my daughter is very astute and, you know, smart in many ways. But academically, you know, I always realised she was never going to reach her potential academically. But she's amazing because she could be sitting, we could be chatting, maybe me and my family or others, thinking she's not listening and then she could repeat everything to you. I always thought she was quite capable in many ways, especially when she was younger and before Muckamore'

'I like to watch football, and I am a big supporter of Ballymena United'

'He's mischievous. He pulls jokes. He puts on certain - Elvis and stuff, knowing I don't like Elvis. He plays things sometimes for the joke of it. He hangs about mostly. He comes into the kitchen all the time I'm making dinner, because he loves his food. He's very interactive, especially with his brothers, they are into their games and stuff too, so he loves all that. He likes his movies, his music. Yeah, he's just a typical big fella like for that. He just wants the same thing as other people take for granted at that age, you know. I've never had to deal with him in any way like that. He's really good at home...And he's so co-operative and helpful, which is a complete change from when he was younger, when he wouldn't pay no heed to me. But, yeah, he's completely turned himself around and he's more than ready for resettlement. More than ready'

Chapter 4

Care Planning and Record Keeping

Introduction

- 4.1 This chapter examines care planning and record-keeping, which are essential to safe, effective care. Care planning involves assessing an individual's needs, identifying risks and creating a plan with physical and psychological interventions, including medication. Goals are set, and accurate records ensure that the care team understands the intended care approach, document what is delivered (including deviations) and provide a means for evaluating whether the plan is achieving its objectives.
- 4.2 The scope and detail of records depend on patient needs, though organisations typically mandate a minimum set of topics. Regulated professionals are required to comply with statutory standards and employer policies. Records may include statutory assessments for example, under the Mental Health (Northern Ireland) Order 1986 (MHO), clinical evaluations and assessments of capacity and support needs for daily activities such as eating, walking and toileting. Different professions use distinct formats and focus areas. This results in separate records that are consolidated during multidisciplinary team (MDT) meetings to provide a comprehensive overview of care.
- 4.3 Records also capture adverse or potentially adverse events and the actions taken in response, as well as safeguarding referrals where a vulnerable person's human rights may have been breached. They do not capture complaints or incident reports via the Datix information system.

Family experience

- 4.4 Some families told the Inquiry that they were not fully aware of the assessments and care plans developed for their loved ones. This concern was raised by families of patients at Muckamore Abbey Hospital as early as 1999:

'I received no adequate information from Muckamore staff as to Mary's care, treatment or medication. I was never provided with any brochures or leaflets dealing with admission, patients' and family's rights, care and services provided

by Muckamore or resettlement from Muckamore. I never saw Mary's bedroom in Muckamore'.¹

Similar concerns persisted from families of patients admitted in 2017:

'We were not provided with, nor did we have sight of any Care Plan for P96 or any risk assessment, but we assume that he must have had one. We did not know to ask to see these because we simply did not know these should have existed'.²

- 4.5 Families also reported being unaware of their rights when their relative was detained under the MHO 1986:

'We didn't know our rights or anything about Muckamore; nobody told us. It was just felt that Ciaran was taken off us and we had no rights whatsoever over him'.³

- 4.6 The Inquiry heard that before 2005 there were many activities and facilities, such as a workshop and a recreation hall to support long-stay patients,⁴ but the change in the nature of the wards meant that many of the activities and facilities used by the patients disappeared. The recreation hall was knocked down in the early 2000s and there was a reduction in day-care at the same time.⁵ After the transition to an assessment and treatment centre, there were very few activities available within the wards at MAH. This was an abrupt change for many people, who had received structured support prior to admission.

- 4.7 Following the opening of new wards in 2006, care planning continued to be almost exclusively planned around a medical model. Families were often told that admission was necessary to manage medication, which could not be done in the community setting:

'We were told by Dr Carey that Maria was only going to MAH to get her medication tweaked for a couple of months. We were supportive of this at the time, as Maria was so difficult to manage. We thought it would be a good idea to get her medication adjusted and to get her back to herself again to be more manageable'.⁶

'I do strongly remember the meeting with the psychiatrist, who had stated she needed a secure unit - I think that was the issue, where Downshire wasn't a

¹ P22's Sister Transcript – 22/09/22 – Page 28 – Line 8

² P96's Father Transcript – 11/10/23 – Page 14 – Line 5

³ P57's Mother Transcript – 20/10/22 – Page 29 – Line 7

⁴ Eilish Steele Statement – 21/04/24 – Pages 7-9, 19 and 24-28

⁵ Barry Mills Statement – 04/06/24 – Page 25

⁶ P64's Father Transcript – 23/11/22 – Page 29 – Line 9

secure unit - to trial her on this medication, Clozapine. And if we didn't agree to it, then Downshire was the only option, but she would not be able to be trialled on this medication because it required a secure facility. That was the conclusion of the meeting'.⁷

- 4.8 In hospital, patients were given new or different dosages of drugs to manage behaviours or epilepsy. Families frequently queried these decisions, including the evaluation of the impact of medications. Some asked for sight of the care plan:

'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'.⁸

- 4.9 The Inquiry heard that, up to 2011, it was not customary for patients to attend meetings where their care was discussed.⁹

- 4.10 Review frequency varied across wards. In continuing care wards, especially prior to resettlement, assessments of needs and progress were recorded at least annually.¹⁰ Family involvement was unclear. Some families reported mixed experiences, depending on staff:

'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'.¹¹

- 4.11 Long-term patients often had stable care plans that changed infrequently. Around the mid-2000s, a policy required reviews at least every six months or sooner if needed.¹² This continued into 2013.¹³ Nurses were responsible for updating care plans when changes occurred. All patients were routinely reviewed by the MDT, although on many occasions these teams comprised only nurses and doctors.¹⁴ By 2012, nurses also recorded daily progress notes.¹⁵

⁷ P50's Sister Transcript – 19/10/22 – Page 15 – Line 25

⁸ P52's Mother Transcript – 19/10/22 – Page 109 – Line 4 (restricted)

⁹ A12 Statement – 28/03/24 – Page 24

¹⁰ Colin Milliken Transcript – 23/09/24 – Page 117 – Line 24

¹¹ P55's Father – 18/10/22 – Page 34 – Line 1 (restricted)

¹² H330 Statement – 22/05/24 – Page 3

¹³ H260 Statement – 08/04/24 – Page 3

¹⁴ H330 Statement – 22/05/24 – Page 3

¹⁵ RQIA – Mental Health and Learning Disability, Announced Inspection, Finglass - 25 & 26/06/12

- 4.12 A consultant psychiatrist told the Inquiry that families could request a meeting to discuss care and medication:

'On occasion, I discussed medication with family members during family meetings. I met with family members if they requested a meeting. Families were invited to discharge planning meetings and I also sought to involve them in risk management discussions. Meetings with family members were minuted by the ward clerk'.¹⁶

- 4.13 Personal care and personal preferences are vital to care planning. A common theme in family evidence given to the Inquiry was the lack of attention to personal care by some (but not all) staff. This included a lack of attention to personal appearance and personal preferences:

'On one occasion Amanda's hair was cut really short like a boy's haircut. Her hair was usually long. I remember thinking that they did this so her hair would be more easily managed for the staff'.¹⁷

- 4.14 Families also raised concerns about loss of life skills:

'P63's father and myself raised the concerns about P63 becoming more institutionalised, as we seen it, and losing the skills that he had had when he was at home, such as brushing his teeth, dressing and washing with help, helping in the kitchen, looking after himself'.¹⁸

- 4.15 Many patients were autistic and families stressed the need for routine and structure in order to prevent distress. Families tried to share calming strategies, but staff were not proactive in including them in care plans:

'There wasn't any structure for my son and this wasn't good for him. We tried to get them to let him have nail polishes, as this calms him. The staff ignored this for the first couple of weeks and then when someone gave him a nail polish, they saw how this calms him, and the staff began pleading with me to bring some nail polishes for him'.¹⁹

- 4.16 Some of the patients had medical aids provided that were not used by staff as part of the patient's care:

'He has to wear softer shoes because he has Raynaud's Syndrome, and he also has to take medication. We brought in a new pair of shoes [to his] room, and they didn't put them on him. When my son came home, we saw that the

¹⁶ Colin Milliken Statement – 24/07/24 – Page 7

¹⁷ P2's Mother Transcript – 29/06/22 – Page 14 – Line 24

¹⁸ P63's Mother Transcript – 30/11/22 – Page 28 – Line 14

¹⁹ P24's Mother Transcript – 26/09/22 – Page 42 – Line 16

labels were still on the shoes and that they had never been worn. This meant my son wore the same shoes the whole time he was there'.²⁰

- 4.17 Alternative communication methods were often missed in care plans. Some patients used Makaton (sign language) or Picture Exchange Communication System (PECS) before admission, but staff did not continue their use:

'Stephen's vocabulary is very limited. He knows about six words, you know, that's all he can say. But he can point to things. He used to use Makaton language, you know sign language, but then that wasn't carried through at Muckamore ... In the latest home he is in now, they started to use pictorial signs, so the likes of food or wanting to go to the toilet or get washed. He would point to the one he wanted then'.²¹

- 4.18 Patients were vulnerable to personal injury or injury by peers, by staff or by accident. However, the Inquiry heard that families had concerns that staff were not closely monitoring injuries. We heard (and saw in selected patient records) that MAH did not routinely use body charts to monitor physical marks, making it hard to track unexplained injuries. Charts were only completed after injuries were noticed.

Record-keeping standards

- 4.19 Care planning and record-keeping are sometimes governed by statute, such as the MHO 1986 and the Medicines Act 1968. National guidance also applies, for example, the Department of Health, Social Services and Public Safety (DHSSPS) 2010 Deprivation of Liberty Safeguards (DoLS) interim guidance requires care plans to detail any DoLS.²²
- 4.20 Professional regulators, such as the Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) and General Medical Council (GMC), set standards for individual professionals in relation to record-keeping. Employers and commissioners set additional requirements through policy documents and document formats (initially paper-based, increasingly electronic from 2013 onward).

²⁰ P24's Mother Transcript – 26/09/22 – Page 46 – Line 5

²¹ P3's Brother Transcript – 05/07/22 – Page 20 and Page 21

²² MAHI – Additional Materials Referenced Bundle – Page 302 (Interim Guidance on Deprivation of Liberty (2010))

- 4.21 For some of the time period covered by the Inquiry, MAH had few dedicated allied health professionals (AHPs). For example, there had been a patchy occupational therapy service in the years leading up to 2012, though referrals could be made to corporate services.²³ AHPs kept their own records, which were not accessible to MAH ward nurses or doctors, though AHPs could view nursing and medical notes.²⁴
- 4.22 The Regulation and Quality Improvement Authority (RQIA) has a statutory obligation to inspect Health and Social Care Trusts' (HSCTs) quality of care. It reviews care plans during inspections, alongside internal audits such as those conducted by Belfast Health and Social Care Trust (BHSCT).²⁵

Records at MAH

- 4.23 Care planning and record-keeping at MAH evolved over time. In 1999, records were mostly paper-based. The Inquiry did not request these except where they formed part of a patient document request (PDR) but heard that a risk screening tool identified patients needing comprehensive or forensic risk assessments.²⁶ All care plans had resettlement or discharge as a goal.²⁷
- 4.24 From 2006, care planning became more structured, with expanded risk assessments. Sixmile Ward used forensic tools such as Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend (ARMADILLO) (for sexual offending risk) and Historical, Clinical and Risk Management-20 (HCR-20) (for violence risk).²⁸ The children's ward used assessment tools such as the Adaptive Behaviour Scale, Personal Education Plan, Motivational Assessment Scale and Circle of Friends review.²⁹
- 4.25 Doctors prescribed medication following clear protocols, especially for drugs such as lithium and clozapine. Patients on antipsychotic medication were regularly

²³ Heather McFarlane Transcript – 04/06/24 – Page 150 – Line 6

²⁴ RQIA - Mental Health & Learning Disability -Announced Inspection, Cranfield Male Ward -18 & 19/11/13

²⁵ Barry Mills Statement – 04/06/24 – Page 13; MAHI – Mitchell M Bundle – Page 41 – EQC Audit 2009

²⁶ H260 Statement – 08/04/24 – Page 3; Colin Milliken Statement – 24/07/24 – Page 4

²⁷ H260 Statement – 08/04/24 – Page 5

²⁸ Colin Milliken Statement – 24/07/24 – Page 10

²⁹ Christine Keenan Transcript – 13/11/23 – Page 28 – Line 13

monitored for adverse side effects. Medications, including benzodiazepines, were also prescribed on a 'pro re nata' (PRN) basis, that is, only when needed. The decision about when to administer them was made by a registered nurse, who recorded the reason, dosage and effect.³⁰ Increased PRN use was discussed at weekly MDT meetings and triggered care plan reviews.³¹

Nursing care plans

- 4.26 Early care plans at MAH were standardised, not individualised.³² By the late 1980s, the Roper–Logan–Tierney nursing model was introduced, addressing needs like incontinence, risk of choking, management of challenging and aggressive behaviour, and mental health.³³ However, this was a general nursing model for nursing, not tailored for learning disabilities or mental health. Between 2015 and 2017, the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) developed a regional learning disability nursing assessment and care plan.³⁴ However, implementation stalled in 2020 due to the Covid-19 pandemic.
- 4.27 From 1992, MAH adopted the named nurse model, aligning with the 1991 UK Department of Health (DoH) Patient's Charter.³⁵ The named nurse was responsible for providing continuity of care and overseeing the nursing care plan, and attended MDT meetings.³⁶ Staff shortages made this difficult and record-keeping was adversely impacted.³⁷ After 2012, experienced staff left and there were fewer staff who understood the patients' individual needs.³⁸ This became even more difficult following the CCTV disclosures, when completing care plans became more challenging. By 2019, deputy ward managers were completing care plans rather than a patient's named nurse.³⁹

³⁰ H330 Statement – 22/05/24 – Page 25

³¹ H298 Transcript – 12/09/24 – Page 93 and Page 95

³² A6 Statement – 09/02/24 – Page 3

³³ A12 Statement – 28/03/24 – Page 5; H137 Transcript – 08/05/24 – Page 72 – Line 14

³⁴ Linda Kelly Statement (Organisational Modules) – 03/05/24 – Page 5

³⁵ Department of Health (1991) Patient's Charter. Department of Health, London – <https://wellcomecollection.org/works/x58ejyiw>

³⁶ A6 Statement – 09/02/24 – Page 28; H298 Statement – 09/04/24 – Page 6

³⁷ Moira Mannion Statement – 19/09/23 – Page 12

³⁸ H298 Statement – 09/04/24 – Page 24

³⁹ H260 Statement – 08/04/24 – Page 7

- 4.28 In 2013, a policy defined levels of therapeutic observation (also known as close or enhanced observation). These were discussed and agreed at MDT meetings and recorded in nursing notes.⁴⁰
- 4.29 Until 2013, paper care plans were audited monthly by ward managers.⁴¹ The Inquiry did not receive audit examples but heard that managers used a standard checklist and discussed gaps with the named nurse.⁴² As nursing records moved to an electronic format, audits continued.⁴³
- 4.30 In 2013, MAH began transitioning to electronic records. By 2015, records were fragmented; some digital, some paper.⁴⁴ The RQIA found that patients had both electronic records and hard copy files, including letters, appointments, body charts, Modified Early Warning Score (MEWS) charts, medication administration charts, blood and laboratory results and care plan audits.⁴⁵ Some staff reported that electronic records were hard to follow.⁴⁶ In 2015, Erne Ward only had four centrally located computers.⁴⁷
- 4.31 It was unclear how healthcare assistants (HCAs) accessed electronic plans. One HCA employed in 2013 said they never saw a care plan.⁴⁸ Though not responsible for writing care plans, HCAs delivered much of the care and had frequent patient contact. MAH had fewer registered nurses to supervise the HCAs than other types of hospital ward, making access to care plans vital. Instead, HCAs received task sheets from registered nurses at the start of each shift, which lacked context about patient needs,⁴⁹ making it difficult to complete the tasks in a personalised way.
- 4.32 H903 worked at MAH from 1998 to 2016, first as a support worker, then as a registered learning disability nurse. She was based in Conicar and Iveagh wards caring for children, and told the Inquiry:

⁴⁰ A12 Statement – 28/03/24 – Page 10

⁴¹ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 10; A12 Statement – 28/03/24 – Page 59

⁴² H330 Statement – 22/05/24 – Page 24

⁴³ H231 Transcript – 13/05/24 – Page 159 – Line 13

⁴⁴ Moira Mannion Statement – 19/09/23 – Page 9

⁴⁵ RQIA - Unannounced Inspection Report, Moylena – 18/11/15

⁴⁶ Barry Mills Statement – 04/06/24 – Page 27

⁴⁷ RQIA – Unannounced Inspection Report, Erne Ward – 23/06/15

⁴⁸ Paula McCann Transcript – 19/02/24 – Page 63 – Line 9

⁴⁹ H231 Statement – 09/04/24 – Page 5; H885 Statement – 30/04/24 – Page 5

'Patient care plans included 15 activities of living to include details of behaviours displayed by the individual, socialisation and any other relevant care identified by the multi-disciplinary team. I attended Multi-Disciplinary Team meetings which I believe were held weekly. The MDT reviewed each patient's weekly report and discussed if any changes to their care plans were needed ... Therapeutic treatments were documented in patient care plans. These included creating a relaxing environment for patients like reading them a story or listening to music. Some patients liked guided imagery, lying on the sofa of a quiet room with a relaxation script and chill out music. This formed part of patient care plans and formed part of their regular routine. Developing structure and routine for patients was important for their care and keeping them engaged in meaningful activities. I, and staff, always tried to help patients to find new more positive ways of dealing with emotions rather than the use of aggression'.⁵⁰

- 4.33 H112, a nurse at MAH from 2001 to 2018, described care plans as detailed and structured. She worked in wards across the hospital, including the core wards as well as resettlement wards. She described the structure of care plans:

'They would have very much detailed structured activities. I suppose back then the nursing model would have been Roper, Logan and Tierney. So that was where you assess patients into I think, if memory, 15 activities of living, and one of those activities of living would have been a patient's social needs. So, under that category you would have assessed the patient's need about their socialisation and structured activities. So that would have formed very much part of their care plan'.⁵¹

Positive behaviour support plans

- 4.34 Behavioural nurses were available on the children's ward from at least 1994.⁵² It is unclear when behaviour support nurses were introduced to the adult wards, but the Inquiry heard that positive behaviour support (PBS) plans were introduced around 2016.⁵³ These were developed by clinical psychologists and specialist behaviour support nurses.
- 4.35 After their introduction, PBS plans were reviewed regularly at MDT meetings (though by no means everyone had a PBS plan). However, most patients did not receive other forms of psychological intervention. Sixmile Ward patients and a small number of patients on Cranfield Ward had cognitive behaviour therapy (CBT)

⁵⁰ H903 Transcript – 04/06/24 – Pages 129-130

⁵¹ H112 Transcript – 10/09/24 – Page 11 – Line 14

⁵² Christine Keenan Statement – 03/11/23 – Page 1

⁵³ H298 Statement – 09/04/24 – Page 21

as part of their care plan, delivered by a psychologist.⁵⁴ Clinical psychologists were in extremely short supply, and they maintained their own records, which were not stored on the ward, and which were not integrated into the main clinical record.⁵⁵

Medical care plans

- 4.36 The Inquiry heard that the medical staff used a biopsychosocial model to develop treatment plans tailored for individual patients. While these plans were sometimes discussed with patients, and occasionally families, there was no formal process for doing so. Medication decisions, including the use of PRN (as needed) medication, were typically discussed during ward rounds.⁵⁶ Treatment plans were documented by the senior house officer (SHO), and any changes were reviewed at MDT meetings.⁵⁷ The Inquiry heard that medical staff viewed their role as focused on diagnosis and treatment. More comprehensive care planning, including personal care, was primarily the responsibility of nursing staff, in consultation with the MDT, patients, families and carers.⁵⁸

Care plans for restraint and seclusion

- 4.37 At times, patients' emotional states became so dysregulated that restrictive interventions, such as physical restraint or seclusion, were necessary to ensure safety. To promote safer and more appropriate use of restraint, formal training was introduced in the late 1990s under the 'care and responsibility' model (see Chapter 7 (Restrictive Practices)). Initially, staff used a restrictive practice checklist to guide these decisions. However, this approach produced standardised responses that were not recorded in patient notes and lacked individualised assessment or therapeutic planning.⁵⁹ This required:
- Discussion of the intervention with medical staff and the patient's family;
 - Documentation of the care plan and each instance of restraint in the patient's notes.⁶⁰

⁵⁴ H330 Statement – 22/05/24 – Page 24

⁵⁵ See Chapter 3 & Chapter 9 for the day-to-day availability of psychologists.

⁵⁶ Colin Milliken Statement – 24/07/24 – Page 6 and Page 7

⁵⁷ Equivalent to the new Foundation Year 2 doctor

⁵⁸ H73 Statement – 20/03/24 – Page 4

⁵⁹ RQIA - Mental Health and Learning Disability, Unannounced Inspection, Cranfield ICU – 01/07/13

⁶⁰ A12 Statement – 28/03/24 – Page 8

- 4.38 In 2012, the RQIA reviewed Cranfield Intensive Care Unit (ICU) and noted high levels of challenging behaviour. Despite this, care planning and documentation were clear, and patients reported feeling safe and well cared for despite the need for restrictive practices. Seclusion records aligned with BHSCT (Trust) policy, and observation levels were clearly documented and regularly reviewed.⁶¹ Other RQIA reviews, however, were nothing like as positive. For example, one patient said they did not feel safe on the ward, and another review resulted in 34 recommendations.⁶²
- 4.39 Seclusion care plans were required to be agreed in advance, although one witness said the care plans were rarely used between 1999 and 2013.⁶³ A consultant psychiatrist told the Inquiry that while on-call consultants were informed of seclusion episodes, they were not contemporaneously notified of restraint interventions. Both types of intervention were discussed retrospectively at MDT meetings.⁶⁴
- 4.40 In 2014, detention care plans were introduced for patients detained under the MHO 1986.⁶⁵ These included justifications for any restrictive practices. From May 2015, physical interventions were also recorded in the incident reporting system, with a requirement to document the reason for each intervention.⁶⁶
- 4.41 In 2014 the seclusion policy required continuous observation by a nominated staff member, with direct checks every 15 minutes and hourly registered nurse visits. Seclusion policies are discussed in more detail in Chapter 7. Initially observations were recorded on paper and stored in ward offices, not in patient notes. These were later incorporated into the electronic records system.⁶⁷ This was undertaken only by registered nurses even though HCAs often conducted the observations.⁶⁸

⁶¹ RQIA – Announced Inspection, Cranfield ICU – 29/06/12

⁶² RQIA Cranfield ICU Inspection Report 2011; RQIA Cranfield ICU Inspection Report, 2014

⁶³ H137 Statement – 09/04/24 – Page 7

⁶⁴ Colin Milliken Statement – 24/07/24 – Page 8

⁶⁵ RQIA - Mental Health and Learning Disability, Unannounced Inspection Erne - 09 & 10/12/14

⁶⁶ John Veitch Statement (Organisational Modules) – 19/09/24 – Page 74

⁶⁷ A14 Statement – 20/05/24 – Page 12

⁶⁸ H231 Transcript – 13/05/24 – Page 163 – Line 17

- 4.42 The records seen by the Inquiry suggest that staff were not always clear on the definitions of restraint and seclusion. Terms such as ‘clinical holds’ were seen in the notes but are not present in BHSCT policies. Similarly, episodes described as ‘low stimulus’ or time spent locked out in the garden at the Psychiatric Intensive Care Unit (PICU) were not recorded as seclusion and therefore escaped the scrutiny applied to formally recorded seclusion events.
- 4.43 A senior nurse, H260, told the Inquiry that by 2019 every seclusion event on Sixmile Ward had to be recorded as an incident on the electronic software (Datix) and documented on the patient’s record, and a senior nurse manager informed when seclusion was used.⁶⁹
- 4.44 The Inquiry heard evidence that when CCTV was reviewed following the 2017 revelations, it seemed that many episodes of seclusion were not properly conducted or recorded. From then on, however, not surprisingly, greater attention was paid to documentation when seclusions were recorded. 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.⁷⁰

Quality assurance of record-keeping

- 4.45 In 1999, Health and Social Care (HSC) hospitals were not subject to formal inspection, and the Inquiry was not supplied with any external audits or reviews of care plans before the creation of the RQIA in 2005. In 2009 the RQIA took over the role of the Mental Health Commission (MHC), which had until then visited patients subject to a mental health order in hospital; this included MAH. The Inquiry did not request historic material pertaining to the MHC but did explore the role of the RQIA. This is dealt with in Chapter 14 (External Agencies Inspection and Oversight).

⁶⁹ H260 Statement – 08/04/24 – Page 12

⁷⁰ P96’s Father Statement – Page 100 (restricted)

4.46 The Inquiry heard that prior to 2005 the North and West Belfast Health and Social Services Trust (NWBHSST) (then managing MAH) used a quality assurance audit tool, Evaluating Quality Care (EQC), to assess compliance with policies and procedures, including care planning. Audit findings were presented to management, and action plans were developed and monitored by the Executive Steering Group.⁷¹ The audit team included professionals from nursing, social work, medical staff, estates and hotel services, reflecting a multidisciplinary approach.⁷² In later years, external audits were introduced, with the independent team 'Equate' conducting twice-yearly audits of care plans.⁷³

Regulation and Quality Improvement Authority (RQIA) oversight

4.47 The RQIA is responsible for inspecting NHS bodies under their statutory duty of quality, as set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The role of the RQIA is further discussed in Chapter 14. The RQIA began inspecting HSC hospitals in 2007. It assumed oversight responsibilities for patients subject to the MHO in 2009.⁷⁴

4.48 As part of its inspections, the RQIA conducts care record reviews, initially at ward level, later at hospital level. Findings on care planning at MAH varied significantly over time and across wards.

4.49 Several RQIA inspections identified examples of good practice:

- In 2010, assessments at Cranfield Women's Ward were complete, though not all identified needs were reflected in care plans;⁷⁵
- Finglass Ward had detailed assessments and regular reviews, with families involved in incidents. Records contained detailed needs assessments and care plans that had been reviewed on a regular basis;⁷⁶

⁷¹ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 7

⁷² Barry Mills Statement – 04/06/24 – Page 13

⁷³ Bert Lewis Statement – 10/07/24 – Page 10

⁷⁴ Briege Donaghy Transcript – 03/05/23 - Page 33 - Line 6

⁷⁵ RQIA – Quality Improvement Plan, Announced Inspection, Cranfield Female - 13 & 14/12/10

⁷⁶ RQIA – Mental Health and Learning Disability, Announced Inspection - 25 & 26/06/12

- In 2016, Cranfield 2 Ward had up-to-date risk assessments aligned with regional guidance;⁷⁷
- In 2016, Cranfield Men's Ward had thorough risk assessments and progress notes; PICU showed evidence of patient and carer involvement in risk planning, and safeguarding protection plans were regularly reviewed. Protection plans were in place when safeguarding incidents occurred on the ward and were reviewed regularly.⁷⁸

4.50 However, the RQIA also identified recurring concerns:

- In 2013, Cranfield Women's Ward used generic, poorly personalised care plans that lacked clear interventions;⁷⁹
- On Cranfield Men's Ward, DoLS care plans lacked justification for the rationale, therapeutic aim or level of restrictive intervention used;⁸⁰
- In 2016, Donegore Ward raised concerns about senior medical staff input and medication monitoring, including polypharmacy (multiple drugs simultaneously).⁸¹ The medical lead for patient safety and governance and the clinical pharmacist reviewed all current medication prescriptions, changed the prescription where required or provided a rationale as to why the prescription was not changed. The Inquiry heard that one of the consultant psychiatrists had correspondence with the RQIA medical assessor who assured him that:

*'no immediate patient safety concerns are raised and that there is no evidence of high dose anti-psychotic prescribing'.*⁸²

The Inquiry heard that the RQIA did not raise this concern in future reviews.⁸³

4.51 Other inspections revealed gaps in evaluation and communication:

- After PICU closed in 2019, care plans were not updated to reflect the new care environment.⁸⁴

⁷⁷ RQIA - Mental Health Inpatient Inspection Report, Cranfield Ward 2 - 28 to 30/11/16

⁷⁸ RQIA - Mental Health and Learning Disability Inpatient Inspection Report, Cranfield ICU - 06 to 08/12/16

⁷⁹ RQIA - Mental Health and Learning Disability, Announced Inspection - 25 & 26/06/12

⁸⁰ RQIA - Mental Health & Learning Disability, Announced Inspection, Cranfield Male Ward - 18 & 19/11/13

⁸¹ RQIA - Donegore, Dates of Inspection Visit - 28-30/06/16

⁸² Colin Milliken Transcript – 23/09/24 – Page 150 – Line 9

⁸³ Colin Milliken Transcript – 23/09/24 – Page 162 – Line 2

⁸⁴ RQIA - Unannounced Inspection Report - Muckamore Abbey Hospital – 26, 27 & 28/02/19 - Page 13

- In 2018, Malnutrition Universal Screening Tool (MUST) assessments were completed but not reviewed monthly, contrary to BHSCT policy.⁸⁵
- Following an unannounced inspection in October 2020, RQIA observed:
*'From the feedback we received, we found that whilst some families are very happy about the communication they have with the hospital, others either stated that it has been a long journey to reach the currently acceptable level of communication or that they had ongoing difficulties'.*⁸⁶

Safeguarding records and reports

- 4.52 Designated adult protection officer (DAPO) files were held separately from clinical records and rarely reviewed during RQIA inspections. However, the RQIA did issue an Improvement Notice in August 2019 in relation to adult safeguarding at MAH.⁸⁷ This indicated persistent systemic issues in relation to safeguarding, despite the heightened focus on safeguarding from September 2017 onwards.
- 4.53 The serious adverse incident (SAI) level 3 investigation, A Way to Go, concluded that adult safeguarding practice at MAH was inconsistent.⁸⁸ Records failed to demonstrate how adult safeguarding procedures, inspections, professional regulation, police investigations, complaints, clinical governance and internal disciplinary processes were integrated.⁸⁹ The Panel reviewed this and several other reviews, along with patient notes, and found this concern to be well founded. Failure to maintain good safeguarding records limited the ability to understand broader contextual factors that impacted patients.
- 4.54 A DoH review of 60 MAH safeguarding files from 2020 and 2021 found a 'mixed picture of risk and response'.⁹⁰ The review identified concerns about the clarity and fullness of records, with many lacking firm evidence. The safeguarding pro formas were not user friendly and were poorly suited to documenting safeguarding processes. It was often unclear what stages investigations had reached, how

⁸⁵ RQIA - Unannounced Follow Up Inspection Report, Cranfield ICU - 05 & 06/02/18

⁸⁶ RQIA - Unannounced Inspection Report – Belfast Health & Social Care Trust – 27 & 28/10/20 – Page 17

⁸⁷ RQIA - Announced Enforcement Inspection Report - 02 to 16/04/20

⁸⁸ Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go (Nov 2018) as exhibited in Dr Margaret Flynn Statement – 24/04/23 – Page 4

⁸⁹ Minutes of Muckamore Departmental Assurance Group (MDAG) meeting on 1 October 2019

⁹⁰ Owen Barr Statement (Evidence Modules) – 25/04/24 – Page 47 (Exhibit 3) – Muckamore Abbey Hospital Adult Safeguarding File Review, September 2021

decisions were made or what evidence supported them. There were few references to involving alleged victims in investigative processes.⁹¹

Conclusions

- 4.55 While policies and review practices did exist, they did not describe the quality and depth of content required. The records frequently did not reflect the needs of individual patients or accurately describe the care delivered or its efficacy. As clinical governance processes matured, pro formas were introduced and MDTs' agreed interventions were listed. These processes remained largely the responsibility of registered nurses and doctors, with minimal family involvement.
- 4.56 At MAH, most direct patient contact was delivered by HCAs, who had limited formal input into care planning and inconsistent access to care plans. As registered nurse vacancies increased from 2013, and temporary and fixed-term contracts increased, the ability of nurses familiar with patients to regularly review care plans diminished. This worsened significantly after 2017, when a significant number of nurses were suspended and/or left MAH. As a result, understanding patient needs became more difficult and deviations from care plans increased.
- 4.57 Reviews by the RQIA and MAH internal reviews show inconsistent care record content across wards and time periods. It is not possible to determine a consistent theme. The Inquiry found evidence of both good and poor practice in care assessment, planning and evaluation of care.
- 4.58 Staff reported that care planning became more personalised over time. However, families described a loss of established routines post-admission, leading to reduced independence, lapses in personal care and increased distressed behaviours at times. Person-centred care is critical for vulnerable patients with long hospital stays, and while efforts were made, MAH had yet to fully realise this goal.

⁹¹ Owen Barr Statement (Evidence Modules) – 25/04/24 – Page 51

- 4.59 A care plan is only as effective as the system's capacity to implement it. Multiple barriers to implementation were identified.
- 4.60 Care plans and records were primarily managed by registered professionals, often without family awareness. HCAs, who delivered most direct care, relied on second-hand reports by registered nurses. The transition to electronic records was hampered by a lack of terminals,⁹² limiting real-time documentation and communication of care plans to HCAs.
- 4.61 Staffing levels were a critical factor in both delivering and deviating from care plans. Patients with learning disabilities require time, routine and familiarity. Staff shortages reduced time per patient and increased the likelihood of care being delivered by unfamiliar staff. This led to unmet care needs and undelivered planned activities. Shortages in specialist roles (for example, psychologists and occupational therapists) also meant some interventions were unavailable or improperly executed.
- 4.62 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.⁹³ 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.⁹⁴ These experiences were echoed in an RQIA unannounced inspection report of Cranfield Ward in January 2015.⁹⁵ The inspector also noted during direct observations that important care interventions being delivered to patients on the ward on the days of the inspection had not been captured or recorded in the patient assessment or care plan, which should be used as a basis to guide care practices and interventions and help ensure a consistent approach to care delivery. These were not isolated incidents, but part of a broader pattern where deviation had become normalised.

⁹² RQIA – Unannounced Inspection Report, Erne Ward – 23/06/15

⁹³ P52's Mother's Transcript – 19/10/22 – Page 31 – Line 5 (restricted)

⁹⁴ P52's Mothers Transcript - - 19/10/22 – Page 27, Page 31 and Page 34 (restricted)

⁹⁵ RQIA - Mental Health and Learning Disability, Unannounced Inspection Cranfield Men – 12 & 13/01/15

Recommendations

R12	Care plans must be live, person-centred documents. This requires joint ownership with people with learning disabilities and their families rather than simply professional records. While professionals necessarily lead assessments, families should be actively involved in identifying needs. Resulting care plans should be shared with the service user themselves (where appropriate) and families, who should be able to challenge and further contribute to them. People with learning disabilities and/or families should receive a copy of the care plan at agreed intervals and whenever significant changes occur.
R13	All staff involved in delivering care, including healthcare assistants (HCAs), must have full access to the care plan.
R14	Observation records detailing all use of restraint and seclusion should be completed by the individual observing. In HSCT facilities, if the observer is unregistered, a registered staff member should countersign the entry rather than create a second-hand record. In private and 3 rd sector facilities the individual in charge of the shift must countersign and report to the Registered Home Manager at the earliest reasonable opportunity. Sufficient electronic terminals should be available to ensure easy access for inputting records for all staff.
R15	Care plans should be regularly evaluated to assess their impact on people's wellbeing. This is the responsibility of the care team and should include formal, documented input from the service user themselves (where appropriate) and families. Additionally, there should be regular independent reviews overseen by the Public Health Agency (PHA) to assess any deviation from best practice, both in the written plan and in daily care delivery. These reviews should be shared with people themselves and families.
R16	If a care plan cannot be delivered due to issues, such as staffing shortages, this should be recorded as 'missed care' using the Trust's or organisation's incident reporting system.

(This page is intentionally left blank)

Patients are people first

'When she's in the hospital, all the doctors, all the consultants really like her and would get her to draw wee pictures, and she would draw people the way she sees them and they find it hilarious. And so even the consultant has got one of her pictures and has framed it and put it into his office. She would tell them jokes and they would go up to her "Tell us another joke"'

'...in his own way he's a very loving brother, but just through his disabilities, learning disabilities, he's very disruptive at times and challenging. He loves to listen to music. He loves watching CDs. He loves Elvis, Daniel O'Donnell, anything to do with those people, but has very challenging behavioural issues, and that's always where things break down and go wrong, I suppose.'

Chapter 5

Information Sharing and Co-production

- 5.1 Patients in Muckamore Abbey Hospital often have complex, long-standing needs, with families playing a central role in managing them. While admission relates to a change in one set of needs, many other needs remain unchanged. Families bring valuable expertise and strategies in meeting these needs. Working in partnership with families (also known as 'co-production') helps to maintain continuity of care, aiming to reduce avoidable distress and harm for patients.
- 5.2 Co-production goes beyond information sharing. Effective co-production goes beyond person-centred care and communication to patients and their families being actively involved in decision-making. It represents a shift from traditional power imbalances between service providers and users (or their advocates) towards shared decision-making. At the individual patient level, it fosters personalised, rights-based care. At organisational and policy levels, it promotes inclusive planning and accountability.¹
- 5.3 Historically, healthcare operated under a paternalistic model, assuming passive patients who accepted medical authority. While the clinical records contain entries about consulting and communicating with families, this appeared to be a continuation of the passive model, where decisions were made by the professionals alone. The Inquiry heard that many families were simply told that admission to MAH was best, without discussion of alternatives.² This lack of engagement continued after admission, with patients and families informed of care decisions rather than decisions being taken collaboratively.
- 5.4 Effective communication with patients and their families was first included in legislation through the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. This establishes a statutory duty

¹ A. Realpe and L.M. Wallace (2010) What is co-production? The Health Foundation – https://qi.elft.nhs.uk/wp-content/uploads/2017/01/what_is_co-production.pdf

² P55's Father Transcript – 18/10/22 – Page 20 – Line 5 (restricted)

of care on provider organisations.³ The 2006 Quality Standards for Health and Social Care include communication and information as a core theme.⁴ However, co-production is not embedded in legislation and is not a requirement for Regulation and Quality Improvement Authority (RQIA) reviews.

5.5 The Inquiry did hear from a number of staff witnesses about their efforts to communicate effectively with patients and their families. However, information sharing and communication alone are not sufficient for co-production. True co-production requires a cultural shift; staff must be willing to share power. This cannot be achieved through policy alone; it demands education and development. None of the staff witnesses gave examples of co-production, either in their witness statements or in their oral evidence at the hearings.

5.6 P115 was readmitted to MAH between 2006 and 2010. In 2008 (when he was 17 years old) he was in the Psychiatric Intensive Care Unit (PICU) and there was an education tribunal to assess his educational needs. His father told the Inquiry:

'I told the tribunal that I had provided MAH with all the materials they needed to help Eoin communicate and I had explained how to use them to a behavioural nurse, who did not know how they worked, and so she had just put them away in a drawer. I was surprised at the time that the nurse did not seem to know about PECS [Picture Exchange Communication System] and that she did not make use of the materials after they were supplied much and I had explained them. The tribunal recommended that those working with Eoin should understand autism PECS and there should be a proper behavioural analysis and interventions. I understood that funding would be made available to provide the recommended training. However, so far as I am aware, the PECS materials were still not used with Eoin during his time in MAH until one nurse later took it on herself to retrieve them and put them up'.⁵

³ The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 – Section 34 – <https://www.legislation.gov.uk/nisi/2003/431/contents>

⁴ Department of Health, Social Services and Public Safety (2006) Quality Standards for Health and Social Care. DHSSPS, Belfast – <https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care>

⁵ P115's Father Transcript – 27/09/23 – Page 58 – Line 13

- 5.7 Families reported a decline in communication quality over time. One relative told us:

'Communication at MAH has never been very good, but I feel it has deteriorated a lot in the last number of years. This has been exacerbated by things like a poor internet signal, computers with no cameras, failure to be able to get anyone to answer the ward telephones, failure of staff to provide appropriate updates'.⁶

- 5.8 The mother of P113 (who was admitted in April 2017) told us about how the information designed to inform ward staff about the patients' triggers, likes and dislikes seemed to disappear on each move of ward:

[Counsel]: *'There is a reference there in the first page that I referred to about your efforts to share expertise and, specifically, effective ways of encouraging and engaging P113 being disregarded. Is that the type of thing that you were just referring to, those types of triggers and ways of talking him down?*

[P113's Mother]: *When P113 was admitted to Muckamore, we filled in a questionnaire, a sort of, it was a patient passport, if you want to call it, of things he liked, things he didn't like, things that would trigger him. And then when he was moved to all these, from one ward to another, the same questionnaire and the same form was handed to us. We actually said to each other one day, "what happened to [the] form? I thought it was all on computer". But we were told it wasn't and all the staff didn't have access to the computer system. So there was a lot of effort went into, obviously, us telling the staff what we thought worked, but I don't know what happened that information'.⁷*

- 5.9 P90's brother spoke of the lack of communication about his brother's care:

'We have a lifetime of experience with Bryan but we cannot recall ever being asked how to manage Bryan's challenging behaviour in all the 35 years he has been a patient in MAH. I find this shocking'.⁸

He went on:

'There was never great communication with management in MAH, my sister, Brigene and I were invited to multidisciplinary team meetings [MDTMs] on a few occasions but our invitations dwindled off. We were faced with obstacles rather than solutions and in the end it was pointless. Our family wanted to have an active role in the care of Bryan. The voices and concerns of our family have not been taken into consideration. The only recourse for our family in relation to Bryan's proposed resettlement facility has been through the courts. This is unhelpful, stressful, and onerous on top of our caring responsibilities'.⁹

⁶ P90's Sister Transcript – 11/10/23 – Page 93 – Line 23

⁷ P113's Mother Transcript – 26/09/23 – Page 87 – Line 10

⁸ P90's Brother Transcript – 11/10/23 – Page 144 – Line 28

⁹ P90's Brother Transcript – 11/10/23 – Page 145 – Line 15

Information sharing – a first step

- 5.10 At least since 2010, according to RQIA inspection reports, MAH had systems in place for sharing general information, including ward information leaflets.¹⁰ In 2013, materials on managing challenging behaviour were included in ward welcome booklets, presented in an Easy Read format.¹¹
- 5.11 However, the distribution of this information was inconsistent. Some families reported receiving leaflets and updates, while others said they received nothing. This variation in experience, across families, wards and years, was a recurring theme throughout the Inquiry and reflected broader inconsistencies in co-production and communication.
- 5.12 Operational decisions such as ward closures and patient movement were frequently made without consultation,¹² and, in some cases, before families were informed.¹³ One family described the distressing impact of such a decision:
- ‘Around this time, Ciaran was moved to a ward ... called a resettlement ward ... We did not want that to happen at the time. We told H50 we did not want it to happen ... When we went on the holiday to Tenerife in and around April 2008, MAH decided to move Ciaran to this ward in any event ... When we came back from Tenerife, we found Ciaran on the resettlement ward sitting like a zombie in a chair. He had lost a stone in weight in a week, and he was in a terrible state. He was not talking or engaging when we asked questions’.*¹⁴
- 5.13 P96’s Father described being contacted and told that his son was going to be moved within an hour:
- ‘I was telephoned by H50 who informed me that P96 would be moved from PICU to Cranfield 2 in an hour’s time. This was the first that I knew about this plan, there was no social story to prepare P96 for the sudden change to his routine and environment. I sought the details and a copy of the required risk assessment in an e-mail on the 27th December 2018 which I followed up on the 11th January 2019. I did not receive a response until the 14th January 2019, but that did not provide a copy of the risk assessments referred to. Rather, I was informed an external evaluation was being carried out by the Health and Safety Executive. It was only in a letter dated the 3rd of November 2020 that the BHSCT [Belfast Health and Social Care Trust] finally conceded a risk assessment in relation to absconding had not been completed ahead of*

¹⁰ RQIA – Quality Improvement Plan, Announced Inspection, Cranfield Female - 13 & 14/12/10

¹¹ RQIA - Mental Health & Learning Disability, Announced Inspection, Cranfield Male Ward - 18 & 19/11/13

¹² P54’s Mother Statement – 05/10/22 – Page 10 (restricted)

¹³ P96’s Father Statement – 21/09/23 – Page 13

¹⁴ P57’s Mother Transcript – 20/10/22 – Pages 20-21

P96's move from PICU to Cranfield 2 on 21st December 2018 and was not in fact completed until the 21st January 2019, well after my complaints'.¹⁵

Patient-specific information and co-production

- 5.14 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.¹⁶ They are often the ones to resume care after discharge. These families expected to work in partnership with health and social care staff to plan care and make decisions about their relative's future. However, the Inquiry heard that this expectation was frequently unmet in practice until after the patient had been resettled elsewhere:

[Counsel]: 'So is it fair to say then in recent times at least you had a dialogue with the professionals responsible for P117?'

[P117's Mother]: Yes, always been even in Muckamore I still was on the phone, if I wasn't happy about medication. I was always on the phone and speaking to them, not that I always got anywhere, you know, but I always made sure I was always involved. Even now in supported living we are even more involved in every sense.

[Counsel]: So you engage with the professionals and you are satisfied now that they are taking your views on Board?'

[P117's Mother]: Yeah, you have to make them listen, it is the only way you get results'.¹⁷

- 5.15 Many described being excluded from care planning, with their insights overlooked. The Inquiry repeatedly heard that patients had 'kicked off', leading to the use of sedation and/or restraint. In many cases, families believe that recognising behavioural triggers, known to them, could have prevented such incidents.
- 5.16 Strategies for coping with patient behaviour, well known to the families concerned, were either not known to, or ignored by, staff. The failure to recognise and utilise strategies used by families at home caused patients avoidable anxiety and distress.
- 5.17 Many families related how specific requirements of the patients' care were ignored despite the families raising them with staff.

¹⁵ P96's Father Transcript – 11/10/23 – Pages 15-16

¹⁶ P55's Father Statement – 10/10/22 – Page 6 (restricted)

¹⁷ P117's Mother Transcript – 10/10/23 – Page 22 – Line 10

5.18 An admission under the Mental Health (Northern Ireland) Order 1986 (MHO) removes legal responsibility from families, and many reported feeling excluded from care planning and decision-making.

5.19 Families were often told they could not visit during the initial weeks of admission while the patient 'settled in', and this meant there were lost opportunities to share critical information with staff:

'When John was first admitted to Muckamore, myself and family were told by staff, I cannot recall who, that we were not allowed to visit John for a period of time to allow him to settle'.¹⁸

5.20 Some families reported that although they saw staff on the wards whenever they visited, it was difficult to know who they should be speaking to as there was no assigned key worker for their loved one. Staff did not volunteer information about the care planning or the patient's progress:

[Counsel]: 'Did you have -- amongst the staff, did you have like a point of contact, a person you could speak to about your son's care?'

[P24's Father]: There was no one -- no one. No one. I mean there was just a person, we went in -- we went in, like we went into a room, a person brought him in and then she went out again, or he went out, and that was it. We had a half an hour, or maybe 20 minutes, and then we left. There was no one, you know. There was no one I knew we could talk to about it'.¹⁹

5.21 Multidisciplinary meetings sometimes included families, but mostly this was only in discussions around admission and discharge. Families reported inconsistent experiences of co-production. Some felt involved, while others felt excluded.

5.22 Some families reported that they were not given enough information when their loved one was admitted:

'I had no introduction meeting when P77 was admitted to MAH. I recall I might have received a few leaflets but no real information on the hospital, what treatment P77 would receive, who would look after him or how/where he would be looked after. I was very much in the dark in respect of provision of information'.²⁰

¹⁸ P72's Sister Transcript – 24/11/22 – Page 11 – Line 27

¹⁹ P24's Father Transcript – 26/09/22 – Page 21 – Line 16

²⁰ P77's Mother Transcript – 20/06/23 – Page 19 – Line 18

- 5.23 Families told the Inquiry that they were sometimes not informed of the very basic aspects of their loved one's care information they felt entitled to receive:

'I had very little communication with the staff and they didn't let me know what was happening with Kirsty's treatment or care. They said she was an adult and I was never informed about things like medication changes. I would ask for family meetings but I never got an answer'.²¹

'I received no adequate information from Muckamore staff as to Mary's care, treatment or medication. I was never provided with any brochures or leaflets dealing with admission, patients' and family's rights, care and services provided by Muckamore or resettlement from Muckamore. I never saw Mary's bedroom in Muckamore. I was not aware of Mary ever being provided with meaningful leisure or other activities in Muckamore'.²²

- 5.24 Some families told the Inquiry that they did not feel they were able to build good working relationships with staff or raise concerns privately with a key worker:

'We were invited to meetings and these seemed to be on a monthly basis. We were given a family liaison officer - I can't recall her name - and she disappeared after a while. We never had any private time with her or time to build a trusting relationship. There was another man who was supposed to be an advocate for P28 called H93. He was assigned fairly late and seemed to be annoyed he wasn't involved from the start. We didn't know who to trust or, indeed, if anyone assigned to us could be trusted at all. There never seemed to be an opportunity to build up trusting relationships and there was never any privacy away from other clinicians and Social Services' representatives. We never had any private or confidential time'.²³

- 5.25 Experiences of raising concerns were mixed. Some families trusted staff were acting in the patients' best interests, but others felt dismissed or patronised when they raised serious issues about sedation, restraint or seclusion.

- 5.26 Some families reported mixed experiences depending on which staff were involved. However, most reported that their concerns and opinions were not reflected in the decisions made:

'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'.²⁴

²¹ P4's Mother Transcript – 28/06/22 – Page 39 – Line 1

²² P22's Sister Transcript – 22/09/22 – Page 28 – Line 8

²³ P28's Mother Transcript – 28/09/22 – Page 26 – Line 4

²⁴ P55's Father Transcript – 18/10/22 – Page 34 – Line 1 (restricted)

5.27 Others recognised processes existed but felt they were ineffective:

'My husband and I attended meetings at MAH to talk about the plan for Shelley to come home ... There was a meeting every four to six weeks where I told the committee my concerns, but I felt that I had no real input'.²⁵

5.28 As planned ward closures gathered pace from 2012 and recruitment of permanent staff was frozen, the workforce became increasingly unstable. The rise in temporary and agency staff made individualised care more difficult to maintain, particularly for patients who relied on familiar staff for communication and emotional stability:

'The atmosphere changed when different staff were on the ward. The change was due to less familiar staff being on duty for example agency staff. The change of staff was unsettling for some patients, particularly those who were non-verbal, as they had built up a rapport of social cues with the longer term members of staff'.²⁶

Consultation on service planning

5.29 An RQIA safeguarding review in 2008 noted that some wards had patient and carer forums, as well as a larger day-care forum that had previously contributed to capital and policy decisions. The review highlighted efforts to enhance advocacy and service user involvement through independent organisations such as the advocacy service Bryson House and mental health charity Mencap.²⁷

5.30 However, by 2018, an assurance team brought in by BHSCT following the CCTV revelations found:

'There was no clear evidence of consultation with people with learning disabilities/families/carers/key organisations for people with a learning disability in the development of policies'.²⁸

5.31 P90's sister told the Inquiry about her experiences with a patient forum in recent years:

'In attempts to improve communication for families, and after much discussion, I along with the then Interim Director For Learning Disabilities at Belfast Trust, H287, set up a carers forum. The purpose of this group was to afford relatives a forum whereby they could come together, raise issues or concerns, and learn

²⁵ P29's Mother Transcript – 11/10/22 – Page 13 – Line 3

²⁶ H230 Transcript – 15/05/24 – Page 134 – Line 27

²⁷ RQIA – Review of the "Safeguards in place for children and vulnerable adults in mental health and learning disability hospitals" in HSC Trusts, Overview Report - June 2008

²⁸ Owen Barr Statement (Evidence Modules) – 25/04/24 – Page 17 (Exhibit 1) – First Draft Report of the Independent Assurance Team (April 2018)

from other relatives' experience. The forum was to be attended by a minimum number of Trust officials to allow relatives to speak openly and if on occasions it was felt to be required, other professionals would be invited to attend a meeting. Issues raised would then be taken back to the relevant people in the Trust and resolutions sought. As time passed and management changed, more and more managers began to attend and relatives found that when they raised an issue they were told "this is not the right place" or "we will discuss this outside the meeting" ... Subsequently people felt they were being put down, and the manager would not come back to discuss the issue with them so it never got resolved. Relatives became despondent, and gradually actually stopped coming. I am generally the only relative who consistently remains attending these meetings. I have often told myself I was going to stop attending these meetings but I keep going as I would not want another relative to turn up and feel overwhelmed or unsupported. I do feel that MAH management have destroyed what was initially a good communication tool, and a support network for families facing many challenges'.²⁹

- 5.32 The Inquiry also heard that families' experiences of co-production in relation to resettlement experiences varied widely. While some families felt fully involved in planning and decision-making, the majority did not. The success of resettlement often depended on the quality of communication with families, who knew the patient best.

Conclusions

- 5.33 Although co-production has been increasingly promoted in recent years, the evidence presented to the Inquiry would suggest that the prevailing culture at MAH remained one of informing patients and families, rather than working collaboratively with them. As a result, routines and strategies that were effective at home were not incorporated into hospital care, which remained standardised rather than person-centred. Moreover, a lack of co-production in policy writing and planning reinforced a standardised approach to care that benefited few, if any, patients.
- 5.34 There was a significant failure consistently to involve families, many of whom knew the patients best, in care planning and decision-making. This meant that opportunities for the provision of the best care to patients were lost and increased the risk of behavioural distress and dysregulation.

²⁹ P90's Sister Transcript – 11/10/23 – Page 94 – Line 12

- 5.35 Many families reported feeling excluded, disenfranchised or marginalised from the care of their loved ones, when they had much to offer. This meant that staff lacked deeper knowledge about patients' preferences, needs and comforts.
- 5.36 The lack of communication with relatives is likely to have led to poorer care being provided to patients through the lack of knowledge of likes, dislikes and physical necessities and comforts.

Recommendations

R17	Creating a co-produced care environment, where people with learning disabilities, families and professionals work collaboratively, requires a fundamental shift in practice. As well as organisational commitments, staff will need education and facilitation to transition to this way of working. Specific training in co-production should be designed and delivered to all those caring for people with learning disabilities and autistic people. Service users and families should be offered the opportunity to attend where appropriate.
R18	Specific processes rather than policies should be designed to ensure there is good communication with families and carers to ensure co-production takes place and is effective. Evidence of co-production should be an element of clinical audit of people's healthcare records.
R19	The 2006 Quality Standards for Health and Social Care should be amended to require HSC organisations to provide all people with learning disabilities, and if they lack capacity, their family or advocate, with the opportunity to share in all decision-making about their care plan, including assessments, treatment plans, evaluations of care and placements. The RQIA should include performance against the new standard in its announced inspections.
R20	Properly trained independent advocates should be made available to service users and families to support effective communication with staff and for raising concerns and complaints. DoH/SPPG should specify the level of advocacy services required for people with learning disabilities in the annual commissioning plan.
R21	All providers of learning disability services should appoint a human rights officer, as seen in Sheffield Health Partnership University NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust. This role should support staff and monitor the progress of the service towards a human rights-based, co-produced service.
R22	All documents relevant to the service user's experience and intended for their information must be made available in Easy Read format.

Do you see me?

'My son really loves being in the pool and it is important for movement for him, as he doesn't get much exercise. He gets a lot from trips to the swimming pool, as it is sensory stimulation and a big part of his week'

'My brother was very good on the farm. He would check the time with us, as he could not really tell the time, but then he goes out to check the cattle in the morning, that they were all healthy and he would have fed them. He would have bottle-fed some of the animals and he had his own pet lambs and calves. When one of the kittens was sick, he would go and pull some milk from the goat and feed it. Similarly, if he found a lamb suffering from cold or shock, he would draw 10cc of poitín and put it down its throat'

Chapter 6

Patients' Property and Finance

Introduction

- 6.1 The Inquiry heard from families that there were serious issues around the handling of both money and property when their loved ones were in Muckamore Abbey Hospital (MAH), and several examples are given in Chapter 1 (The Patient Experience). This included claims that money was misused by staff and that property and clothing was lost or misappropriated.
- 6.2 While some patients lack the capacity to manage their own finances and were subject to Article 116 of the Mental Health (Northern Ireland) Order 1986 (MHO) (see paragraph 6.23), some patients were deemed to have capacity to manage their own money and did so independently. Common law standards apply to the care of their property and finances and health and social care (HSC) organisations have policies that cover all patients.

Trust policies and procedures

- 6.3 Between 1993 and 2007, the North and West Belfast Health and Social Services Trust (NWBHSST) was responsible for MAH and had policies detailing the processes and record-keeping required. When the Belfast Health and Social Care Trust (BHSCT) was created in 2007 it continued to use the legacy NWBHSST policy¹ until it approved its own policies in 2015.²
- 6.4 Until around 2002, all patient cash was held centrally in the hospital's cash office. However, following complaints from patients about having to walk to the cash office to access funds, a new system was introduced. Each patient was allocated a locked drawer in a 'Bisley cabinet' on the ward, where a small amount of cash was stored.³ Ward managers were responsible for reconciling receipts with the cash

¹ Brona Shaw Transcript – 07/06/23 – Page 38

² Gordon Smyth (Organisational Module) Statement – 07/06/24 – Page 70 (Exhibit Tab 7) – BSO Internal Audit Patient's Private Property Muckamore 2019/20

³ A document cabinet with multiple drawers

held in each envelope weekly, with periodic checks conducted by a local manager.⁴

- 6.5 Larger sums of money were held by the MAH cash office when BHSCCT was formally appointed to receive and manage patient benefits.⁵ The cash office maintained a separate bank account for patients' money and administered their finances through a ledger system. It also provided a secure facility for valuable items of property.⁶
- 6.6 In 2015, BHSCCT produced a finances and private property policy specific to learning disability hospitals.⁷ This increased the number of patients randomly selected per ward for monthly monitoring checks and requiring the cash office to produce transaction and fluctuation reports.

Financial governance

- 6.7 Despite the policies, James Wilson (a project manager at the Cedar Foundation disability charity, who worked on Cranfield Ward in October 2017 for several weeks) described the process by which staff accounted for money taken out of a safe in the nurse's office as 'not overly particular'.⁸ The Inquiry heard that some families did not receive details of how money being held on behalf of patients was being spent. Staff often asked families to bring in cash for trips and outings but many did not get receipts:

'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'.⁹

'I complained to the cash office in the administration building of MAH in and around 2014/2015. I wanted to know the balance on P77's account. I was advised by a woman who was working at the administration desk at the time on the telephone that I was not entitled to this information as this was P77's money. The woman would not provide me with any details. I did not understand this as I was the person supplying the money. About a year later, I contacted the administration desk again and got to speak to a different woman who did provide me with P77's balance which was £100 at that time. I had

⁴ Miriam Sommerville Transcript – 08/06/23 – Pages 124-125

⁵ Brona Shaw Transcript – 07/06/23 – Page 43 – Line 18

⁶ Brona Shaw Transcript – 07/06/23 – Page 46 – Line 4

⁷ Chris Hagan Statement (Evidence Modules) – 20/03/23 – Page 10031 (Exhibit T08.06) – BHSCCT Patient's Finances and Private Property Policy April 2015

⁸ James Wilson Transcript – 08/02/24 – Page 22 – Line 9

⁹ P5's Mother Transcript – 29/09/22 – Page 21 (restricted)

*expected it to be a lot more given the amount of money that I was handing into MAH at the time. I recall my sons saying to me that they did not understand how other families who were less well off than us could afford to pay all of the money that I was paying into MAH every week’.*¹⁰

6.8 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.¹¹ One witness was informed that her sister’s benefits and allowances amounted to about £40,000. After her sister’s death in January 2020, the witness was informed that only £20,000 remained in the account and she was not provided with a breakdown of how the rest had been spent.¹²

6.9 Even families who held legal authority over financial matters, such as controllers or those with lasting power of attorney, described sporadic and limited access to information about their relative’s personal private property account.¹³

6.10 Some families told the Inquiry that they had simply trusted the staff, assuming money handed over would be used appropriately:

*‘I did give an envelope every week with £10 in it. This was spending money for Roberta. I put it in her bag when I handed it over to staff to let them know it was there. This was for crisps or drinks. I just took it for granted that the staff would spend it on Roberta. I wanted them to have some money to buy her things when she was out. However, I never questioned them on what they spent it on and I never got any receipts or change’.*¹⁴

6.11 Others felt that money had gone missing. One former patient described a system between 1998 and 2011 where cash withdrawal forms were signed and countersigned, but alleged that staff accessed drawers containing money and personal items without proper oversight:

‘If I wanted money for something, like if I wanted to get a takeaway meal at the weekend or buy Christmas presents, the procedure was that I had to complete and sign a form which the staff then kept as a record of the withdrawal. The form had to be countersigned by a member of Muckamore staff, normally the staff in the office in the Administration Block. I did this at the Administration Block. I recall money going missing from these drawers and disputes that patients had with staff members. I believe that this money was taken by staff

¹⁰ P77’s Mother Transcript – 20/06/23 – Page 32 – Line 12

¹¹ P110’s Mother Transcript – 28/09/23 – Page 32 (restricted)

¹² P22’s Sister Transcript – 22/09/22 – Pages 30-31

¹³ P107’s Brother Transcript – 27/09/23 – Page 110; P99’s Nephew Transcript – 14/09/23 – Page 34

¹⁴ P23’s Mother Transcript – 22/09/22 – Pages 68–69

members but they denied it. All of the staff had keys or access to keys for the drawers. As well as money, the drawers also contained things like patients' passports and their cigarettes. I do not recall the names of the people involved in these incidents. I did not see and was not aware of cameras covering the areas with the patient drawers ... One of the patients requested money but was told that there was no money in the drawer. When the patient, whose name I do not recall, questioned the member of staff, H270, the patient was told that the money had already been signed for. The patient (who I have named) indicated to me, the patient concerned, asked to see the sheet which recorded the money being removed. The sheet was not signed. That patient was able to communicate with me by writing messages but the staff did not realise that he was able to write. Following this, and similar incidents, I am of the belief that staff were dipping into the patient's money, taking what they wanted, as only staff were allowed in that area. I am also aware of issues around the signatures of patients being falsified, although I cannot recall specific dates or the names of patients or staff members involved. I do not think money went missing, I know money went missing. I recall one patient ... who told me that he had his signature falsified. I do not recall his surname'.¹⁵

6.12 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.¹⁶

6.13 Where families did receive financial records, they often found them confusing and opaque:

'Our family did have a concern with the ability to access and use Bryan's money. MAH staff might have bought things that were not for Bryan's benefit. A member of staff, whose name I do not recall, suggested to our brother, Aidan, that Bryan's money would need to be topped up as she had purchased an expensive aftershave for him costing around £80 and his money was running low. We did not see this staff member again after this incident, nor was there any evidence of it being purchased. I found the whole thing unusual as family always provided toiletries and clothing for Bryan. My brother Aidan and I took over Bryan's financial affairs as financial controllers in 2014 when our mother became ill. I requested financial statements from the Belfast Trust up to and including the final closing statement for 2014. At that time Bryan's account with the Belfast Trust inexplicably had approximately £1,000 in it. The financial documents provided by the Belfast Trust included a transaction account kept by MAH. It was all recorded using codes so I could not see how his money was being spent'.¹⁷

¹⁵ P76 Transcript – 12/09/23 – Pages 21-22

¹⁶ P54's Mother Transcript – 13/10/22 – Page 26 (restricted)

¹⁷ P90's Sister Transcript – 11/10/23 – Page 110

Property

- 6.14 Families also described how clothes were not well maintained.¹⁸ They reported that personal clothing and bedding and toys also went missing.¹⁹ The Inquiry heard from a number of families that property often went missing, causing distress to their loved ones. One family member told us:

'All the nice things that we bought P28 were gone. All his cars and toys too. P28's Barney toy, which was so precious to him, was gone. We never got any explanation for this. I bought some expensive Tonka trucks that were supposedly indestructible, and they disappeared. We reported this to the nurse in charge, or the nurse who was on duty, but there was no explanation'.²⁰

- 6.15 Another witness told the Inquiry:

'I recall one further incident. I am not sure of the date or who was involved, but I received a telephone call from a person who called themselves the coordinator on the ward. I do not recall her name or the date that this happened. The woman explained that she had been clearing out P17's wardrobe and that a lot of his clothes were done. I asked what I could do to help. She said that she needed to buy new clothes for P17, and asked that I bring up £300 and put it in an envelope and leave it on the ward. She said that she would go to town and she would buy P17 new clothes. I recall that this was shortly before P17's birthday, which is the 21st April, so I went out and bought four new shirts. When I brought these up to the hospital, I opened P17's wardrobe to put them in. I found that he had lots of good clothes'.²¹

- 6.16 A system was introduced for recording the deterioration and disposal of personal items and a ward 'condemned book' was started. However, as staffing levels changed and temporary staff increased, this process was increasingly overlooked as new staff were unaware of the procedure.²²

- 6.17 In contrast, inspections by the Regulation and Quality Improvement Authority (RQIA) revealed a more mixed picture. An unannounced RQIA inspection of Finglass Ward in September 2011 identified concerns about financial controls in relation to patients' property, but a November 2011 RQIA patient experience

¹⁸ P1's Sister Transcript – 28/06/22 – Page 97

¹⁹ P107's Brother Transcript – 27/09/23 – Page 108 – Line 3; P54's Mother Transcript – 13/10/22 – Page 19 (restricted)

²⁰ P28's Father Transcript – 28/09/22 – Page 97 – Line 14

²¹ P17's Brother Transcript – 12/10/22 – Page 17

²² A12 Transcript – 13/05/24 - Page 39 – Line 10

review of Killead Ward found that all patients understood how to access their money and expressed no concerns about its management.²³

- 6.18 During an announced visit to the Psychiatric Intensive Care Unit (PICU) in July 2013, the RQIA observed strong financial governance practices. Patient cash was checked and countersigned by two staff members twice daily, with additional weekly checks by the deputy ward manager and monthly checks by the operational manager.²⁴ Inspectors noted that receipts were attached to forms and records were appropriately maintained.
- 6.19 An RQIA review in December 2013 of the management of patient finances across all BHSCT mental health and learning disability inpatient facilities noted that at MAH twice-daily checks of ward cash holdings were made at the changeover of staff shifts. The operations manager conducted a monthly audit and reconciliation of patients' money retained on the ward against the cash ledgers. The cash office on site at MAH had issued monthly statements to the ward of all transactions on the Patients' Private Property (PPP) account. However, the RQIA noted there was no process to record when relatives removed valuable items and no record of which staff accessed keys to secure storage. The RQIA recommended that BHSCT create a procedure for authorising payments to relatives for large purchases and/or recurrent sums of monies.²⁵
- 6.20 BHSCT introduced a pro forma that required the names of the two staff who checked and countersigned patient cash and the reason for opening the Bisley drawers to be recorded. The Trust also began revising its transport charging policy and committed to updated training for all staff on handling patient finances.²⁶
- 6.21 By July 2014, the RQIA found all staff on Moylena Ward had received up-to-date training in handling patients' monies. Patients were no longer expected to purchase activity or occupational therapy materials as part of their therapeutic activities. However, the recommendation to record staff access to the Bisley

²³ RQIA – Patient Experience Report, Killead – 29/11/11

²⁴ RQIA - Mental Health and Learning Disability, Unannounced Inspection, Cranfield ICU – 01/07/13

²⁵ RQIA - Monitoring of Patients Finances in Mental Health & Learning Disability, Inpatient Facilities (Article 116 Mental Health (NI) Order 1986) Belfast Health & Social Care Trust December 2013

²⁶ BHSCT response to RQIA Financial Inspections BHSCT Report and QIP December 2013

drawer, and the reason for access, was not met.²⁷ In contrast, all the 2013 recommendations were implemented on Kilead Ward by 2014 and almost entirely on Cranfield Ward by 2015,²⁸ with only one patient on Cranfield who had not had their financial capacity assessment completed in full by November 2015.²⁹

- 6.22 Further RQIA recommendations were made in July 2016 regarding cash management on Erne Ward. A further unannounced inspection in 2017 found that financial transactions and the storage of patient money were being handled in accordance with Trust policy.³⁰

Article 116 and Article 107 of the Mental Health Order 1986

- 6.23 The management of the finances of patients detained under the Mental Health (Northern Ireland) Order 1986 (MHO) is governed by Article 116. This legislation applies when a patient is deemed incapable, by reason of mental disorder, of managing and administering their property and affairs. In such cases, an HSC trust may receive and hold money or valuables on the patient's behalf. Any use or disposal of these assets must be for the patient's benefit, with regard given to the sentimental value that any article may have for the patient, or would have but for their mental disorder.³¹
- 6.24 In 2009, the Department of Health, Social Services and Public Safety (DHSSPS) issued guidance through 'Misappropriation of Residents' Monies – Implementation and Assurance of Controls in Statutory and Independent Homes' (Circular 57/2009), and since September 2012 Trusts have been prohibited from holding more than £20,000 on behalf of any one patient without the consent of the RQIA. These restrictions do not apply where a controller has been legally appointed to manage the patient's affairs.³² Where patients received benefits but lacked mental capacity, an 'appointee' could be requested from the Department for Work and

²⁷ RQIA - Mental Health and Learning Disability- Unannounced Inspection, Moylena - 08 & 09/07/14

²⁸ RQIA - Mental Health and Learning Disability, Unannounced Inspection, Donegore -18 &19/11/14; RQIA - Mental Health and Learning Disability, Unannounced Inspection Cranfield Men - 12 & 13/01/15

²⁹ RQIA - Mental Health Inpatient Inspection Report, Cranfield Ward 2 - 28 to 30/11/16

³⁰ RQIA - Unannounced Follow Up Inspection Report, Erne Ward 2 - 4 & 05/09/17

³¹ Chris Hagan Statement (Evidence Modules) – 20/03/23 – Page 9910 (Exhibit T08.01) – RQIA (2014) Monitoring of Articles 116 of The Mental Health (NI) Order 1986 2013/2014

³² Chris Hagan Statement (Evidence Modules) – 20/03/23 – Page 9910 (Exhibit T08.01) – RQIA (2014) Monitoring of Articles 116 of The Mental Health (NI) Order 1986 2013/2014

Pensions to act on their behalf. In 2019, BHSCT was acting as the appointee for 13 patients.³³

- 6.25 The MHO defined a role for the Mental Health Commission (MHC), later transferred to RQIA in 'preventing or redressing loss or damage to patients' property'.³⁴ The Order also imposed a requirement on the Trust to seek consent of MHC, later RQIA, for retention of patient monies above a specified amount.³⁵ That in turn gave rise to a responsibility on the part of MHC to monitor the arrangements put in place by Trusts to safeguard patients' monies. The Inquiry was unable to obtain a clear picture of how this responsibility was discharged in practice. The Commission's annual report for 2008 recorded:

*'In order to fulfill its commitment the Commission normally carried out an annual review of the financial position of each patient who came within Article 116 (i). As Chief Executive I learnt in April 2008 that the Secretariat had been instructed to cease all work on the annual review of patient monies. This matter was reported to the Audit Committee and the full Commission in May 2008. Arrangements have been made to reinstate the annual review for 2008/09'.*³⁶

The former interim Chair of MHC who gave evidence to the Inquiry was unable to provide further detail of this matter.³⁷

- 6.26 In November 2008, a joint meeting between the MHC Visiting Committee and the RQIA (prior to the transfer of MHC's functions to the RQIA in April 2009) agreed that the MHC would write to all Trusts confirming they could manage the accounts of those patients falling under Article 116 who held more than £5,000. A full list of such accounts was to be provided to the RQIA for review the following year.³⁸ RQIA noted that, as of March 2010, 222 patients across BHSCT services met the Article 116 criteria and held over £5,000 in their accounts.³⁹ The Executive Director of Finance at BHSCT had responsibility for good governance around Article 116, overseen by the Audit Committee. RQIA was informed that no internal

³³ Gordon Smyth (Organisational Modules) Statement – 07/06/24 – Page 76 (Exhibit Tab 7) – BSO Internal Audit Patient's Private Property Muckamore 2019/20 – Page 76

³⁴ Mental Health (NI) Order 1986, Article 86

³⁵ Mental Health (NI) Order 1986, Article 116

³⁶ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 87 (Exhibit 7) – 12th Annual Report and Accounts 2007-2008

³⁷ Paul McBrearty Transcript – 20/10/24 – Page 42

³⁸ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 26 (Exhibit 3) – Note of the meeting of the Visiting Committee held on 17th November 2008

³⁹ MAHI – Additional Materials Referenced Bundle – Page 287 (Overview Report of Monitoring by RQIA of Article 116 Payments under the Mental Health (Northern Ireland) Order 1986 from 1st April 2009 - 31st March 2010 Page 10)

audit of patient monies addressing the statutory Article 116 had been conducted in inpatient facilities during the 2009/10 financial year,⁴⁰ despite its predecessor, NWBHSST, having carried out regular audits.⁴¹ There was no evidence that it had monitored compliance with the safeguards required under Article 116.

- 6.27 In January 2012, BHSCT confirmed that no audits of the management of patients' monies in line with Article 116 had been undertaken during the 2010/11 financial year either. Nor did the Trust provide any alternative assurance data. In response, the RQIA wrote in July 2012 seeking assurances that robust monitoring would be introduced and requesting confirmation that all money and valuables had been returned to the 23 patients discharged between 2009 and 2011.⁴²
- 6.28 By October 2012, 39 patients in MAH each had more than £20,000 in their Trust-held account, with balances ranging from £20,599 to £47,767,⁴³ and the RQIA noted that some patients required significant support to manage their finances.
- 6.29 It is unclear how these patients' finances were monitored between 2012 and 2014, but the RQIA observed in 2019 that a financial audit had last been completed in 2015.⁴⁴

RQIA Improvement Notice 2019

- 6.30 An unannounced RQIA inspection in February 2019 identified serious concerns about financial governance at MAH.⁴⁵ It is unclear how Maureen Edwards (then BHSCT Director of Finance) responded, however an unannounced follow-up inspection in April 2019, and a focused review in July 2019, continued to assess how BHSCT was fulfilling its responsibilities under Articles 107 and 116 of the MHO 1986.⁴⁶

⁴⁰ MAHI – Additional Materials Referenced Bundle – Page 287 (Overview Report of Monitoring by RQIA of Article 116 Payments under the Mental Health (Northern Ireland) Order 1986 from 1st April 2009 - 31st March 2010 Page 9)

⁴¹ Miriam Somerville Transcript – 08/06/23 – Pages 124-125

⁴² Data furnished by RQIA to the Inquiry

⁴³ Data furnished by RQIA to the Inquiry

⁴⁴ RQIA - Unannounced Inspection Report - Muckamore Abbey Hospital – 26, 27 & 28/02/19 - Page 24

⁴⁵ MAHI – Additional Materials Referenced Bundle – Page 109 (BHSCT Board Confidential Meeting Minutes – 07/03/19)

⁴⁶ RQIA - Announced Follow up Finance Inspection – Muckamore Abbey Hospital – 01/07/19

6.31 As a result of these inspections, the RQIA issued an Improvement Notice on 16 August 2019.⁴⁷ The inspection team had found missing documentation relating to appointee arrangements for five patients. No referrals had been made to the Office of Care and Protection for patients whose accounts exceeded £20,000, as required under Article 107 of the MHO 1986. There was no evidence of plans to seek the required consent from the RQIA to hold patient balances above £20,000. Moreover, there was no process in place to regularly review patients' benefits entitlements or to identify changes in their financial circumstances. Financial documentation was inconsistent, there was non-completion of patients' property records and there were gaps in weekly and monthly ledger checks at ward level by senior managers.⁴⁸

6.32 The RQIA issued an Improvement Notice requiring the BHSCT to:

- Comply with Articles 107 and 116 of the MHO 1986;
- Ensure appropriate documentation when acting as appointee for patient benefits and ensure patient is receiving the correct entitlements;
- Institute a robust system to ensure appropriate records are kept, ensure staff responsible for income and expenditure are appropriately trained, and require senior staff to conduct ward-level audits in line with Trust policy;
- Conduct a comprehensive audit of financial controls relating to patients at MAH.⁴⁹

We discuss the Trust Board's response to the Improvement Notice in Chapter 13 (Senior Management and Trust Board Governance).

6.33 In April 2020 the RQIA lifted the Improvement Notice for Financial Governance that it had issued in August 2019.⁵⁰

6.34 The RQIA made an unannounced visit to MAH in October 2020, after which it recommended that BHSCT ensure that all patients were subject to a monthly audit

⁴⁷ RQIA Improvement Notice Ref IN000004 – 16/08/19

⁴⁸ RQIA - Announced Follow up Finance Inspection – Muckamore Abbey Hospital – 01/07/19

⁴⁹ RQIA Improvement Notice Ref IN000004 – 16/08/19

⁵⁰ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 1211 (Exhibit PMcN1 Tab21.01) – 21 September 2020 Muckamore Abbey Hospital – Update to Trust Board

of monies and valuables by ward managers and an audit at least annually, conducted by the assistant service manager. As a result, a process audit of different patients' finance records each month was proposed.⁵¹

Conclusions

- 6.35 The Inquiry found significant inconsistencies in how patient property and finances were managed across wards and over time at MAH. Patients and their families raised serious concerns about the handling of clothing and personal belongings as well as the use and monitoring of patients' money.
- 6.36 While policies and procedures were in place, the BHSCT, after assuming responsibility for MAH from the NWBHSST, failed to implement robust assurance mechanisms to mitigate an obvious risk.
- 6.37 In a setting where patient money, property and finances were vulnerable to misuse, there was no consistent, transparent system adopted to reassure patients and families that money and belongings were fully and properly accounted for.
- 6.38 While there were sporadic checks within MAH, there appeared to be little second-tier checks by BHSCT staff from outside the Antrim site.
- 6.39 There was a lack of effective auditing to ensure that the Trust's policies and procedures in relation to Article 116 were being properly followed. This failure likely contributed to inconsistent application of checks and controls, increasing the risk of misuse or abuse of patients' property, including cash, clothing and other personal belongings. Robust oversight mechanisms should have been in place to safeguard these items and uphold patient trust.

⁵¹ RQIA - Unannounced Inspection Report – 27 & 28/10/20

Recommendations

R23	All organisations taking responsibility for property and/or finance for people with learning disabilities and autistic people should institute regular checks of adherence to their policies. This includes local checks, corporate checks and periodic internal audit checks.
R24	Policies must be specific as to records to be kept and for routes to disclosure for relevant family members and people with learning disabilities and autistic people themselves where possible.
R25	The records kept must be easy to manage by staff and easily comprehensible to others, including people with learning disabilities and autistic people, carers and relatives.
R26	Information about the use of cash and other property and six-monthly accounts (or such period as appropriate upon discharge of the person) should be available to the service user concerned where possible and to the family where appropriate. Where appropriate an Easy Read version should be made available.
R27	RQIA should examine the provider organisation's internal assurance processes and make recommendations where they are insufficient.

(This page is intentionally left blank)

'He loves driving, he loves out driving, mm-hmm. We would drive for hours just - we've drove to Donegal and back without stopping, so we have, just to get him out in the car. He loves it....And he knows everywhere. He's very good at instant street view. He goes from our house right over the top into Glengormley and around to his aunt's house and then down into Carrick and back again. He just - he loves it, so he does...'

'Well, she couldn't really put sort of words together, you know, she would have just pointed and she could have said "mum" and "dad", and she called me "Kaki" or something. She'd all different sort of wee words for -- but we all knew what she was saying. It was just that she could -- her speech wasn't very, very good. So we accepted that and just we went along with it and that was it'

Chapter 7

Restrictive Practices

Introduction

- 7.1 The use of restrictive practices, particularly physical restraint, the use of ‘pro re nata’ (PRN) medication and seclusion, at the hospital has been a deeply contentious issue, and one about which the Inquiry received substantial evidence. Across several wards, there emerged a concerning pattern of overuse of physical restraint, in circumstances where it was either unwarranted or where alternative de-escalation strategies may have worked preventatively. Similarly, seclusion was employed inappropriately on a considerable number of occasions. While the Panel was unable to quantify the extent of misuse of either restraint or seclusion, the qualitative evidence presented was significant.
- 7.2 A 2019 Care Quality Commission (CQC) interim review of the use of restraint and seclusion for people with a mental health problem, learning disability and/or autism in hospitals in England found that a high proportion of people in segregation had autism, that some hospital wards did not have a built environment that was suitable for people with autism and that many staff who worked directly with the people in segregation were unqualified.¹ The Inquiry was told many MAH staff did not have behavioural training so were not equipped to use diversionary strategies to divert patients away from causing harm to themselves, other MAH staff, other patients or property.²
- 7.3 To understand the use of restrictive practices at MAH, it is essential to be clear on what we mean by this terminology. This chapter begins by defining these terms and identifying the broader legal and policy context influencing the use of restraint and seclusion in learning disability settings.

¹ Care Quality Commission (2019) Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability or autism: Interim report. CQC, Newcastle upon Tyne – <https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people>

² Christine Keenan Transcript – 13/11/23 – Pages 22-23

- 7.4 Staff told the Inquiry their understanding of the term ‘restrictive practice’ had expanded over the years:

*‘The term “restrictive practice” has expanded in recent years to include locked doors and restriction from items. An externally locked door or doors that were locked within the building was for the purpose of keeping patients safe and to avoid the risk of absconding. Going back 20 years, I think some of this was custom and practice. The practice has evolved over time towards an increased movement of patients around wards’.*³

- 7.5 When considering the evolution of restrictive practices at MAH, it is important to note that staff were working to different policies and procedures across the 22-year time frame considered by the Inquiry.

Defining restrictive practices: Key legal and policy context

- 7.6 In March 2023 (after the conclusion of the Inquiry’s Terms of Reference (ToR)) the Department of Health (DoH) issued a key document: the ‘Regional Policy on the use of Restrictive Practices in Health and Social Care Settings’ in Northern Ireland, which included the regional operational procedure for the use of seclusion.⁴ This policy marked the culmination of over two decades of evolving definitions and guidance on restrictive practices in health and social care.
- 7.7 The 2023 regional policy defines restrictive practices as ‘an umbrella term’ that encompasses an ‘entire range of interventions that are considered restrictive and which infringe a person’s rights’.⁵ They are interventions that ‘limit a person’s movement, day to day activity or function’.⁶ This echoes the UK Government’s definition, which describes restrictive practices as ‘planned or reactive acts that restrict an individual’s movement, liberty and/or freedom to act independently’.⁷

³ H189 Statement – 29/05/24 – Pages 25-26

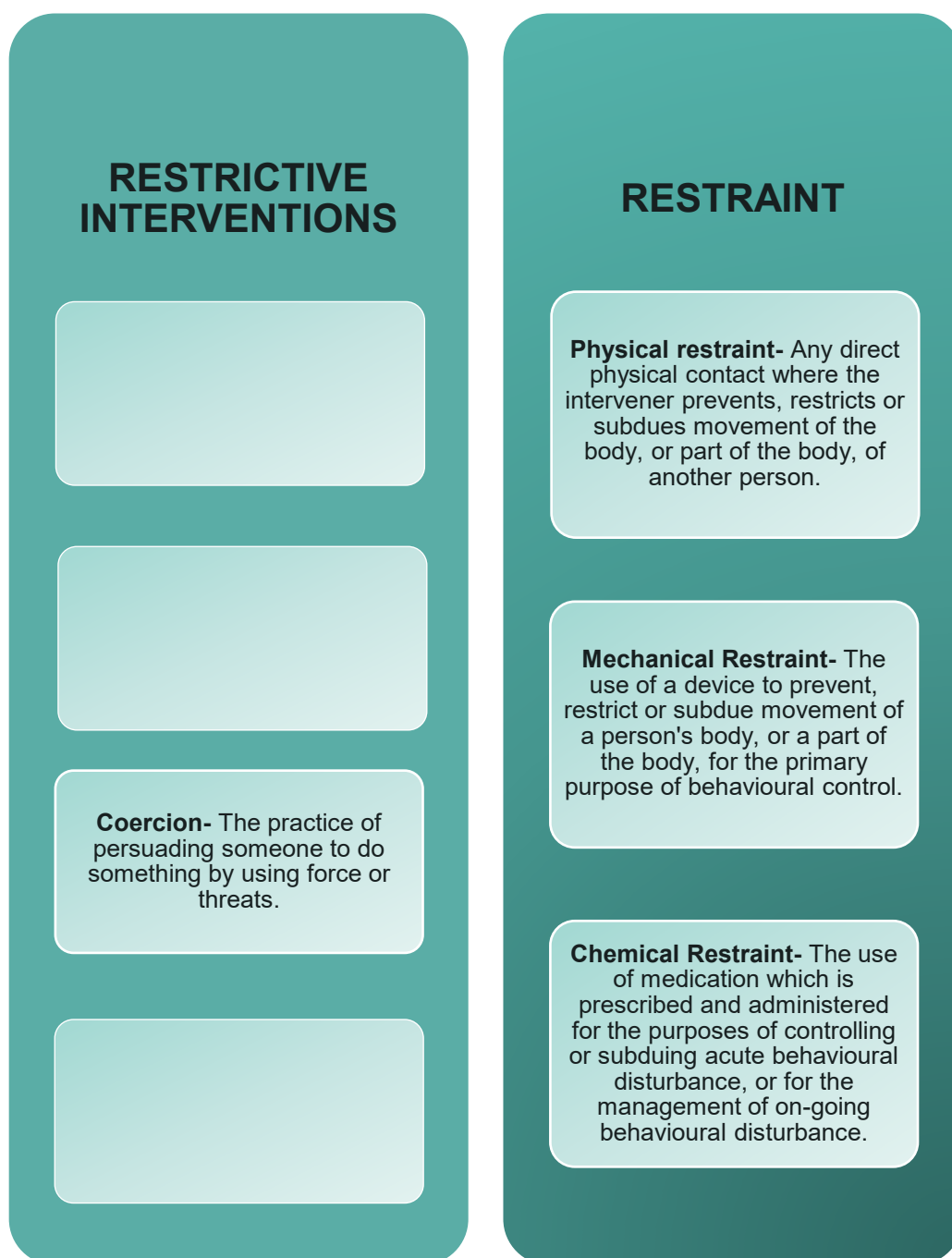
⁴ Department of Health (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And regional operational procedure for the use of Seclusion. DoH, Belfast – www.health-ni.gov.uk/sites/default/files/publications/health/doh-Regional-Policy-on-the-use-of-Restrictive-Practices-in-Health-and-Social-Care-Settings-March-2023.PDF

⁵ DoH (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings – Page 6

⁶ DoH (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings – Page 9

⁷ HM Government (2019) Reducing the Need for Restraint and Restrictive Intervention. HM Government, London – <https://assets.publishing.service.gov.uk/media/5d1387e240f0b6350e1ab567/reducing-the-need-for-restraint-and-restrictive-intervention.pdf>

7.8 Restrictive practices are subdivided into restrictive interventions and restraint.⁸



⁸ DoH (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings – Page 9

- 7.9 According to the 2023 guidance, evidence supporting the therapeutic benefits of restraint and seclusion is limited.⁹ Best practice therefore requires that:

*‘restrictive interventions, restraint and seclusion should only be used as last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others’.*¹⁰

- 7.10 Seclusion is a form of restrictive intervention and is defined as:

*‘The forcible denial of the company of other people by constraint within a closed environment’.*¹¹

This is likely to involve confinement in a room without an individual being able to freely exit. The Mental Health (Northern Ireland) Order 1986 (MHO) Code of Practice notes that seclusion ‘is an emergency management procedure’, to be used only in the ‘short term’ and as a ‘last resort’, once all other behavioural management strategies have been exhausted.¹² The DoH’s 2023 regional policy explicitly states that:

*‘Seclusion is always a deprivation of liberty and must therefore have a legal authority prior to being carried out. Secluding a person without a legal authority is unlawful’.*¹³

- 7.11 In 1999, the Eastern Health and Social Services Board (EHSSB) produced a report on the use of seclusion, with a particular focus on MAH,¹⁴ which distinguished seclusion from ‘time out’, the latter being a therapeutic intervention defined by the Mental Health Commission (MHC) as:

*‘a behavioural procedure involving the removal of an individual from a rewarding to a non-rewarding situation as a consequence of behaviour which has been specified as undesirable’.*¹⁵

- 7.12 The EHSSB report observed that the use of seclusion fluctuated across the 1990s and was limited to a small number of patients. While no evidence of abuse was

⁹ DoH (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings – Page 6

¹⁰ DoH (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings – Page 2

¹¹ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 7768 (Exhibit BW124) – EHSSB Report on the Use of Seclusion with particular emphasis on Muckamore Abbey Hospital June 1999

¹² Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 7785 (Exhibit BW125) – DHSS MHO 1986 Code of practice; Page 7970 (Exhibit BW126) Example of HSST Policy of Seclusion; Page 8063 (Exhibit BW128) – Regional Policy on the Use of Restrictive Practices in HSC Settings And Regional Operational Procedure for the Use of Seclusion Consultation Document

¹³ DoH (2023) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings – Page 4

¹⁴ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 7765 (Exhibit BW124) – EHSSB Report on the Use of Seclusion, with a particular focus on Muckamore Abbey Hospital June 1999

¹⁵ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 7768 (Exhibit BW124) – EHSSB Report on the Use of Seclusion, with a particular focus on Muckamore Abbey Hospital June 1999.

found at that time, it was noted that the MAH courtyard was sometimes used when a patient required seclusion and the designated seclusion room was occupied.¹⁶ Following this, a requirement was introduced to record instances of courtyard use for seclusion purposes.

- 7.13 The Department of Health, Social Services and Public Safety (DHSSPS) published 'Guidance on Restraint and Seclusion in Health and Personal Social Services' in August 2005 and further guidance was issued in 2010, under the title 'Promoting Quality Care – Good Practice in the Assessment and Management of Risk in Mental Health and Learning Disability'.¹⁷ This emphasised the need for professionals to consider the impact of interventions on an individual's human rights.
- 7.14 Following the revelations of abuse at Winterbourne View Hospital in England, the DoH Chief Social Work Officer shared the English Department of Health's 2012 response, 'Transforming Care', with departmental policy and professional leads in 2013.¹⁸
- 7.15 Despite the issuance of guidance, the Regulation and Quality Improvement Authority (RQIA) 2013 overview report on safeguarding of children and vulnerable adults in mental health and learning disability hospitals found that, although all health and social care trusts (HSCTs) had policies and procedures in place for the management of restrictive interventions, further staff training was required.¹⁹ A 2016 audit found that the DHSSPS 2005 guidance on restraint and seclusion had not been used to inform Belfast Health and Social Care Trust (BHSCT) policies, although the Southern Health and Social Care Trust (SHSCT) had used this guidance to inform its approach.²⁰

¹⁶ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 7778 (Exhibit BW124) – EHSSB Report on the Use of Seclusion, with a particular focus on Muckamore Abbey Hospital June 1999

¹⁷ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/2023 – Page 7892 (Exhibit BW126) – Human Rights Working Group on Restraint and Seclusion – Guidance on Restraint and Seclusion in Health and Personal Social Services August 2005; Page 7656 (Exhibit BW123) – Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010

¹⁸ Sean Holland Statement – 28/06/24 – Page 62

¹⁹ Michael McBride Statement (Organisational Modules) – 28/06/24 – Page 1224 (Exhibit 49) – RQIA Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in NI Overview Report February 2013

²⁰ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 1665 (Exhibit T07.01) – Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust

- 7.16 The Mental Capacity Act (Northern Ireland) 2016 (MCA) provides the statutory framework for the use of deprivation of liberty (DoL) including restraint, for individuals aged 16 and over who lack capacity to consent. This came into use in practice on 02 December 2019. From this date, a legal authority must justify the use of restrictive practices, from which point use of restrictive practices requires legal authority.²¹ Without such authority the use of restraint could amount to an offence against the person and may also breach Article 3 (prohibition of torture), Article 5 (the right to liberty) and Article 14 (prohibition of discrimination) of the Human Rights Act 1998.²²
- 7.17 The lawful use of restraint and DoL may be authorised under the MHO 1986, the MCA 2016 or by an order from a court. The MHO authorises patients to be detained for assessment for up to 14 days (Article 4) or for treatment for up to six months initially (Article 12) or, in an emergency where a place of safety is required, for 48 hours. Patients who have not been detained under one of these articles (known as voluntary patients) may be detained by a registered mental health or learning disability nurse for up to six hours pending assessment by a psychiatrist (Article 7). In emergency situations, the common law defence of necessity may be relied upon to apply restraint for the minimum period necessary.²³ The Inquiry heard that registered nurses at MAH did use Article 7 at times.²⁴
- 7.18 Enhanced observations are not covered by the MHO 1986, but they are addressed in the Mental Health Act 1983 Code of Practice (2015).²⁵ Enhanced observations are when one or more members of staff must be in close proximity to a named patient, sometimes continuously. A 2018 independent assurance team review found that the BHSCT levels of supervision/observations within learning disability inpatient services had been approved in 2013 and should have been reviewed in 2016.²⁶

²¹ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 61

²² Professor Roy McClelland Statement – 03/03/23 – Page 1185 (Exhibit T02.09) – The Bamford Review – Living Fuller Lives

²³ Mark McGuicken 1st Statement – 13/02/23 – Page 3194 (Exhibit MMcG-64) – Human Rights Working Group on Restraint and Seclusion – Guidance on Restraint and Seclusion in Health and Personal Social Services – August 2005

²⁴ Eilish Steele Transcript – 04/06/24 – Page 27 – Line 10

²⁵ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 1580 (Exhibit T06.01) – Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust

²⁶ Owen Barr Statement (Evidence Modules) – 25/04/24 – Page 37 (Independent Assurance Team Final Report)

The evolution of restrictive practices at MAH – physical restraint

- 7.19 In the 1990s, the Eastern and Northern Health and Social Services Board introduced formal training in dealing with patient aggression. ‘Care and responsibility’ training was commissioned from Ashworth Hospital in Liverpool, accompanied by the development of local policies.²⁷ A local cascade training programme was also implemented.²⁸
- 7.20 A number of staff witnesses told the Inquiry that prior to the 1990s, there had been no formal training or oversight of what would later become known as restrictive practices.²⁹ However, following the introduction of structured training in 1996, concerns were raised by colleagues regarding the conduct of three staff members, who were subsequently dismissed.³⁰
- 7.21 Care and responsibility training permitted a certain amount of pain to be applied as part of physical restraint techniques. Around 2010, it was replaced by Management of Actual or Potential Aggression (MAPA) a programme developed by the Crisis Prevention Institute (CPI).³¹ MAPA emphasised safe, straightforward holds that reduced the risk of patient injury, and each ward at MAH had a CPI-accredited instructor who completed annual update training from CPI to maintain their licence.³² MAPA training was initially provided by Positive Options and later by the Health and Social Care (HSC) Clinical Education Centre. Training was mandatory and was repeated annually.³³ The use of MAPA with individual patients was discussed by multidisciplinary teams (MDTs) and noted in care plans.³⁴ The decision on when to use MAPA lay with registered nurses. Unregistered staff may have begun MAPA restraint but would then activate their alarm to summon assistance from registered staff.

²⁷ Eilish Steele Statement – 23/05/24 – Page 31

²⁸ Clinton Stewart Statement – 02/05/24 – Page 3

²⁹ Clinton Stewart Statement – 02/05/24 – Page 3; Brendan Ingram Statement – 25/07/24 – Page 5

³⁰ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/2023 – Page 7775 (Exhibit BW124) – EHSSB Report on the Use of Seclusion with particular emphasis on Muckamore Abbey Hospital June 1999

³¹ Eilish Steele Statement – 23/05/24 – Page 32

³² A12 Statement – 20/05/24 – Page 8; Eilish Steele Transcript – 04/06/24 – Page 30 – Line 13; Clinton Stewart Transcript – 10/06/24 – Pages 47-48

³³ A12 Statement – 20/05/24 – Page 7

³⁴ Bert Lewis Statement – 10/07/24 – Page 12

- 7.22 New staff received physical intervention training first, with behavioural support techniques following later:

'There were two areas of concern that I had. Firstly, for new staff, the first training and induction they get is physical training, MAPA training, although it is an excellent program, it is more concerned with physical intervention, so the first training they go through is the physical side of dealing with patients. Secondly, because of the staff shortages, we had to combine fire training and personal relationship training sessions and these sessions were in addition to their MAPA training'.³⁵

- 7.23 However, in October 2020, Rodney Morton, (then Executive Director of Nursing and Allied Health Professionals at the Public Health Agency (PHA)) contacted the CPI and discovered that MAPA had since been updated to focus more on responding to distress and conflict resolution, and the CPI had created Prevention First and Safety Intervention training. This had not yet been adopted by the training provider in Northern Ireland and was subsequently introduced into undergraduate nurse education in Northern Ireland in autumn 2021.³⁶ It is now mandatory for all MAH staff to complete it within the first 12 weeks of employment.

The evolution of restrictive practices at MAH – seclusion

- 7.24 In cases involving voluntary patients, it was possible for the patient to become temporarily detained using powers under the MHO 1986 to enable the use of seclusion. A doctor or nursing officer could make this decision,³⁷ but this may not have proceeded to a long-term detention order.³⁸

- 7.25 The Inquiry heard that seclusion rooms had been in existence at the hospital for some time before the period covered by our ToR. The rooms had undergone various changes over time:

'Seclusion was another form of restrictive practice. I recall when I worked in Fintona North in 1983 there was a seclusion room which was a single bedroom with very little in it other than a bed frame and a mattress. Again, the use of seclusion could only be used if it was prescribed by the consultant for an individual patient. It was used as a last resort to stop patients harming themselves or other people around them such as other patients, staff or visitors. I recall that staff had two minds on the use of seclusion. It was sad that it needed to be used but it was the last resort if everything else failed. It

³⁵ Barry Mills Statement – 04/06/24 – Page 19

³⁶ Rodney Morton Statement (Organisational Modules) – 31/05/24 – Pages 27-28

³⁷ Eilish Steele Statement – 21/05/24 – Page 29

³⁸ Eilish Steele Transcript – 04/06/24 – Page 27 – Line 23

was used for the least amount of time possible. When seclusion was being used the nurse in charged had to telephone the doctor who would have questioned as to why you were using seclusion. If seclusion was used it was recorded in the care plan and in the clinical notes for the patient. The time seclusion started and the time it ended would all be recorded. We also had to record how the patient reacted whilst in seclusion. I recall that a seclusion record book was introduced at some time in the 1990s and then a seclusion care plan was introduced sometime in the 2000s. This was a detailed and comprehensive document for each patient. The nurse would have initiated the seclusion but it always had to be reported to the doctor. A nurse had to remain outside the seclusion room at all times and had to do a visual check every 15 minutes by engaging with the patient and making sure the patient knew that the nurse was there. There were prescribed timeframes, the specific details I do not recall, however if a patient had been in seclusion for more than two hours there had to be a review of the decision to maintain the seclusion by a medical officer. If the patient was in seclusion for four hours, both the nursing officer and the medical officer had to visit the ward. I believe that all of the staff in MAH followed the seclusion policy and procedure. The practice of nurses and ward staff was checked by senior management. The number of times that seclusion was used on a ward was collated into the weekly and monthly reports and we discussed this at multidisciplinary meetings’.³⁹

- 7.26 Eilish Steele (former staff nurse and latterly a senior nurse manager), also described how seclusion had been used in Fintona North:⁴⁰

[Prof Murphy]: ‘Can I just ask, given what you’ve just said about all the effects the environment had on patients, it sounds like for some patients those effects were so painful and difficult to deal with that they lost it –

[Ms Steele]: Yeah.

[Prof Murphy]: – ended up secluded and then ended up detained, which makes it sounds like the hospital is making people worse.

[Ms Steele]: Yeah.

[Prof Murphy]: Is making them detained because the conditions are so bad?

[Ms Steele]: Yes. I understand what you’re saying and how that might appear, but I think it’s to emphasise that this person who was voluntary, it was a question of immediate alert to a consultant and to senior management that this is a voluntary patient who came in voluntary and we were placing them in. And I accept that the trigger may well have been the environment, but still the way that the person was presenting at that time, it was felt to be the only safe way to contain them. As I said, it wasn’t that it would have been immediate detention there and then for a five-minute situation. That still would have been reported through and discussed and discussed in-depth at the multidisciplinary meeting. But if something was requiring a longer period of time, or happening very often then, the patient’s legal status was considered.

[Prof Murphy]: I mean, I think the tricky thing is that it’s making it sound as though the hospital was making people worse, and maybe it was. Was there

³⁹ Eileen McLarnon Transcript – 06/02/24 – Page 58 – Line 16

⁴⁰ Eilish Steele Transcript – 04/06/24 – Pages 21-24

no discussion of how to tackle the environmental issues that were bringing it about, like the overcrowding, like the mix of patients, like the level of noise?

[Ms Steele]: Yes, there was, and always was what could and would we do any different. That was exactly why we pushed hard for the new hospital and the benefits of the PICU [Psychiatric Intensive Care Unit] in Cranfield that would deflect. I mean, that was one of the things of the focus groups that was very much talked about within the de-escalation of aggression and the lack of MAPA training would have been the triggers, how to avoid having to use the seclusion. But with the opportunities of the buildings, of the number of patients that we had at that time, there was no alternative'.⁴¹

- 7.27 From 1999, the MAH seclusion policy had required patients be checked every 15 minutes, usually by a healthcare assistant (HCA). The 2021 policy introduced more stringent requirements, including continuous monitoring by a registered nurse.⁴² A senior nurse manager and a doctor needed to be contacted at the point at which seclusion commenced. It also required a doctor to attend and physically observe the patient within one hour of seclusion commencing. If the patient fell asleep, seclusion would be terminated immediately.⁴³
- 7.28 The MHC's 2001 visit to MAH noted that policies on seclusion, management of aggressive and violent patients, and levels of supervision and observation had been formally approved in October 2000.⁴⁴
- 7.29 Before the introduction of electronic records, seclusion was recorded using dedicated audit forms and patient notes and in daily reports submitted to the nursing officer. The nursing officer recorded names, dates and times of each episode of seclusion. Additionally, the Evaluating Quality Care (EQC) audit tool monitored seclusions by ward, while weekly core/management reports highlighted seclusion data of individual patients.⁴⁵ The use of restrictive practices was also required to be reported on an incident form (initially on paper and later via the software programme Datix). These forms detailed what factors precipitated the intervention, the individuals involved and the specific restrictive techniques used.

⁴¹ Eilish Steele Transcript – 04/06/24 – Page 25 – Line 20

⁴² H282 Transcript – 25/06/24 – Page 146 – Line 22

⁴³ H282 Transcript – 25/06/24 – Page 147 – Line 8

⁴⁴ Martin Dillon 1st Statement (Evidence Modules) – 28/03/23 – Page 39 (Exhibit T02.02) – Report of the Mental Health Commission Visit to MAH June 2001

⁴⁵ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 10

7.30 When BHSCT moved to electronic records, HCAs, who typically conducted seclusion observations, were unable to input directly into the system. As a result, registered nurses had to transcribe the observations, increasing administrative workload and raising concerns about accuracy in transferring the data across.⁴⁶

7.31 One witness told the Inquiry:

'There was a seclusion policy at MAH. All staff within the hospital were aware of this policy and it would have been accessible to all staff at ward level in a policy folder. It would have been referenced in training events such as MAPA. The charge nurse would make the ultimate decision on whether or not seclusion was to be used. Permission would be sought from the medical staff with a specific reason for the need for the use of seclusion. The patient would have been monitored when in seclusion, with staff writing down their observations in a seclusion recording sheet. There was a specific time for recording, every five minutes for the first 15 minutes, and then at 15-minute intervals. Regular reviews were completed by nursing staff on seclusion incidents, but I cannot recall the specific incidents'.⁴⁷

The same witness described how seclusion was reviewed quarterly during senior nurse meetings, and that each incident was cross-checked against the patient's daily notes at ward level.⁴⁸

7.32 One former resident of MAH expressed concern about the lack of supervision of patients in seclusion. In his experience, seclusion failed to achieve its intended purpose of giving space for an individual to calm down:

'In the seclusion room, there was no buzzer or any way of summoning staff. The only way of getting the attention of staff was from banging on the door. This did not always work, and staff would not always come to the door when I or other patients banged on it. This was common during mealtimes when staff were doing other tasks'.⁴⁹

7.33 Another individual who experienced seclusion as a patient expressed concerns that seclusion was used as a punishment:

'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

⁴⁶ Barry Mills Statement – 04/06/24 – Page 19

⁴⁷ H298 Transcript – 12/09/24 – Page 94 – Line 28

⁴⁸ H298 Transcript – 12/09/24 – Page 95 – Line 26

⁴⁹ P76 Transcript – 12/09/23 – Page 28 – Line 16

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'.⁵⁰

- 7.34 The newly built 'core hospital' opened in 2006. The Psychiatric Intensive Care Unit (PICU) had a purpose-built seclusion facility with toilet facilities.⁵¹ The rest of the wards were fitted with bedroom door alarms that alerted staff when a patient left their room. However, the Inquiry heard that the status of this practice was unclear: at times it was treated as a restrictive practice, while at other times it was considered a patient safety measure and not subject to classification as a restrictive practice.⁵²
- 7.35 Initially, Sixmile Ward used a non-allocated bedroom as a seclusion unit. However, following an RQIA inspection, the ward began using the purpose-built seclusion room in PICU. When a patient was not able to walk to this room, the Police Service of Northern Ireland (PSNI) would be asked to attend.⁵³ On occasion the PSNI used mechanical restraint to facilitate this transfer.⁵⁴
- 7.36 The seclusion policy required that medical staff would be informed contemporaneously (although there was no requirement in the policy that the use of physical restraint should be notified to medical staff in real time). The on-call psychiatrist would consult with the ward's nurse in charge to agree on a plan for moving a patient out of seclusion. If a patient remained in seclusion for more than four hours, a consultant was required to carry out an on-site assessment.⁵⁵
- 7.37 Multiple versions of the seclusion policy were issued from 2013 onward, each introducing minor changes to the responsibilities of nurses and doctors.⁵⁶ The seclusion policy introduced in 2014 required:
- Seclusion to be prescribed by medical staff, with the operational decision to seclude being made by a registered nurse;

⁵⁰ P122 Statement – 19/09/22 – Page 3 (restricted)

⁵¹ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 29

⁵² H330 Statement – 22/05/24 – Page 29

⁵³ H231 Transcript – 13/05/24 – Page 165 – Line 7

⁵⁴ H260 Statement – 08/04/24 – Page 12

⁵⁵ Colin Milliken Transcript – 23/09/24 – Pages 165-167

⁵⁶ A12 Statement – 28/03/24 – Page 12

- Doctor attendance was not mandatory;
- Seclusion rates were to be monitored and reported monthly to hospital management;
- Families were to be informed of every seclusion episode for patients under 18 years old, and of the first episode only for adults;
- Continuous observation by a nominated staff member were required, with direct checks every 15 minutes and hourly registered nurse visits.⁵⁷

7.38 The Inquiry heard that dedicated staff training on the use of seclusion only began in 2019.⁵⁸ In 2019, a visiting English mental health trust team reported that the MAH seclusion facility was in line with the England and Wales Mental Health Act 1983 Code of Practice (2015) and the practice described by staff was in line with the MHO 1986. However, the team reported that some staff had not seen the updated seclusion policy and were unfamiliar with the changes.⁵⁹

Evolution of restrictive practices at MAH – low stimulus room & segregation

7.39 MAH staff also gave evidence about ‘low stimulus rooms’ and ‘pods’. The Inquiry heard that low stimulus rooms would not be seen as seclusion, though their use would be documented in the patient's care plan. These rooms were sometimes chosen by patients voluntarily, and at other times were recommended by nursing staff to help de-escalate patient distress. The hospital's seclusion policy did not cover low stimulus environments.⁶⁰

7.40 Low stimulus and seclusion were viewed very differently at MAH. The Inquiry heard that Sixmile Ward had a ‘low stimulus room’ that could be locked but was only used for supporting de-escalation.⁶¹ Bert Lewis (former charge nurse and latterly day service manager at MAH) told the Inquiry that use of a low stimulus room would not have been seen as a form of seclusion but according to him it would have been recorded as a restrictive practice. While Sixmile Ward did not

⁵⁷ Chris Hagan (Evidence Modules) – 20/03/23 – Page 4998 (Exhibit T04.40) – Seclusion within Learning Disability Inpatient Services Procedure – Children and Adults (Page 5230)

⁵⁸ A12 Statement – 28/03/24 – Page 12

⁵⁹ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 1578 (Exhibit T06.01) – Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust August 2019

⁶⁰ Bert Lewis Transcript – 11/09/24 – Page 61 – Line 22

⁶¹ H282 Statement – 31/05/24 – Page 28

have a seclusion room but did have a low stimulus room, the converse was true in Cranfield, which did not have a low stimulus room but had a seclusion room on PICU. Mr Lewis told the Inquiry that occasionally the seclusion room was used as a low stimulus environment. He went on to confirm:

[Dr Maxwell]: *'So if the nurse decided they needed some low stimulus time, would that be a deprivation of liberty if it wasn't the patient's choice?'*

[Mr Lewis]: *Yeah.*

[Dr Maxwell]: *It would?*

[Mr Lewis]: *Yeah, yeah. Yeah, I believe so.*

[Dr Maxwell]: *So it should have been recorded as a seclusion?*

[Mr Lewis]: *Not as a seclusion. It would have been recorded as a restrictive practice, but not a seclusion.*

[Dr Maxwell]: *The Inquiry has heard that there were quite detailed approach as to how seclusion was recorded and how often they had to be reviewed.*

[Mr Lewis]: *Yeah.*

[Dr Maxwell]: *Did those rules apply to low stimulus as well?*

[Mr Lewis]: *Ehm, they didn't. The seclusion policy as such didn't, didn't apply to low stimulus'.⁶²*

He went on to say that it wasn't clear whether HCAs could initiate transfer to a low stimulus room:

[Dr Maxwell]: *'So they would do it first and then inform the registered nurse afterwards, rather than suggest it to the registered nurse?'*

[Mr Lewis]: *Ehm, I couldn't say exclusively on that.*

[Dr Maxwell]: *There wasn't a clear policy?*

[Mr Lewis]: *No.*

[Dr Maxwell]: *So potentially healthcare assistants could be making this decision without reference to a registered nurse.*

[Mr Lewis]: *They could be making this decision but informing straight away the decision was made like'.⁶³*

7.41 Staff reported that patients sometimes requested 'voluntary seclusion'. For example, one patient used an unallocated side room on Sixmile Ward every morning. He was aware that he tended to become aggressive in the morning and asked to be put in the room between 8am and 9am. Nursing staff on the ward contacted the consultant psychiatrist each morning for assessment.⁶⁴ Before the core hospital was built, on Fintona North Ward another patient would request that she be placed in seclusion if she began to feel anxious or overwhelmed.⁶⁵ Another witness told the Inquiry:

⁶² Bert Lewis Transcript – 11/09/24 – Page 61 – Line 6

⁶³ Bert Lewis Transcript – 11/09/24 – Page 63 – Line 13

⁶⁴ H231's Statement – 09/04/24 – Page 9

⁶⁵ A6 Statement – 09/02/24 – Page 15

'On many an occasion patients requested seclusion. This is where the patient would be taken to a seclusion room but the room would be unlocked. Some of the patients wanted away from the noise of the ward and wanted some quiet time. This later became known as "time out". This was very much at the patient's request. Through the years patients' doors to their bedrooms operated on the basis of a lock which needed a key to be opened from the outside but the patient could open it without a lock from the inside. Patients liked this as it made them feel safe in their bedrooms. The use of patient requested seclusion was also recorded in the notes, the reason why it was requested, the time it was used and how long it was used for. I do not believe that any form of restrictive practice was used by any staff in the hospital until unless the staff member believed that it was needed and it was a measure of last resort'.⁶⁶

7.42 The Inquiry also heard that patients would be given 'time out' in the garden, but this was not understood to be seclusion, even though the patients did not appear to be able to let themselves back into the ward.⁶⁷

7.43 One member of staff explained that restrictive practices could be used as a positive tool in the early days of an admission, however, as the therapeutic relationships between patients and staff developed, this was replaced by appropriate de-escalation techniques, leading to fewer physical interventions.⁶⁸ More recent professional consensus is that restrictive practices are never a positive tool.

7.44 The Inquiry heard that families were not adequately informed about the legal basis for the use of restrictive practices, nor under what authority such measures were being implemented:

'I understand that P105 was a voluntary patient when he was put in seclusion several times in June 2017. No-one explained to me the significance of P105's voluntary admission for the use of restraint or seclusion, or what I could do if MAH did want to detain P105. I query the legal[ity] of the seclusions whilst P105 was a voluntary patient'.⁶⁹

7.45 Some families told the Inquiry that when they were informed about the use of restrictive practices, they were not given the rationale for why they were being used:

⁶⁶ Eileen McLarnon Transcript – 06/02/24 – Page 60 – Line 2

⁶⁷ Eilish Steele Transcript – 04/06/24 – Page 84 – Line 7

⁶⁸ A10 Statement – 09/02/24 – Page 6

⁶⁹ P105's Mother Transcript – 14/09/23 – Page 55 – Line 6

'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'.⁷⁰

'On a number of occasions when I visited P77 when he was first admitted to MAH, I was told that P77 was either, not available for the visit as he was sleeping, or he was in seclusion and I could not see him. I would only be told this after I attended MAH ... I was given no information on what seclusion meant or where seclusion was. I was given limited information on how often and the duration of time that P77 spent in seclusion'.⁷¹

7.46 A number of staff told us that there were clear procedures for informing next of kin when restrictive practices were used. Staff reported that families were notified either at the time of, or shortly after, the first instance of physical restraint or seclusion.⁷² One staff member, who worked at MAH from 1978 to 2011, told the Inquiry that next of kin were always promptly informed when an individual was placed in seclusion for the first time, although in the earlier years not all families had a telephone. In such cases, staff discussed alternative notification arrangements with families in case the need for seclusion arose again.⁷³ Staff said that while some families were unhappy about the use of seclusion, others were content that their relative had somewhere safe to go.⁷⁴

7.47 The Inquiry also heard that some patients were housed in 'pods'. The MHO 1986 recognises that some patients who demonstrate behaviours that are deemed dangerous, but who do not meet the threshold for high-security measures, can be supported with special accommodation (although the Panel observes this is still a restrictive practice). While the MHO 1986 does not explicitly refer to segregation, a visiting team from an English mental health trust noted that the Mental Health Act 1983 Code of Practice, published in 2015, does provide support for such

⁷⁰ P52's Mother Statement – 13/10/22 – Page 22 (restricted)

⁷¹ P77's Mother Transcript – 20/06/23 – Page 24 – Line 3

⁷² Bert Lewis Statement – 10/07/24 – Page 12; H330 Statement – 22/05/24 – Page 31

⁷³ Eilish Steele Statement – 23/05/24 – Pages 30-31

⁷⁴ Eilish Steele Statement – 23/05/24 – Page 37

arrangements.⁷⁵ However the team noted that BHSCT had no formal process for the use of segregation (described in the Inquiry as ‘pods’) as opposed to seclusion.

7.48 This evolution of the understanding of restrictive practices, and the lack of appropriate physical facilities, may explain how staff appeared at times to have blurred the distinction between DoL (such as not letting patients into the garden), low stimulus areas and seclusion and enhanced observations. Certainly, the difference was not explained to families, although the BHSCT 2015 restrictive interventions policy included the use of ‘social restrictions’ such as the use of the garden.⁷⁶ DoL legislation was only enacted in Northern Ireland in 2019, following the commencement of the MCA 2016. This is further discussed in Chapter 18 (Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty).

7.49 An RQIA inspection report from summer 2021 found that restrictive practices were proportionate, used as a last resort, subject to careful MDT review and reduced or discontinued when necessary.⁷⁷ By 2023, the number of seclusions had reduced significantly, although this reduction may have been influenced by fewer acute admissions and a lower overall patient population.⁷⁸

Medication as a restrictive practice

7.50 The use of PRN (as required) medication to control or subdue disturbed or violent behaviour, rather than for the treatment of a formally diagnosed physical or mental illness, is considered a restrictive practice.⁷⁹ The 2015 National Institute for Health and Care Excellence (NICE) guidance (NG10) on the management of violence

⁷⁵ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 1578 (Exhibit T06.01) – Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust August 2019

⁷⁶ Chris Hagan Statement (Evidence Modules) – 20/03/23 – Page 5199 (Exhibit T04.38) – BHSCT Use of Restrictive Interventions for Adult and Children’s Services 2015

⁷⁷ Martin Dillon 1st Statement (Evidence Modules) – 28/03/23 – Page 176 (Exhibit T06.01) – RQIA Inspection report 28/07/21 – 19/08/21

⁷⁸ H282 Transcript – 25/06/24 – Page 147 – Line 14

⁷⁹ HM Government (2019) Reducing the Need for Restraint and Restrictive Intervention. HM Government, London – <https://assets.publishing.service.gov.uk/media/5d1387e240f0b6350e1ab567/reducing-the-need-for-restraint-and-restrictive-intervention.pdf>

and aggression advises that rapid tranquillisation or seclusion should be considered as alternatives to manual restraint lasting longer than 10 minutes.⁸⁰

7.51 A number of BHSCT policies (from 2010, 2011 and 2015)⁸¹ note that:

'A service user may be prescribed 'as required medication' for use in emergency situations where their behaviour becomes more disturbed. The medication may have a sedating effect thereby reducing the risks'.⁸²

But they add that:

'Medication should be prescribed with a clear therapeutic aim and must not be used as a means of exerting control over service users. Prescribed medication must be reviewed regularly to ensure that principle is adhered to. Staff have a responsibility to observe and report service user behaviour as accurately as possible to assist prescribers when making prescribing decisions. Once medication has been prescribed, staff have responsibility to continually observe and assess service users for the effect of medication on their mental state and for the emergence of side effects'.⁸³

7.52 Medication as a restrictive practice should therefore only be used if other behaviour management techniques have failed. The first line should be psychological interventions to prevent or de-escalate dysregulated behaviours. As we discuss in Chapter 7 (Restrictive Practices), there were insufficient psychologists and behavioural therapy nurses at MAH to do this, and medication as a restrictive practice became the default position. The Inquiry also heard from a consultant psychiatrist that shortages of nurses and HCAs sometimes meant diversionary strategies were not possible to de-escalate a patient's behaviour, meaning PRN sedation was then required:

[Dr Maxwell]: *'So are you saying then that the shortages in ward staff, of both Registered Nurses and healthcare assistants, meant that there were less therapeutic interventions between the ward staff and the patient, and less activities, which resulted in patient's mental health and behaviour becoming more distressed?*

[Dr Hughes]: Yes.

⁸⁰ National Institute for Health and Care Excellence (2015) Violence and aggression: short-term management in mental health, health and community settings (NG10) NICE, Manchester – <https://www.nice.org.uk/guidance/ng10>

⁸¹ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 5156 (Exhibit T04.36) – Belfast Trust 'Use of Restrictive Practices in Adults' (SG15/09) - August 2010; Page 5177 (Exhibit T04.37) – Belfast Trust 'Use of Restrictive Practices in Adults' (SG15/09), 01.2011; Page 5199 (Exhibit T04.38) – Belfast Trust 'Use of Restrictive Interventions for Adult & Children's Services' (SG 15/09) – May 2015

⁸² Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 5161 (Exhibit T04.36) – Belfast Trust 'Use of Restrictive Practices in Adults' (SG15/09), - August 2010

⁸³ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 5168 (Exhibit T04.3) - Belfast Trust 'Use of Restrictive Practices in Adults' (SG15/09) – August 2010; Page 5190 (Exhibit T04.37) – Belfast Trust 'Use of Restrictive Practices in Adults' (SG15/09), 01.2011; Page 5213 (Exhibit T04.38) – Belfast Trust 'Use of Restrictive Interventions for Adult & Children's Services' (SG 15/09) – May 2015

[Dr Maxwell]: *But that at the point at which the patient became distressed you had to do something which was some sedation?*

[Dr Hughes]: *Yes, if -- everything else we had was tried and failed. So, I mean, I saw, you know, daily examples of nurses using, you know, distraction, diversion, those sorts of things and, you know, in a huge proportion of cases that worked.*

[Dr Maxwell]: *But if there weren't enough nurses to give enough time to each patient to do that ...*

[Dr Hughes]: *Yes. Yes.*

[Dr Maxwell]: *And the patient became distressed.*

[Dr Hughes]: *Yes.*

[Dr Maxwell]: *You're saying that however they got there, that patient was distressed.*

[Dr Hughes]: *Yes.*

[Dr Maxwell]: *And you had to treat that, which might have involved sedation?*

[Dr Hughes]: *Undoubtedly, yes'.⁸⁴*

7.53 As seen in Chapter 1 (The Patient Experience), families frequently raised concerns with the Inquiry that they felt their relative was significantly overmedicated. However, it remains unclear whether these concerns relate to medication prescribed for a diagnosed condition or to PRN medication used as a form of restrictive practice. The Inquiry recognises that decisions around the use of medication are a balance of risks and benefits, and that sometimes the risks, for example the sedative effects of certain drugs, may be outweighed by the benefit of reducing epileptic fits. The Inquiry also recognises that certain drugs must be managed by experts outside MAH, such as neurologists.

7.54 Both nursing and medical staff informed the Inquiry of a shift toward reducing the use of PRN medication to manage behaviours.⁸⁵ This was consistent with the finding of the 1999 EHSSB review of seclusion, which reported that the use of close observation had increased and there was a decline in reliance on medication as a form of restrictive practice.⁸⁶ The use of close observation continued to rise over time.⁸⁷

'Overall, patients had become more disturbed and there was less of a medical drug regime. I felt that there was more knowledge, on the ward and in MAH,

⁸⁴ Damien Hughes Transcript – 24/09/24 – Page 62 – Line 3

⁸⁵ Eilish Steele Statement – 23/05/24 – Page 31

⁸⁶ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 7777 (Exhibit BW124) – EHSSB Report on the Use of Seclusion with particular emphasis on Muckamore Abbey Hospital June 1999

⁸⁷ Barry Mills Statement – 04/06/24 – Page 23

*of medication and the focus was less on doping someone up and more about research. I recall that a lot of patients had a change of prescription’.*⁸⁸

7.55 Evidence from family members suggested that, for some patients, PRN sedation still remained a very frequent intervention. While PRN medication can be appropriate, it should not be a long-term strategy. Where a patient’s behaviour remains dysregulated, other interventions (including psychology and changing the physical environment to reduce triggers) should be used. The Panel concludes that using PRN medication as a first-line intervention over a long period is not therapeutic and can be described as overmedication. This is not unique to MAH or even to Northern Ireland. People with a learning disability are thought to be 16 times more likely and autistic people seven times more likely to be prescribed an antipsychotic than the general population. ‘Stopping over medication of people with a learning disability and autistic people’ (STOMP) is a national NHS England work programme to stop the inappropriate prescribing of psychotropic medications.⁸⁹

7.56 PRN prescriptions must be re-prescribed every 52 days and reviewed at least annually for each patient.⁹⁰ However, it appears that initially there was little review of PRN usage at MAH, looking at trends across all patients rather than by individual, although the rate of PRN usage was latterly included alongside seclusion rates in the monthly reports considered within MAH. In 2018 MAH started employing a clinical pharmacist who attended MDT meetings. Her role was to consult on dosages of medications and advise on correct administration and any monitoring requirements necessary. She told the Inquiry that she worked alongside the MDT to review treatments and encourage adherence to policies and guidelines.⁹¹ She told the Inquiry that there had not been a clinical pharmacist at MAH for ‘at least ten years’ before she was appointed’.⁹²

⁸⁸ Eilish Steele Statement – 23/05/24 – Page 31

⁸⁹ NHS England Stopping over medication of people with a learning disability and autistic people (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP) – <https://www.england.nhs.uk/learning-disabilities/improving-health/stomp-stamp/>

⁹⁰ Eilish Steele Statement – 23/05/24 – Page 86

⁹¹ Stephen Guy and Deirdre Murray Transcript – 27/06/23 – Page 8 – Line 12

⁹² Stephen Guy and Deirdre Murray Transcript – 27/06/23 – Page 40 – Line 28

7.57 A consultant psychiatrist confirmed to the Inquiry that the use of PRN sedation across the hospital was not monitored and agreed that it would have been useful:

[Prof Murphy]: *'I think PRN wasn't monitored in terms of trends, was it, the way that seclusion, and incidents, and physical intervention were treated - were analysed for trends?*

[Dr Hughes]: *Yes, I certainly have no evidence to contradict that. What I can say is that at an individual patient level in Cranfield we worked very hard to monitor the use of PRN medication. But I'm not aware of the same systems being in place for an overall review of use within the hospital, for example.*

[Prof Murphy]: *Do you think they should have been analysed for trends in the same way that some of the other restrictive practices were analysed?*

[Dr Hughes]: *Yes*'.⁹³

7.58 The Inquiry also heard from Stephen Guy (former Lead Pharmacist for BHSCT) who confirmed that there had been no clinical audits of the use of PRN sedation until a quality improvement project in 2022.⁹⁴ The HSC 2022 'Regional Guideline for the Management of Acutely Disturbed Behaviour (ADB) through the use of Pharmacological De-escalation and Rapid Tranquillisation'⁹⁵ has a section on monitoring and review (including audit) that references the Prescribing Observatory for Mental Health (POMH).⁹⁶ POMH is run by the Royal College of Psychiatrists and the Inquiry was supplied with letters from POMH to Stephen Guy in 2010, detailing the data entry process and giving a unique code for BHSCT data submissions.⁹⁷ It is unclear whether this included MAH or was limited to BHSCT mental health services.

7.59 The Royal College of Psychiatrists' Quality Network for Learning Disability Services (QNLD) Standard 171 says:

'The safe use of high-risk medication is audited at a unit level, at least annually. Guidance: This includes audit of the use of medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines'.

⁹³ Damien Hughes Transcript – 24/09/24 – Pages 62-63

⁹⁴ Stephen Guy and Deirdre Murray Transcript – 27/06/23 – Page 50 – Line 16; Page 74 – Line 25

⁹⁵ Brona Shaw and Stephen Guy Statement – 07/06/23 – Page 276 (Exhibit T02.05) – HSCNI Regional Guideline for the Pharmacological Management of Violent and Aggressive Behaviour in Adults, Children and Young People

⁹⁶ Brona Shaw and Stephen Guy Statement – 07/06/23 – Page 318 (Exhibit T02.06) – BHSCT Regional Guideline for the Management of Acutely Disturbed Behaviour April 2022

⁹⁷ Brona Shaw and Stephen Guy Statement – 07/06/23 – Page 865 (Exhibit T07.07) – Letter from POMH-UK Central Project Team February 2010

Standard 172 says:

'A range of local and multi-centre clinical audits is conducted, which include the use of evidence-based treatments, as a minimum'.⁹⁸

The Inquiry did not receive any audit findings relating to medications at MAH prior to 2022.

- 7.60 Oversight of medication for patients detained under the MHO 1986 was the responsibility of the MHC, now held by RQIA. The MHC Annual Report 2007-2008 noted that, across Northern Ireland, only seven prescriptions had been queried by the MHC. In the Annual Report and Accounts 2008-2009, five were queried and subsequently found acceptable by the Commission Medical Panel.⁹⁹ Even if all the queried prescriptions were at MAH, which cannot be determined, this represented only a small percentage of the MAH patient population at the time.

The changing needs of the patients

- 7.61 Following the publication of 'Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland' in 2005, MAH began to accelerate the transition from a long-stay placement to an assessment and treatment centre. This shift meant that many patients were resettled into the community, resulting in a reduction in the number of wards. Those who were harder to resettle tended to be patients with challenging behaviour, meaning that the patients left in MAH were proportionately more challenging (though there were fewer of them than in previous years). Staff also reported that new admissions presented with more challenging behaviours and that moving existing patients between wards led to increased aggression by patients.
- 7.62 Mealtimes were reported to be a trigger for challenging behaviours from patients.¹⁰⁰ The Inquiry heard evidence of a vicious cycle: patient distress, often stemming from lack of structure or unmet personal care needs, leading to

⁹⁸ Royal College of Psychiatrists (2021) Quality Network for Learning Disability Services (QNLD) Standards for Inpatient Learning Disability Services Fourth Edition – Page 27. RCPsych, London – https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-fourth-edition-standards.pdf?sfvrsn=5fce5d7f_2

⁹⁹ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 62 (Exhibit 7) – Mental Health Commission for Northern Ireland, 12th Annual Report & Management Review 2007-2008; Page 122 (Exhibit 8) – Mental Health Commission for Northern Ireland, 13th Annual Report & Management Review 2008-2009

¹⁰⁰ Eilish Steele Transcript – 04/06/24 – Page 24 – Line 3

distressed behaviour, which staff managed through restraint, sedation and/or seclusion. The Inquiry heard that behavioural support nurses for adult services did not appear to be available until the mid to late 2010s.¹⁰¹

- 7.63 As incidents of challenging behaviours increased, so too did levels of aggression, both between patients and against staff. Data provided by the BHSCT indicates a marked rise in reported inappropriate/aggressive behaviours from 2011. Patient-on-patient incidents recorded on Datix rose in that period from 297 to 869.¹⁰² Patient-on-staff incidents also surged in that period from 563 to 2,505.¹⁰³ Staff who gave evidence to the Inquiry described some wards where there was a positive atmosphere, but on other wards violence and aggression were regarded as an expected part of the job:

'With regards to violence and aggression within MAH, physical assaults were daily. The level of aggression however varied and often no serious injuries were sustained. Within the hospital due to the frequency of these incidents it was just accepted that violence and aggression was a part of the job and people expected to get assaulted daily, albeit these were mostly minor assaults. Staff became de-sensitised to this and I suppose on reflection what was accepted as "normal" would not have been acceptable in any other workplace. At times however the level of aggression and assault was more significant and had the potential to cause very serious injury. I myself felt afraid at times working with some patients who would have seriously assaulted staff, but again this was just part of the job. There are a few incidents that have stuck with me over the years as being traumatic. I recall one incident where a patient pulled me to the ground by my hair however I just had to get back up and continue to try, de-escalate, and manage the situation regardless of my own fear and anxieties and pain. The patient remained agitated and required staff support and reassurance and leaving the area was not an option. I recall incidents [where] staff were injured and bleeding but they had to continue to assist in managing the incident, using physical restraint, as the patient was so highly agitated and likely to seriously harm someone that it was not possible for staff to safely leave despite their injuries or emotional distress. There were periods of time when a particular patient was very unsettled or acutely unwell and every day you were coming in to work knowing you or your colleagues would be seriously assaulted and this seemed never ending. The aim of your shift was to get to the end of the day with no one being hurt (either patient or staff) and this was the definition of a good day. I recall a staff member being assaulted and the patient using a knife to try and stab the staff member in the stomach. There were so many incidents they were just normal day to day

¹⁰¹ A14 Statement – 20/05/24 – Pages 18-19; Barry Mills Statement – 04/06/24 – Page 28

¹⁰² Chris Hagan 1st Statement (Evidence Modules) – 20/03/24 – Page 5490 (Exhibit T05.06) – MAH Overview Charts 09-22

¹⁰³ Chris Hagan 1st Statement (Evidence Modules) – 20/03/24 – Page 5490 (Exhibit T05.06) – MAH Overview Charts 09-22

practice however I do recall some occasions when I actually thought people's lives could have been at risk. When I was heavily pregnant, I was still working with very unsettled and aggressive patients, talking to them, attempting to de-escalate the situation, and on one occasion I was involved in using physical intervention whilst heavily pregnant but had I not done so the patient or other staff present would have been seriously harmed'.¹⁰⁴

7.64 Over time, the staff began to describe the use of 'low level holding', or 'clinical holds', a form of physical intervention applied for short time durations.¹⁰⁵ These restrictive practices were deemed necessary to carry out personal hygiene and sometimes took place following a family request for a best interests meeting involving the clinical team and the patient's family,¹⁰⁶ though these are not mentioned in any BHSC policy.

7.65 Despite a perceived change in patient needs and a demonstrable increase in reported aggressive incidents, the Inquiry heard that staffing levels did not change in the five years prior to 2017.¹⁰⁷

Monitoring of the use of restrictive practices at MAH

7.66 Following the introduction of formal training in restrictive practices, a manually completed audit form was submitted to the general nursing office for sign-off by a designated manager and entry into a database.¹⁰⁸ Monthly reports were presented to the nursing services team, the core hospital management team and the medical staff committee.¹⁰⁹ However, these reports did not feed into any overarching corporate clinical governance process.¹¹⁰

7.67 From about 2002, monthly seclusion reports were presented at core group meetings (see for example the minutes of 03 September 2002). These appear to have become routine, and by 2007 the monthly seclusion reports summarised the number of seclusions (and which rooms were used), the length of seclusions, and the time of day of seclusions. It was common for there to be more than 30

¹⁰⁴ H330 Statement – 22/05/24 – Pages 27-28

¹⁰⁵ H330 Statement – 22/05/24 – Page 31

¹⁰⁶ H189 Statement – 29/05/24 – Page 28

¹⁰⁷ Barry Mills Statement – 04/06/24 – Page 37

¹⁰⁸ Eilish Steele Statement – 23/05/24 – Pages 32-33; Barry Mills Statement – 04/06/24 – Page 22

¹⁰⁹ Eilish Steele Statement – 23/05/24 – Page 33; Clinton Stewart Statement – 02/05/24 – Page 3

¹¹⁰ Clinton Stewart Transcript – 10/06/24 – Pages 48-51

seclusions per month and sometimes there were more than 100 per month. Typically, seclusions lasted a few hours at most, but occasionally they were longer than four hours. In some months, there were astonishing rises in numbers of seclusions, for example, over 500 in December 2012, and it was clear that a small number of patients were being held in seclusion far more than others.¹¹¹

- 7.68 The seclusion figures were gathered into annual reports, so that high-level trends could be observed. Over time, the monthly reports became more detailed, so that by 2015 they included graphs of the number of incidents requiring physical intervention, as well as details of seclusions. By 2017, the number of safeguarding incidents was also included, and by 2018 use of PRN was added to the reports. However, although the reports were presented at the core group meetings, the minutes of the meetings say very little about any discussion of the trends or of actions to reduce the use of restrictive practices.
- 7.69 Following the 2017 CCTV revelations, incidents were reviewed during purposeful inpatient assessment (PIPA) meetings. These discussed the previous 24 hours or weekend and how any incidents were managed.¹¹²
- 7.70 Seclusion rates at MAH remained stable from May 2018 to April 2019.¹¹³ In February 2020, it was noted that both observation and seclusion policies required review.¹¹⁴
- 7.71 A live governance report (a weekly report of a standard set of clinical governance indicators) was introduced from October 2018 and weekly hospital situation reports (SITREPs), containing more qualitative information, from early 2019.¹¹⁵

¹¹¹ Data provided by BHSCT and analysed by the Inquiry

¹¹² A14 Statement – 20/05/24 – Page 27

¹¹³ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 1578 (Exhibit T06.01) – Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust August 2019

¹¹⁴ Michael McBride Statement (Organisational Modules) – 28/06/24 – Page 1793 (Exhibit 69) – Report on Professional Nursing Assurance – Muckamore Abbey Hospital, Findings, Recommendations and Action Plan February 2020

¹¹⁵ Cathy Jack Statement (Organisational Modules) – 14/06/24 – Page 30 and Page 242 (Exhibit T09.01) Muckamore Abbey Hospital Weekly Safety Report 26, 30.08.2019

7.72 Esther Rafferty (former Service Manager and Associate Director of Nursing for MAH) was both managerially and professionally responsible for the practice of registered nurses as well as HCAs, and ultimately had responsibility to ensure processes were in place to ensure compliance with policy. Esther Rafferty agreed that clinical holds amounted to a restrictive practice and should have been recorded; however, she confirmed that no audits of restrictive practices were undertaken at MAH,¹¹⁶ despite the high risks associated with non-compliance. This was also true of other policies, including the seclusion policy. The viewing of CCTV footage in late 2017 revealed unauthorised use and lack of recording of seclusion. This failure to monitor practice allows for suboptimal practice to become routine, as part of the process of normalisation of deviance (which is discussed in paragraph 7.77).

Supporting staff as part of managing restrictive practices

7.73 The CQC in England has noted that training alone is not sufficient to ensure best practice when working with people who display challenging behaviours:

'Training alone is not enough. Staff also need emotional support if they are to keep the positive attitudes that are required. Working with people with severe challenging behaviour can have a physical and emotional impact on staff. Staff may sustain physical injuries, particularly when they use physical restraint. This may have a negative impact on the therapeutic relationship with patients'.¹¹⁷

7.74 The Inquiry was told that following incidents, staff were supposed to be debriefed and sometimes there would be an MDT review:

'So when de-briefs were introduced it was about identifying learning. The process would have been doing occupational health referral, if somebody was -- and it kind of feels, looking back, it's a bit tick-boxy, and certainly some -- in more recent experience I think there's probably a need for more psychological support and emotional support for staff about diffusing situations for them, as opposed to de-briefing situations straight away. I think it was clear for me that there wasn't enough staff to enable people to feel supported. So you were -- if staff got injured, I think the best that they got maybe was, you know, some time away from the working environment for a cup of tea, or to have a cry, to have a chat with somebody'.¹¹⁸

¹¹⁶ Esther Rafferty Transcript – 15/10/24 – Page 104 – Line 19

¹¹⁷ Care Quality Commission (2019) Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism: Interim report – Pages 9-10. CQC, Newcastle upon Tyne – https://www.cqc.org.uk/sites/default/files/20191118_rssinterimreport_full.pdf

¹¹⁸ H189 Transcript – 27/06/24 – Page 20 – Line 6

The witness went on to explain that it was more of a learning exercise for the organisation than an emotional support for staff:

*‘Certainly, I mean we, we did have a de-brief model, and again -- we had two de-brief models that we had available, which was through the MAPA training programme. But the coping model, as I said, it seemed a bit “processy”, and it was more process, and it seemed a bit impersonal for the staff that had been injured. But it did involve looking at patterns to behaviour and investigating if there was alternatives and ways we could respond to it’.*¹¹⁹

- 7.75 However, a viewer observing behaviours in the historic 2017 CCTV footage told the Inquiry that, on some occasions, despite the debrief policy, staff members were assaulted by patients and received no immediate post-incident support. This lack of response was attributed to staffing constraints:

*‘I also noted that on some occasions staff had been assaulted by patients and were not provided with any immediate post-incident support to enable them to leave the area. This is a consequence of staffing being at the bare minimum for much of the time which results in a traumatised workforce who then perhaps overreact in situations because of their own unmanaged fears and anxieties. Perhaps there needed and needs to be a different approach to staffing models in such services which focuses on the maximum required as opposed to the minimum required’.*¹²⁰

- 7.76 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.¹²¹
- 7.77 Evidence heard by the Inquiry suggests that the changing understanding of deprivation of liberty and restrictive practices over the period of the Inquiry’s ToR, together with the failure to update policies and provide dedicated training, led to some ambiguity around what was or was not acceptable practice at MAH. The continuation of ‘old’ practices that would now be considered unacceptable restrictive practices and the uncorrected deviations from concurrent policies became the way things were done at MAH. This was compounded by a failure to support staff who had been assaulted by patients, which led some to anticipate assaults and use restrictive practices prospectively. This is a well-recognised phenomenon known as ‘normalisation of deviance’, a concept from safety science

¹¹⁹ H189 Transcript – 27/06/24 – Page 21 – Line 7

¹²⁰ H189 Statement – 29/05/24 – Pages 12-13

¹²¹ A11 Statement – 31/05/24 – Page 44 (restricted)

that occurs when problematic practices become routine due to the absence of corrective interventions, leading staff to believe managers think this is acceptable even though it is contrary to official policy.¹²² This was seen, for example, in a thorough review of why the NASA Challenger rocket failed.¹²³

Concerns about restrictive practices in other services managed by BHSCT

7.78 In 2014, concerns had been raised about the use of restraint and the management of challenging behaviours at the Iveagh Centre, a children's learning disability ward not on the MAH site.¹²⁴ The BHSCT Board's confidential minutes of 03 July 2014 reflect a decision to adopt a positive behaviour support (PBS) approach, with individual behaviour support plans implemented for each child. However, PBS strategies aimed at reducing the use of seclusion and physical interventions were not introduced to MAH until 2016.¹²⁵

7.79 In 2016, the RQIA also raised concerns about Beechcroft, a BHSCT-run children and adolescent mental health services (CAMHS) centre, and requested a review of the use of restraint and rapid tranquillisation practices to ensure that practice was compliant with Article 5 (the right to liberty) of the Human Rights Act 1998.¹²⁶

Concerns about restrictive practices at MAH

7.80 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.¹²⁷

7.81 BHSCT policy required ward staff to record the use of restrictive practices in the nursing notes every time they were employed.¹²⁸ However, when the historic

¹²² D. Vaughan (2004) 'Theorizing Disaster: Analogy, historical ethnography, and the Challenger accident', *Ethnography*, 5(3), pp. 315-347 – <https://doi.org/10.1177/1466138104045659>

¹²³ Vaughan (2004) 'Theorizing Disaster: Analogy, historical ethnography, and the Challenger accident'

¹²⁴ Mark McGuicken 2nd Statement (Evidence Modules) – 26/05/23 – Page 3292 (Exhibit MMcG-299) – BHSCT 2013-14 End Year Assurance and Accountability Meeting 16 June 2014

¹²⁵ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Pages 29-30; Mairead Mitchell (Organisational Modules) Statement – 25/04/24 – Page 11

¹²⁶ Michael McBride (Organisational Modules) Statement – 28/06/24 – Page 472 (Exhibit 24) – Update on MHL D Bi-Lateral Liaison Meeting DHSSPS September 2016

¹²⁷ Eilish Steele Statement – 23/05/24 – Page 62 (restricted)

¹²⁸ Barry Mills Transcript – 26/06/24 – Page 136 – Line 7

CCTV was first viewed in 2017, it was clear that some staff were using interventions that they regarded as minor without recording them as restrictive practices:

'The staff on the ward and the Ward Managers assured me that it was being done, and I could see it in the system, the times, but subsequently as we started to look at the CCTV they weren't being recorded accurately, there was times out, they weren't the right times on them, and it just concerned me whether the staff hadn't got the training even for the recording of it accurately. But the written record of it may not have been done right'.¹²⁹

- 7.82 Barry Mills (former Clinical and Therapeutic Services Manager) explained that physical restraint incidents that were not recorded were 'fairly minor', implying that staff may not recognise them as restrictive practices (reflecting the normalisation of deviance discussed in paragraph 7.77):

[Mr Mills]: '... there were fairly minor involvement, but it was still maybe holding or escorting someone through, or supporting them in a hold. It wasn't always people lying on the ground. They could have been sitting beside them and giving them assurances. Actually, what was most upsetting to me was that it would appear to be good practice, it just wasn't being recorded ...

[Dr Maxwell]: So, would it be fair to say things that used quite intense MAPA techniques, holds that involved more than one person, having the patient on the floor, that these were being recorded? The ones that weren't being recorded were good practice, but were less intense, and maybe not perceived as restrictive practices by the staff?

[Mr Mills]: That's exactly the way'.¹³⁰

- 7.83 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'.¹³¹

As a result, the Director of Adult Social and Primary Care (ASPC) told the Inquiry that the seclusion policy was singled out for review.¹³²

¹²⁹ Barry Mills Transcript – 26/06/24 – Page 106 – Line 2

¹³⁰ Barry Mills Transcript – 26/06/24 – Page 141 – Line 20

¹³¹ A5 Transcript – 07/02/24 – Page 79 (restricted)

¹³² Marie Heaney Transcript – 26/09/24 – Page 45 – Line 14

- 7.84 In contrast, the Inquiry heard from a senior nurse who worked at MAH from August 2018 to September 2020, and she described the application of very strict procedures regarding the use of seclusion:

'Six Mile did not have a seclusion room, but there was a bedroom called Room 7 that was used for seclusion when needed. The room was not allocated to a patient. Where a nurse on the ward considered seclusion may benefit a patient, as per hospital policy, the patient was assessed by the dedicated MAH consultant psychiatrist, Dr. H50. If Dr. H50 was not available, an out-of-hours consultant, who was often off site, attended the ward to carry out an assessment on the patient within one hour of contact. There were occasions when the out-of-hours consultant did not attend within the hour as under the policy. Where this occurred, it was escalated through Datix ... When a patient was placed into seclusion in Room 7, staff who were usually Band 3, stood outside the room at all times and monitored the patient. The staff member who was observing the patient would record information on the patient's presentation during the seclusion period. The information gathered was added to the patient's records on PARIS and added to their seclusion care plan ... After the RQIA inspection, it was decided by senior staff on the ward that as PICU was the only ward with a purpose built seclusion room, and was very close to Six Mile, it was to be used when needed. A patient was only to be transferred to the seclusion room on PICU if they were able to walk. Where a patient was not able to walk to the room the PSNI would be asked to attend to bring them. For example, when P18 became distressed, he would sometimes destroy property and use it as a weapon on staff. If he was placed in a MAPA restraint and continued to display aggressive behaviours, nurses assessed if seclusion would help him to become settled. There were occasions when the PSNI were called to transfer P18 across to the seclusion room in PICU as he could not walk. Staff remained outside the door during these times'.¹³³

- 7.85 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.¹³⁴

- 7.86 The Inquiry also heard that families' concerns about injuries sustained during physical restraint were not adequately explained:

'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

¹³³ H231 Transcript – 13/05/24 – Pages 162-165

¹³⁴ P54's Mother Statement – 05/10/22 – Pages 24-27 (restricted)

*investigation or report on this incident and do not know what happened with regards to our complaint’.*¹³⁵

- 7.87 Families also suggested that, at times, behaviour that triggered restrictive practices was itself a response to staff actions:

*‘Staff do things to trigger P118’s behaviour in the first place and then say that medication or seclusion are necessary to control behaviours which the staff themselves have caused’.*¹³⁶

- 7.88 Families often had a limited understanding of what seclusion involved or what the seclusion room was like. Very few appear to have seen it first-hand:

*‘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’.*¹³⁷

- 7.89 Another witness described both her own and her daughter’s experience of the seclusion room:

‘In addition to these concerns, I had concerns about the use of seclusion. I first became aware of it when H40 told me about a previous incident when Alicia was in Cranfield Ward and had hit out at a nurse. H40 told me that Alicia had been taken to a de-escalation room for about 15 minutes, and there was always a doctor with her. He said this worked a treat. I thought this would be a therapeutic room with someone to talk to her about what had happened. I had no idea this might have been the seclusion room. In fact, when Alicia was admitted, I was not informed there was a seclusion room, what it was for or any procedures relating to its use. It was only when I saw the seclusion room in 2016 that I thought back to what H40 had said and realised that it was the seclusion room that he said would work a treat. I could not believe that this was what anyone would think would work a treat, never mind a consultant psychiatrist. I believe the seclusion room could only instil fear and punishment, and it was a cruel, inhumane practice which should never have been part of a

¹³⁵ P117’S Mother Transcript – 10/10/23 – Page 29 – Line 13 (restricted)

¹³⁶ P118’s Mother Transcript – 09/10/23 – Page 114 – Line 18

¹³⁷ P121’s Sister Statement – 03/10/23 – Page 15 (restricted)

hospital. I now find it difficult to accept this as being an accurate description of Alicia's experience of the seclusion room and believe that it shows there was a complete failure by all professionals and organisations to recognise the impact it has had on her and others. It was only after Alicia had subsequently been put in the seclusion room while she was in PICU, and explained to me what it was like, that I appreciated its true impact. Alicia told me she had been put in jail and was really scared and that she was crying. I did not press Alicia about this because I did not want to distress and agitate her further.

'I asked H397, senior nurse at PICU, to show me the seclusion room but he refused because he said there were patients in the ward. I then asked Laura Waite for assistance. She was able to arrange for H397 to show me the seclusion room. I was brought through the ward to visit the seclusion room. There was a door beside the sensory tent which went down a dark corridor to the seclusion room. I was shocked by what I saw. The room was about three and a half foot wide and was more like a cupboard. There was only a large leather chair inside, which took up most of the room. The room was very dark. There was no window. It was a dismal, small, cold dark room and not therapeutic in any way.

'I asked how the patients get attention if they need water, the toilet or felt unwell. I was thinking particularly of Alicia, who had seizures. H397 said that in those circumstances, they press the buzzer. I pressed the buzzer but it was not working. H397 then explained the buzzer was checked every week, that there was always a member of staff outside the door, and he said he had appreciated that the room needed to be renovated, which he had discussed with management'.¹³⁸

- 7.90 Some relatives expressed the view that staff resorted to seclusion when it ought to have been used as a measure of last resort:

'I feel that P105's behaviour was not appropriately managed and I understand that MAH resorted to putting him into the seclusion room. I understand this should only be used as a last resort. P105's notes and records show that he was put into the seclusion room on 8th June 2017 with the door being locked for less than an hour as P105 had tried to leave. Then on 14th June 2017, P105 was put into seclusion on three occasions for periods varying from just over half an hour to over two hours. Subsequently, on 16th June 2017 he was secluded for nearly four hours, from 1640 to 2100 hours. I recall when I visited P105 on 16th June 2017, he had just come out of the seclusion room. When P105 came out he was calm and lucid. I did not see there was any reason for him still to be in there, or if anyone had been monitoring to check if his behaviour had improved. I did not realise at the time that it was just a chair in the seclusion room'.¹³⁹

¹³⁸ P109's Mother Transcript – 21/09/23 – Pages 32-34

¹³⁹ P105's Mother Transcript – 14/09/23 – Page 53 – Line 4

Conclusions

- 7.91 The definition and understanding of restrictive practices evolved over the period covered by the Inquiry's ToR. Practices that now appear unacceptable may have been consistent with guidance at the time. While policies and training on physical restraint were in place prior to 1999, the ambition was for techniques to shift over time towards behavioural support and de-escalation rather than using physical restraint. However, this was not the reality.
- 7.92 PRN medication was used to manage patients' behaviours, and the Inquiry heard that this reduced over the period under review, replaced by close observation where one or two staff remained with the patient continuously.
- 7.93 Environmental pressures, including the mixing of patients with differing needs due to ward closures, increased dysregulation and rising incidents of peer-on-peer abuse, combined with staffing shortages, meant that prescribed staff-to-patient ratios for close supervision were often unmet. The failure of BHSCT to provide a therapeutic environment for patients at MAH compromised patient safety, leading to increased use of medication as a restrictive measure. The absence of robust monitoring of medication trends as a form of restraint represented a significant missed opportunity to intervene and reduce its use.
- 7.94 However, the lack of psychologists and behavioural therapists meant that the underlying causes of behaviours that challenge were not being addressed and indeed some patients appeared to find close observation stressful. The end result was that the use of medication as a restrictive practice was still more prevalent than it needed to be.
- 7.95 There appeared to be no regular review of the use of medication for short-term management of behaviour. Many relatives told the Inquiry that they believed patients were overmedicated and this was apparent from their appearance and behaviour. Some described their loved ones as appearing 'zombified' (see Chapters 1 and 2).

- 7.96 Staff distinguished physical restraint from seclusion. The seclusion policy contained detailed procedures, including requirements for medical and managerial notification. In contrast, physical restraint was managed by registered nurses on the ward and discussed at weekly MDT meetings.
- 7.97 Families reported being told about restrictive practices in general terms but lacked understanding of what they entailed in practice. Many expressed shock on learning how frequently these practices were used. Although staff confirmed that they would tell the next of kin of each occurrence, this was not the experience of patients' families.
- 7.98 There appeared to be little awareness of how changing ward conditions may have triggered the use of restrictive practices. The shift in reasons for admission to MAH, particularly the rise in behaviour-related admissions, did not appear to prompt a review of how restrictive practices were managed.
- 7.99 A combination of factors led some staff to believe that practices that are now seen as unacceptable were, in fact, acceptable interventions.

Recommendations

R28	The Restraint Reduction Network identifies six principles to avoid the use of restrictive practice. While there is evidence that some Trusts have adopted these principles, further action is needed to ensure the principles are fully embedded. These principles must be embedded in policies and practices. The principles are: i. Organisational commitment – led by executive directors ii. Performance monitoring – using metrics to track restrictive practices iii. Human rights-based education – comprehensive training for staff iv. Personalised reduction plans – tailored strategies for individual patients v. Service user involvement – engaging patients in shaping restraint reduction strategies vi. Post-incident support and learning – structured debriefing and reflection for both patients and staff
R29	All facilities providing residential services for people with learning disabilities and autistic people should provide sufficient psychology input for each patient, to obviate the need for restrictive practices in all but the most exceptional circumstances.

R30	HSCTs should appoint a non-executive director (NED) to act as a champion for restraint reduction, with a mandate to hold executive directors accountable for delivery.
R31	The effectiveness of the education programme for staff in relation to restraint reduction should be measured through defined data metrics. This is to ensure that every instance of restraint is clearly justified and appropriately utilised.
R32	HSCTs should implement a comprehensive set of balanced performance measures across all services for people with learning disabilities, including those commissioned from third-party providers. These measures should include: • Trends in the use of restrictive practices • Trends of aggressive behaviour incidents, including peer-on-peer aggression and patient-on-staff aggression • Positive experience, including quality of life measures.
R33	To ensure meaningful interpretation of these trends, all HSCTs should adopt statistical process control (SPC) charts, as developed by Walter Shewhart in 1939. SPC charts use calculated upper and lower control limits to distinguish between normal variation in a stable process and significant long-term shifts in performance. These charts provide a clear visual flag as to when further investigation is warranted, promoting a data-driven approach to service improvement.
R34	All HSCTs should develop two clear operational debriefing policies. The first should apply to both staff and people with learning disabilities and autistic people who are involved in, or affected by, aggressive behaviour. A separate debriefing after any restraint or seclusion incident should also be developed. This should include both staff and people with learning disabilities and autistic people, and should specify that debriefing should be facilitated by staff outside of the immediate service delivery unit.
R35	Given the elevated risk of inappropriate use of restrictive practices with individuals with learning disabilities and/or autistic people, BHSCT and all HSCTs should automatically place any inpatient facility or facility for people with challenging behaviour on its risk register.
R36	Use of seclusion should be considered an extraordinary and exceptional intervention. Each intervention should be subject to a serious event audit, conducted by a professional outside the service provider's learning disabilities services. This audit should be shared with the person's next of kin and the RQIA.
R37	Education and training on the use of restrictive practices should be grounded in human rights principles and the dedicated human rights specialist appointed in accordance with Recommendation 21 (R21) should work with staff on this approach.

Do you see me?

'My son's greatest pleasure in life is watching Winnie the Pooh type DVDs, being on the swing in the garden or playpark and having fun.'

'He is gentle, loving, and caring. He was a very happy child, very full of life and he took an extremely active part in the lives of his extended family...When he visited his cousins, he would take centre-stage and give long speeches in his own babbling.'

'My son was delighted to visit Disney World....he sang to his favourite Disney songs as he travelled, loving every minute... He coped very well with his life and enjoyed it.'

'My son had an interest in art. At daycare he had the opportunity to do art and he really liked it.'

You know, my daughter was just non-stop. Very good at washing paintings. If you had a decent painting, it went in the sink. So I had a lot of paintings on the wall that looked like they had -- they were abstract art, but they actually had been something to look at at one stage, so I just put it back up. She loved washing things, shoes and good things, you know, anything at all went in. She would have poured out all your wine. You know, she was just always up to no good.'

Chapter 8

Complaints and Concerns

Introduction

8.1 The Inquiry heard from family members of patients at the hospital who detailed their experiences of making complaints to the hospital. Some expressed uncertainty about whether they should be making a complaint at all. Others feared that voicing concerns might adversely affect the care their loved one received. A number of witnesses felt intimidated, believing that if they made a complaint, their loved one might lose their place at Muckamore Abbey Hospital (MAH) or be prevented from returning. Others found the complaints process opaque and confusing, reporting a lack of clarity about how it worked. Many witnesses told the Inquiry they were unaware of whether a complaint was ever investigated or, if it was, how. A recurring theme was a lack of trust in the system. This is explored in more detail in Chapter 1 (The Patient Experience).

8.2 In this chapter we examine the development of complaint management processes and guidance at both regional and Trust level during the period covered by our Terms of Reference. We explore how complaints were handled in practice for patients and their families at MAH, considering what mechanisms of external oversight were available to support and scrutinise the complaints process.

Regional complaint management policy and process

8.3 Following the 1994 Wilson Review of National Health Service (NHS) complaint management across the UK, Northern Ireland introduced standardised procedures for managing complaints. These were introduced with the Department of Health, Social Services and Public Safety (DHSSPS) publication 'Acting on Complaints' (1995) and were effective from 1 April 1996.¹

8.4 The standardised complaints procedure involved three stages. Stage 1 was local resolution by the provider organisation, namely trusts. If the complainant was unhappy at the end of this, they could request a second stage. Stage 2 involved

¹ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 35

independent review, managed by the Health and Social Services Boards (HSSBs). HSSBs were responsible for appointing non-executive directors (NEDs) to the role of 'convenor', which included responsibility for considering requests for independent review. Convenors could reject, refer the issue back to the provider organisation for further action or choose to convene a review panel. If the complainant remained dissatisfied, a third stage involved external oversight. Stage 3 was scrutiny by the Northern Ireland Commissioner for Complaints (since 2016, the Northern Ireland Public Services Ombudsman).² The Inquiry did not receive information about any complaints that entered Stage 2 or 3 of the complaints process in relation to MAH.

- 8.5 In 2000, the DHSSPS issued further guidance on complaints involving children's social services, highlighting special arrangements required under Article 45(3) of the Children (Northern Ireland) Order 1995.³

- 8.6 In 2005, the Northern Ireland Human Rights Working Group on Restraint and Seclusion issued its 'Guidance on Restraint and Seclusion in Health and Personal Social Services'.⁴ This recommended annual monitoring of complaints relating to restraint and seclusion. It remains unclear whether this was accepted by Health and Social Care Boards (HSCBs), which issued contracts to HSCTs.⁵

- 8.7 By April 2009, a shift to regional HSCBs had abolished Stage 2 (independent review) of the complaints procedure. The HSCB's role was to monitor complaint handling and promote organisational learning. It was no longer responsible for independent review of individual complaints.

- 8.8 The HSCB Regional Complaints Group was established in 2009, chaired by the director of social care. Membership of this group included board directors and representatives from the Patient and Client Council (PCC).⁶

² Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Pages 37-38

³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3202 (Exhibit MMcG-64) – Guidance on Restraint and Seclusion in Health and Personal Social Services 2005

⁴ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 3254 (Exhibit CH1 T04.08) – Guidance on Restraint and Seclusion in Health and Personal Social Services 2005

⁵ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3202 (Exhibit MMcG-64) – Guidance on Restraint and Seclusion in Health and Personal Social Services 2005

⁶ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 39

8.9 In 2013-2014, the DHSSPS Quality Safety and Experience Group was established, with the Regional Complaints Group becoming one of its subcommittees. This group was tasked with reviewing issues arising from serious adverse incidents (SAIs), patient experience and complaints. In 2021, the group and its subcommittees were stood down and replaced by a weekly director-led safety briefing, where concerns relating to complaints could be raised.⁷

8.10 Regional complaints guidance updated in 2022 describes a complaint:

'A complaint is "an expression of dissatisfaction that requires a response". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such'.⁸

Trust-level complaint management processes

8.11 In April 1996, the Eastern Health and Social Services Board (EHSSB) issued its procedure for handling complaints, outlining how regional policy should be implemented within HSCTs. Around the same time, the EHSSB established a complaints committee, chaired by a NED of its board. The PCC also attended the committee's meetings.⁹

8.12 In 2005, the North and West Belfast Health and Social Services Trust (NWBHSST) conducted a review of policies and procedures for safeguarding children and vulnerable adults in MAH. It noted that all complaints were discussed weekly by the hospital management team.¹⁰ Complaints and incidents were well documented and appropriate actions were taken.¹¹

8.13 Until 2009, complaints by patients about other patients, theft of possessions or causing bodily harm were typically handled informally on the wards and were not

⁷ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 40

⁸ Department of Health (2022) Guidance in Relation to the Health and Social Care Complaints Procedure – Page 20. DoH, Belfast – <https://bso.hscni.net/wp-content/uploads/2022/07/HSC-Complaints-Standards-and-Guidelines.pdf>

⁹ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 38

¹⁰ Miriam Somerville 1st Statement (Evidence Modules) – 27/04/23 – Page 5 (Exhibit MS/1) – Eastern Health and Social Services Board and North and West Belfast Health and Social Services Trust: Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in Muckamore Abbey Hospital December 2005

¹¹ Miriam Somerville 1st Statement (Evidence Modules) – 27/04/23 – Page 17 (Exhibit MS/1) – Eastern Health and Social Services Board and North and West Belfast Health and Social Services Trust: Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in Muckamore Abbey Hospital December 2005

processed through the formal complaints procedure.¹² The Assistant Director for Learning Disabilities for NWBHSST told the Inquiry that he was aware that families had raised concerns about bruising and other injuries, which were often unexplained as no incident had been observed.¹³

- 8.14 Until at least 2011, ward staff completed daily and nightly reports. The duty nursing officer reviewed these alongside incident forms and summarised them in the senior nurse communication book. This book, along with incident forms, was submitted to the site director the next working day for review and sign-off.¹⁴
- 8.15 When the Belfast Health and Social Care Trust (BHSCT or the Trust) was established in 2007, it retained the EHSSB's legacy complaints policy until its own was approved in 2010.¹⁵ In line with 2009 HSCB guidance, the emphasis was on resolving complaints locally and as close to the patient as possible.¹⁶ Staff were expected to attempt to find a resolution and to provide the complainant with a copy of the trust's complaints leaflet at first contact. If the complaint was resolved locally, it was recorded on a local complaint record form. It was also forwarded to the complaints department for entry onto the electronic complaint management system (Datix).
- 8.16 If local resolution by staff was not possible, the issue was escalated to the relevant line manager. They would then inform BHSCT's complaints department. Complainants who wished to speak with someone not involved in their care were referred to the complaints manager or another appropriate senior person.¹⁷
- 8.17 The complaints manager was responsible for grading all complaints, both locally resolved and centrally managed, using the risk framework set out in the adverse incident reporting policy and procedure. Complaints graded as 'red' (high risk)

¹² H298 Transcript – 12/09/24 – Pages 83-84

¹³ Oscar Donnelly Statement (Organisational Modules) – 28/06/24 – Page 28

¹⁴ Elish Steele Transcript – 04/06/24 – Page 94 – Line 3

¹⁵ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Pages 015552-015553 (Exhibit T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments April 2010

¹⁶ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015453 (Exhibit T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments April 2010

¹⁷ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015563 (Exhibit T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments April 2010

were immediately escalated to the senior complaints manager, who then notified the co-directors of risk and governance and the relevant service group. The appropriate director was then informed, who in turn alerted the chief executive. The co-director or director would then agree the appropriate level of investigation to be undertaken.¹⁸

- 8.18 The BHSCT Board was required to ‘monitor and review the overall reporting performance and receive regular reports’.¹⁹ However, the Board Assurance Committee and its reporting committee did not review individual complaints, focusing instead on trends and overall complaint management.²⁰ While the policy emphasised the importance of staff responding with patience and empathy, it also acknowledged that in some cases no further action could reasonably be taken. Complainants could be classified as an unreasonable, demanding or persistent complainant.²¹
- 8.19 The BHSCT policy was updated in 2013 to clarify the interface with SAI investigations and to distinguish between a complaint and an enquiry.²² A further update was provided in March 2017, specifying that a complaint procedure could not progress if there was a disciplinary process.²³
- 8.20 Families struggled to understand why complaints could not be investigated while safeguarding procedures were ongoing. The Department of Health (DoH) 2020 independent leadership and governance review of MAH considered a number of complaints, including P96’s father’s complaint, which was still open and unresolved at the time of the investigation:

‘The third incident considered was a complaint about an assault on a patient at PICU [Psychiatric Intensive Care Unit] which occurred on 12th August 2017. This assault was not reported to the patient’s father until 21st August 2017.

¹⁸ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015566 (Exhibit T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments April 2010

¹⁹ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015560 (Exhibit T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments April 2010

²⁰ Brenda Creaney 1st Statement (Evidence Modules) – 22/02/24 – Page 24

²¹ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 15576 (Exhibit T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments April 2010

²² Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Pages 15586-15587 (Exhibit T11.04) – Belfast Trust Policy and Procedure for the Management of Complaints and Compliments September 2013

²³ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Pages 15639-15641 (Exhibit T11.05) – Belfast Trust “Policy and Procedure for the Management of Complaints and Compliments March 2017

The father was understandably concerned about the delay in notifying him especially as he was used to being regularly contacted by the staff about his son. A thorough review of all of the evidence led the Review Team to conclude that the delay in notifying the father was due to a breach of the Trust's adult safeguarding policy rather than an attempt to hide misdoings. The incident of the 12th August 2017 was immediately reported by a staff nurse who witnessed it. The Nurse in Charge failed to initiate the adult safeguarding arrangements at that time. Instead he emailed the Deputy Charge Nurse (DCN) seeking to meet in order to discuss a concern. At the meeting on the 17th August the DCN considered the information to be vague and emailed the staff nurse for details as he was on leave. As soon as matters were brought to the attention of the Charge Nurse on 21st August all appropriate action was taken in a timely manner, including notification to the patient's father. Following a meeting with MAH staff on 25th August the father complained to the Trust. Due to an incorrect email address, this was not received by the Complaints Department until the 29th August. In a letter to the father dated the 30th August 2017 he was advised that at the completion of the safeguarding investigations any outstanding matters could be addressed through the complaints procedure. The safeguarding investigation concluded in November 2018. The complaint remains open and incomplete. The Review Team considered this unacceptable'.²⁴

- 8.21 While policies refer to the interface with safeguarding referrals, serious adverse events and staff disciplinary investigations, both staff and patients' families gave evidence that there was ambiguity over which procedures took precedence. Families were frustrated that they could not get answers while other investigations were in progress. This ambiguity persisted even after the MAH CCTV footage was revealed, leading to increased tensions between ward staff and social work teams.²⁵
- 8.22 Nevertheless, minutes from the MAH Core Group show that complaints were regularly discussed by MAH managers.²⁶ They were also included in the BHSCT Adult Social and Primary Care Directorate governance dashboard.²⁷
- 8.23 The 2017 BHSCT policy update introduced several governance enhancements. It established that the Trust's complaints review group would meet quarterly to review ongoing complaints, identify trends, discuss cases of particular concern

²⁴ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital – Page 7. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

²⁵ A3 Statement – 02/11/23 – Pages 6-8

²⁶ John Veitch Statement (Organisational Modules) – 31/05/24 – Pages 136-139

²⁷ Catherine McNicholl 1st Statement (Organisational Modules) – 28/06/24 – Page 44

and agree on shared learning. Complaints were required to be a standing agenda item at both directorate and divisional governance meetings. Additionally, an annual comments, concerns, complaints and compliments report was to be submitted through the Trust's assurance framework structure and published on the BHSCT website. Following the discovery of CCTV footage in 2017, the weekly live governance report began including the number of complaints received each week.²⁸

8.24 The policy was further updated in 2020.²⁹ This update introduced clearer distinctions between:

- A complaint – an expression of dissatisfaction about care or services provided by the Trust;
- A concern – a remark, opinion or observation about a patient's treatment or care that is a matter of interest, importance or anxiety;
- An enquiry – a request for further information, such as appointment waiting times.³⁰

8.25 The Service User Experience Feedback Group replaced the former Complaint Review Group.

8.26 Managing complaints became particularly challenging where criminal investigations, vulnerable adult investigations or child protection investigations were concurrently underway.³¹

Interface with other processes

8.27 Although policies referenced the interface between complaints, safeguarding referrals, SAls and staff disciplinary investigations, both staff and patients' families reported ongoing uncertainty about which procedure took precedence.

²⁸ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Pages 106-109

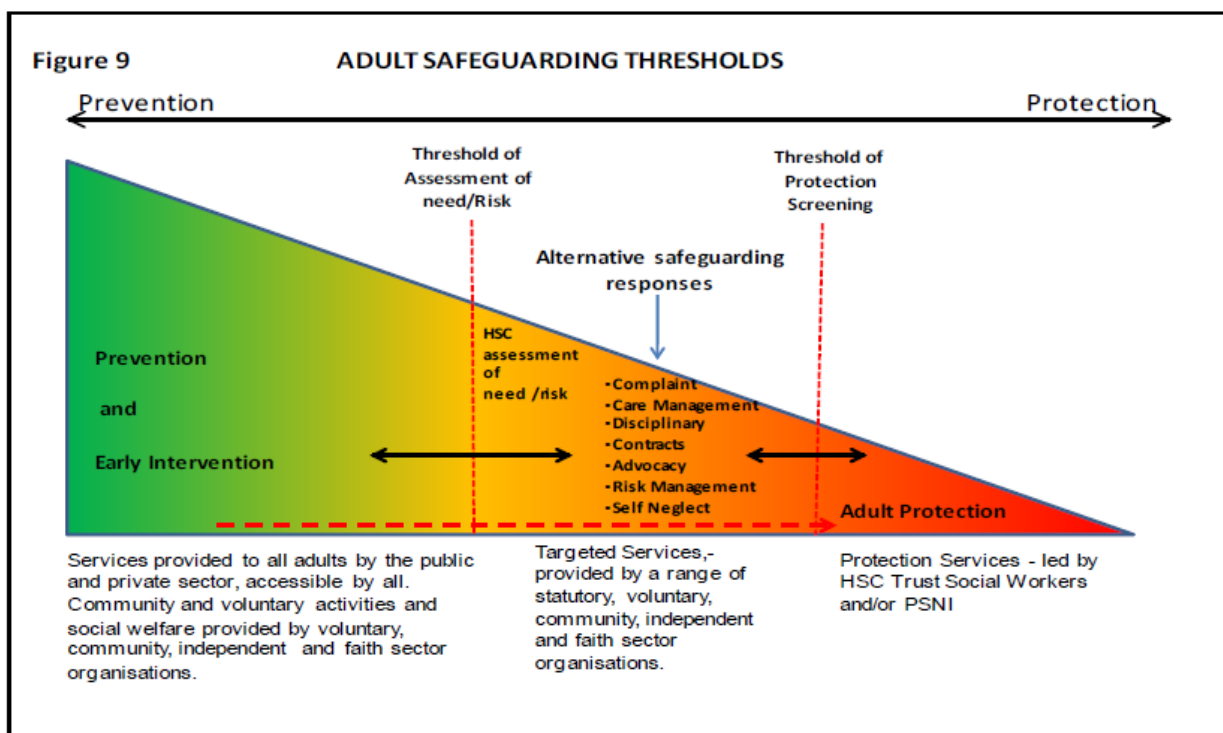
²⁹ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015692 (Exhibit T11.06) – Belfast Trust Policy and Procedure for the Management of Comments, Concerns, Complaints & Compliments April 2020

³⁰ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015702 (Exhibit T11.06) – Belfast Trust Policy and Procedure for the Management of Comments, Concerns, Complaints & Compliments April 2020

³¹ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 015569 (Exhibits T11.03) – Belfast Trust Policy and Procedure for the Management of Complaints & Compliments April 2010

8.28 The 2015 DHSSPS policy, 'Adult Safeguarding: Prevention and Protection in Partnership', describes a continuum of responses to safeguarding concerns.³² However, it lacked clear operational guidance on how to determine when an issue should be treated as a complaint versus when it should trigger an adult safeguarding response (see Figure 8.1).³³

Figure 8.1: Adult safeguarding thresholds



Patient and family experience of raising concerns

8.29 Families who gave evidence to the Inquiry did not refer to different stages of a complaints management process. Instead, they described ward-based resolution processes. Many appeared unaware that they could escalate their concerns to the BHSCT complaints department or to the Northern Ireland Commissioner for Complaints (later the Northern Ireland Public Services Ombudsman).

³² Department of Health, Social Services and Public Safety (2015) Adult Safeguarding: Prevention and Protection in Partnership. DHSSPS, Belfast – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>.

³³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3689 (Exhibit MMcG-72) – Adult Safeguarding Prevention and Protection in Partnership July 2015

8.30 A 2005 review of MAH found that information leaflets explaining patients' rights and how to complain were available, and that families/carers were to be informed of all incidents.³⁴

8.31 The reality described by some families was markedly different. Families frequently complained that they were unaware of accidents or incidents until they visited the hospital and observed injuries, or there were significant delays in informing them:

'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'.³⁵

8.32 P90's sister suggested that communication at the hospital had never been good but had deteriorated. She referred to:

'a culture of divide and conquer where relatives are actively discouraged from communicating with other families. We have felt for a long time that families are not always being told the truth. Our feeling is that if something works in the Trust's favour you will be told, but if it is something which would not be good for the Trust, or might get someone into hot water, then you will either be given an alternative version or you're not informed at all. I am aware from my work with SPFM [Society of Patients and Friends of Muckamore] that other families have had similar experiences'.³⁶

P121's sister told the Inquiry:

'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 BHSC. 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 BHSC has not explained this. No one has ever explained that the incidents that have happened could be reported as SAIs'.³⁷

8.33 When families did express concerns, they were often unclear about how their complaints would be investigated, and whether they would be handled under the

³⁴ Miriam Somerville Statement (Evidence Modules) – 27/04/23 – Page 21 (Exhibit MS/1) - EHSSB & NWBHSSST Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in MAH – December 2005

³⁵ Margaret Flynn Statement – Page 16 – A Way to Go Family Interview – Page 14 (restricted)

³⁶ P90's Sister Transcript – 11/10/23 – Pages 93-94

³⁷ P121's Sister Statement – 03/10/23 – Page 25 (restricted)

SAI protocol or the joint protocol for safeguarding incidents. When complaints were made, relatives said that there was no satisfactory response.³⁸

- 8.34 P96's father recounted the experiences (of which he was aware) of a number of families not understanding the process of how to make a complaint, or how to make one effectively. He told the Inquiry:

*'I believe that an aide-memoire could provide a starting point for families so that they know what to do if they come in and find that their loved one has bruising or something similar. I believe that the aide-memoire could set out a guide to making an effective complaint. I believe that this could help to ensure that complaints are given more credence'.*³⁹

- 8.35 The Inquiry also heard that some relatives expressed a fear of making complaints, worried it might negatively affect their loved one's care. The Inquiry heard that in some cases these fears may have been justified:

'I complained to the BHSCT about the temperature because I felt that there was a risk of heat stroke to some patients. After my complaint, I received a reply by letter and then a telephone call from a female manager. I recall the manager was upset with me for complaining and said I should have come to her first, and told me she would get fans into the ward. As far as I am aware, nothing was done about the temperature and I do not believe I would have received a letter, telephone call or any assurance if I had not gone to the manager first. In my experience, MAH did not respond well to complaints ... I also recall a previous incident involving a staff member called H71 who when I was raising concerns regarding P105's admission to MAH, he said "I wouldn't be making any complaints. You're lucky we had a bed for him. We might not have a bed for him next time"'.⁴⁰

*'However, I did not want to pursue litigation because Alicia was still in MAH and under their care and I was concerned that they had all the power, and I was worried about the repercussions on Alicia if I made a complaint'.*⁴¹

- 8.36 Families had mixed experiences of raising concerns and many faced significant difficulties. Often their concerns were based on what patients had reported to them. In the absence of corroborating evidence, staff sometimes described patients as 'poor historians' who had misremembered or misrepresented events. When concerns were not upheld, many parents nevertheless trusted that staff were acting in the best interests of their relatives:

³⁸ P1's Sister Statement – Page 23 – Letter dated 19 December 2014 from P1's Mother and P1's Father to the BHSCT

³⁹ P96's Father Transcript – 11/10/23 – Page 30 – Line 25

⁴⁰ P105's Mother Transcript – 14/09/23 – Page 49 – Line 13

⁴¹ P109's Mother Transcript – 21/09/23 – Page 40 – Line 24

'Well, she sort of tried to brush it off and sort of, like, calm me down, and that's sort of what normally happens, you know. You know, you question yourself. I had said to myself "Are these people hurting my child? Are they?", and then you thought to yourself, "But they're nurses" and, to me, nurses were like angels; you trust them like the way you would trust your GP'.⁴²

- 8.37 Others raised their concerns but felt they were not properly investigated and that the responses they received were defensive:

'It was "Protect the institution at all costs", that's what I felt. And from a legal point of view, hearing stock phrases of "It's not up to standard, yes", you know, these kind of like -- they came -- they tripped too easily off the tongue, that we were not the only family that this was happening to. But there seemed to be no willingness to get to the root of the problem of what was happening in Muckamore Abbey'.⁴³

- 8.38 These perceptions were reinforced when staff appeared to be in charge of investigating their own actions. Whether this was the reality or not, the concerns expressed reflect a lack of clear communication of process and outcome:

'We lodged a complaint about the way the Disability Service Manager dealt with P12's admission to MAH in 2002. The complaint was dealt with by the Disability Services Manager, and she found that it could not be upheld'.⁴⁴

- 8.39 Another witness told the Inquiry:

'One of the things we were coming up against is that we were making complaints, but they were investigating themselves. You know there was no independent oversight here'.⁴⁵

- 8.40 Another described how they felt about the process:

[Counsel]: *'Were you, or your mum, or your sisters who were present, was anybody given any information about a complaint's procedure or ...*

[P26's Uncle]: *No, there was no -- there was none of that. It was just, you know, it was like talking to yourself. And you see that was probably one of my biggest fears was if us as, you know, people that hasn't special needs couldn't be listened to, who is going to listen to P26 with special needs, you know?'⁴⁶*

- 8.41 From 2014 onwards, the impending closure of MAH appeared to overshadow all other concerns, with a prevailing view that investigating individual incidents was not necessary:

⁴² P2's Mother Transcript – 29/06/22 – Page 34 – Line 2

⁴³ P1's Sister Transcript – 28/06/22 – Page 73 – Line 4

⁴⁴ P12's Brother-in-law Transcript – 29/06/22 – Page 74 – Line 1

⁴⁵ P1's Sister Transcript – 28/06/22 – Page 84 – Line 11

⁴⁶ P26's Uncle Transcript – 26/09/22 – Page 103 – Line 18

'I got the sense that everyone knew, and it was a case of "We just shut down Muckamore and they'll all go away and that will be the problem solved", but the problem won't be solved because my brother is still being cared for by the Trust. The same structures are still in place. Martin will need care for the rest of his life and the Trust structures that enabled this abuse to happen are still happening'.⁴⁷

- 8.42 Some families were reluctant to raise concerns formally due to fears about potential repercussions:

'My parents did not file a complaint about the incident with MAH. I remember my father saying that he was afraid that if he made a complaint, MAH may not allow her to come home. As I had recently started working for the Belfast Health and Social Care Trust, I did not want to cause any issues by raising a formal complaint'.⁴⁸

'I am very worried that if I complain about P105's treatment at MAH and he needs to go back there again, he could be targeted or poorly treated. I believe that it is a very important issue for families and something the Inquiry should consider'.⁴⁹

- 8.43 Some patients also expressed fear themselves about speaking up. P9 confided in his brother, saying:

'... you don't talk'.⁵⁰

- 8.44 In some cases, the length of the investigation was so prolonged that it effectively negated the purposes of an effective complaint process:

'On the 9th October 2021, as part of the usual family celebrations for Bryan's birthday at MAH, we organised a party for him celebrate his 55th birthday. Due to Covid 19 restrictions, special arrangements were required and agreed with Bryan's named nurse H520 and H521, another member of staff. The agreement was that one family member was permitted to be with Bryan bringing the cake and presents and the rest would participate from home via Zoom. H520 and H521 decorated the room. When our brother, Aidan, arrived at the agreed time he was denied entry by agency staff. The cake and presents were taken from him. He was not allowed to celebrate Bryan's birthday with him and the Zoom with the rest of the family did not take place. I made complaints and requested information from H330, the ward manager, H230, the assistant service manager, H300, the service manager and H522, the director for learning disability for the Belfast Trust. By the time H522 eventually responded a year had passed and she indicated that as the incident had happened a year ago and most of the staff had gone, she could not get any information about it. She said, "we are very sorry that this happened". This

⁴⁷ P1's Sister Transcript – 28/06/22 – Page 73 – Line 23

⁴⁸ P50's Sister Transcript – 19/10/22 – Page 12 – Line 18

⁴⁹ P105's Mother's Transcript – 14/09/23 – Page 57 – Line 22

⁵⁰ P9's Brother Transcript – 30/06/22 – Page 14 – Line 16

was the first time in Bryan's life that his birthday had not been celebrated. This was very upsetting to the family'.⁵¹

- 8.45 Even when relatives and patients used the Trust's formal complaints process, they often remained dissatisfied with the response:

'We note that you have not addressed the final query in our letter, relating to the details of the abuse suffered by our son at the hands of staff members'.⁵²

'Your letter is little more than a covering letter to the action points for the future. It expresses neither regret nor apology. I think there is a measure of complacency in your statement "I hope that the recent meeting has reassured you that all possible efforts are being made to provide A with the appropriate care and treatment"'.⁵³

The Ombudsman's office replied to the Trust's chief executive officer (CEO) following a complaint about the lack of an MRI scan:

'The response appears to be seriously inadequate ... Nevertheless, I consider that rather than commence what could be a lengthy process, a better approach would be for you as CEO to provide a full, detailed, written response'.⁵⁴

One patient wrote to the Under-Secretary of State for Northern Ireland Paul Goggins MP, who appears to have consulted the Trust. MAH advised Mr Goggins that it would not be good for the patient's health to receive a reply from him, but instead to tell the patient the complaint had been passed to MAH. However, it appears he visited the patient and wrote to her to thank her for the visit in 2007.⁵⁵

- 8.46 Several family witnesses mentioned their lack of knowledge of support they could receive via advocacy services and the lack of information about such services:

'P118 did not have an advocate in MAH. After discharge we learned that he could have been provided one through the Belfast Trust but we were not informed about these services at the time. At the last meeting before discharge from Muckamore, I was approached by a male advocate employed by Bryson Care who handed me a service card if P118 required assistance on discharge. Our family did in fact require these services and they continue to provide services and support in which we are very grateful for. P118 is most of all grateful. We were not told at any admission stage that we could have had the support of an advocate'.⁵⁶

⁵¹ P90's Sister Transcript – 11/10/23 – Page 92 – Line 24

⁵² Part of folder of past complaints furnished by BHSCT to Inquiry

⁵³ Part of folder of past complaints furnished by BHSCT to Inquiry

⁵⁴ Part of folder of past complaints furnished by BHSCT to Inquiry

⁵⁵ Part of folder of past complaints furnished by BHSCT to Inquiry

⁵⁶ P118's Mother Transcript – 09/10/23 – Pages 122-123

'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'.⁵⁷

'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'.⁵⁸

- 8.47 Some relatives tried to take their complaint outside the Trust, raising concerns directly with the Regulation and Quality Improvement Authority (RQIA). However, the responses they received appeared to be defensive of the Trust:

'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'.⁵⁹

Advocacy services

- 8.48 The Inquiry heard evidence about advocacy services available to assist patients and families. The services were limited and many families did not seem to be aware of what was available.

⁵⁷ P54's Mother Transcript – 13/10/22 – Page 46 – Line 7 (restricted)

⁵⁸ P54's Mother Transcript – 13/10/22 – Page 66 – Line 13 (restricted)

⁵⁹ P96's Father Statement – 21/09/23 – Page 8 (restricted)

- 8.49 The PCC which is considered in more detail in Chapter 14 (External Agencies Inspection and Oversight) was established in 2009 and had several functions, one of which was providing advocacy services. Its geographical remit was across the whole of Northern Ireland. The Inquiry heard from Vivian McConvey (then Chief Executive of the PCC), who stressed how the organisation had changed significantly since her appointment and that there was now a significantly better focus on advocacy services and specifically a focus on MAH.⁶⁰
- 8.50 There was a recognition that there had been no particular focus on MAH nor evidence of a defined role in relation to the hospital prior to 2019, although the support provided to families would have focused on advocacy. However, between 2009 and 2022 only 33 cases could be identified specifically relating to MAH (2.5 cases per year). It was accepted based on a review of available records that the PCC's approach to advocacy and complaints support had been primarily administrative. This would include providing information on procedures and how to take a complaint forward and helping to prepare a complainant for a meeting.
- 8.51 The Inquiry was told that the commissioning of advocacy services by individual trusts was fragmented and there was a lack of coordination between the services.⁶¹ The very limited role the PCC played in providing advocacy was reflected in the evidence heard from the families of patients, who were largely unaware of its existence.
- 8.52 The Inquiry heard from Jo Marley (then Assistant Director and later Director of Bryson Care). Bryson Care (formerly Bryson House) is part of a large charitable group. It has a turnover of approximately £11 million and over 500 staff.⁶²
- 8.53 So far as Bryson Care's work with MAH was concerned, it focused primarily on patients identified for resettlement. There had been no significant involvement with MAH prior to 2005. In 2009 there was a revised contract to provide

⁶⁰ Vivian McConvey Statement – 30/01/23 – Pages 7-9

⁶¹ Vivian McConvey Statement – 30/01/23 – Page 51

⁶² Jo Marley Transcript – 28/05/24 – Pages 21 – Line 21

independent advocacy services for all patients at MAH, although this continued to focus on resettlement.⁶³

- 8.54 Posters and leaflets were available in MAH advertising Bryson Care's services.⁶⁴ A list of all new patients admitted to MAH was provided to Bryson on a weekly basis and initial meetings would have been set up.
- 8.55 Formal engagement with MAH families by Bryson did not begin until April 2016, but increased as time went on. By 2020-2021 there were almost 400 advocacy appointments, but this would have included many multiple appointments by the same patient or relative and it was difficult to ascertain from the information given how many patients and relatives were actually assisted.⁶⁵ The great majority of these would have been in relation to resettlement.
- 8.56 Any concerns raised by patients or their relatives would have been communicated to the lead ward nurse on duty. Any issue unresolved would have been raised with the divisional nurse or service manager for the hospital.
- 8.57 Until 2019 all visits by Bryson advocates had to be arranged through the hospital otherwise advocates could not get access.
- 8.58 Ms Marley told the Inquiry that one of the challenges to the advocates' work was the fact that the service was funded by BHSCT, which in her view diluted the independence of the service. There were also continuing issues in relation to identifying key contacts at the hospital for advocacy services.
- 8.59 In relation to the 2017 CCTV revelations, Bryson Care only heard about what had happened through advocates having informal discussions. Bryson advocates do not seem to have been aware in any way of the abuse or of any specific issues relating to the CCTV revelations until they were disclosed to them following the footage being reviewed.⁶⁶ A meeting was held on 12 February 2018, after which

⁶³ Jo Marley Transcript – 28/05/24 – Pages 25-26

⁶⁴ Jo Marley Transcript – 28/05/24 – Page 47 – Line 26

⁶⁵ Jo Marley Transcript – 28/05/24 – Pages 38-41

⁶⁶ Jo Marley Transcript – 28/05/24 – Page 62 – Line 21

a more formal relationship was established and a list of services was agreed. This included directly assisting relatives with complaints and safeguarding issues, assisting carers and relatives in meetings with Trust personnel to raise issues of concern, and facilitating interaction between Trust senior managers and patients.

Staff responses to complaints

- 8.60 The BHSCT supplied the Inquiry with a file of 33 complaints spanning the period when North and West Belfast Health and Social Services Trust (NWBSST) was responsible for MAH, from 1999 to 2006.⁶⁷ The complaints covered a range of issues.
- 8.61 Most of the files were paper copies of the ward complaint register. In many cases, investigations were inconclusive due to insufficient evidence to substantiate the claims.
- 8.62 The BHSCT also supplied a spreadsheet detailing 50 complaints related to MAH when it was managed by BHSCT between 2009 and 2022.⁶⁸ It should be noted that policies and processes for recording complaints changed over the years and direct comparisons between NWBHSST and BHSCT cannot be made. Between one and seven complaints were recorded annually (Figure 8.2 shows the breakdown).

Figure 8.2: Complaints registered at MAH 1999-2022 ⁶⁹

	1999-2006	2009-2022	Total
Care and treatment	3	14	17
Resettlement delays	6	8	14
Staff behaviour, assaults or verbal abuse of patients	4	6	10

⁶⁷ Part of Folder of past complaints furnished by BHSCT to Inquiry

⁶⁸ Part of Folder of past complaints furnished by BHSCT to Inquiry

⁶⁹ Records do not appear to be available between 2006 and 2009

Peer-to-peer assault	6	1	7
Personal care	5	3	8
Communications	0	3	3
Use of Mental Health Order (MHO)	3	2	5
Unexplained injuries	1	2	3
Ward moves within MAH	0	2	2
Lack of community support	2	0	2
Lack of patient supervision by ward staff	0	2	2
Clinical psychology	0	2	2
Other	3	5	8
Total	33	50	83

8.63 Staff who gave evidence to the Inquiry described handling complaints informally at ward level, often outside the formal procedures as recommended by the Wilson Review. This was to ensure timely resolution and avoid involving complainants in lengthy bureaucratic processes. However, if the matter could not be immediately resolved to the complainant's satisfaction it should have been escalated. One example from 2010 concerned complaints from relatives about the relocation of patients following ward closures.

8.64 Staff reported being instructed to shut down wards at short notice for financial reasons. The Inquiry heard from Eilish Steele (then Hospital Services Manager) that in around 2010 a Trust-level order was given to close down one of the

resettlement wards. Only two weeks' notice was given to move the patients and there was no engagement with the families.⁷⁰

- 8.65 Staff also spoke about issues surrounding loss of personal clothing, particularly during the 2000s. Attempts were made to manage this, but various factors contributed to the ongoing loss of personal items and there continued to be losses. This is described in more detail in Chapter 6 (Patients' Property and Finance). There were numerous complaints received on this issue:

'I recall some complaints about patients' clothing going missing. I do not recall when this was but I do remember how we dealt with it. The patients' families were given apologies and then the reasons for the issue were investigated. I was involved in investigating the issue. We considered awarding compensation and asked families to provide us with receipts. We found that the clothes were likely thrown away or into the bins by the patients themselves. We looked at ways that this could be prevented in future and whether there were any learnings from the complaint. As a result of this, we asked relatives to protectively mark clothes for the patients'.⁷¹

- 8.66 Staff told the Inquiry that complaints had been made about patient injuries and weight loss. In such cases, ward staff would inform the duty medical officer, who would then speak with the patient's family:

'I recall there were complaints about injuries and loss of weight. I do not recall particular names or time periods, but do recall the process that we adopted and in which I was involved. In scenarios like this, the ward staff would inform the duty medical officer and the general practitioner. I would have been informed. The doctor would speak to the family. The outcomes would include:

- the patient received the treatment they needed;*
- a change to the level or frequency of observation;*
- recording all steps in the patient's notes; and,*
- recording in the patient's care plan and amending it as necessary'.⁷²*

- 8.67 When an allegation of abuse was made against a staff member, the medical officer and nursing officer would examine the patient and speak with them directly. Eilish Steele told the Inquiry:

'Where there was an allegation by a patient or one of their relatives about abuse by a member of staff and this was not witnessed by anyone, the details would have been recorded and then the medical officer and nursing officer, and possibly me, would have spoken to the patient and examined them. The member of staff against whom the allegation was made would have been

⁷⁰ Eilish Steele Statement – 23/05/24 – Page 78

⁷¹ Eilish Steele Statement – 23/05/24 – Page 96

⁷² Eilish Steele Statement – 23/05/24 – Page 96

removed to work in another area. This was done to de-escalate things. The member of staff may have been moved to the other side of the same ward or to another ward'.⁷³

Any further action would be dependent on the findings of the medical officer and the witness statements. The nursing officer might decide there was sufficient evidence to initiate a disciplinary investigation.

External oversight

8.68 The RQIA noted in 2012 that:

'The ward maintains records of incidents occurring on the ward. Patients' relatives indicated that they were informed of any incident or accident. Relatives who contributed to the inspection also indicated they knew how to make a complaint or raise a concern. It was noted that there had been a range of concerns reported to the ward and to RQIA by patients and their relatives. However the ward's complaints records did not reflect this; a recommendation was made in relation to this'.⁷⁴

8.69 A BHSC internal audit report on the management of complaints and incidents at MAH during 2017-2018 gave limited assurance, stating:

'there are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved'.⁷⁵

8.70 Specifically, the audit identified that central files were missing information, and that some files were maintained locally in a piecemeal fashion. As a result, several 'Priority 2' recommendations were made. These are defined as recommendations where failure to implement them could result in the failure of an important organisational objective or have an impact on it. This is distinct from 'Priority 1' recommendations, where failure to implement is likely to result in the failure of an important organisational objective or have an impact on it.⁷⁶ This is discussed in more detail in Chapter 13 (Senior Management and Trust Board Governance).

⁷³ Eilish Steele Statement – 23/05/24 – Page 96

⁷⁴ RQIA – Mental Health and Learning Disability, Announced Inspection, Finglass – 25/06/12 & 26/06/12

⁷⁵ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 55 (Exhibit GS1 Tab 6) – HSCT Adult Social and Primary Care Services Directorate Risk audit – Management of Complaints and Incidents at Muckamore 2017/18

⁷⁶ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 68 (Exhibit GS1 Tab 6) – HSCT Adult Social and Primary Care Services Directorate Risk audit – Management of Complaints and Incidents at Muckamore 2017/18

8.71 Internal audits are considered at the BHSCT Audit Committee. However, Gordon Smyth (then a Non-Executive Director on the BHSCT Board and later Chair of the Audit Committee) told the Inquiry he did not know why an internal audit of complaints at MAH had been commissioned.⁷⁷ He told the Inquiry:

'The audit committee would not have had a role to play in deciding what services should be audited or what the subject of the audit should be'.⁷⁸

8.72 Despite the internal audit report only offering limited assurance and identifying 'significant weaknesses', the Audit Committee Chair did not ensure that the committee revisit the issues to assure itself those weaknesses had been addressed.

8.73 A number of families raised concerns with the PCC or with the RQIA.⁷⁹ Yet the Inquiry found no clear evidence of how this data was collated and analysed, nor whether any thematic discussions took place with BHSCT. It remains unclear whether these cases were considered collectively or handled in isolation.

Conclusions

8.74 Some families reported that they were not aware of issues at MAH before the discovery of CCTV footage and had no cause to complain. However, a number of others who raised concerns expressed that these were not satisfactorily dealt with. Subsequent revelations, identified through viewing CCTV footage, have caused immense anxiety and distress, both to those whose relatives were identified on CCTV and those whose loved ones were not.

8.75 There were few formal complaints recorded over the 22-year period covered by the Inquiry. This may be because staff were resolving concerns at ward level without recording them. It may also be that some families found it difficult to make complaints and did not understand the complaints process.

8.76 Complaints are sometimes associated with safeguarding, SAs and staff conduct. High-level policies note that issues can be raised in any or all of the different

⁷⁷ Gordon Smyth Transcript – 14/10/24 – Page 131 – Line 10

⁷⁸ Gordon Smyth Transcript – 14/10/24 – Page 133 – Line 13

⁷⁹ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Pages 38-39

processes associated with these areas but at the hospital level there was a lack of clarity about which procedure to follow. Where complaints were paused while other procedures were being used, the complainants were not updated regularly, and they failed to understand why another procedure (such as the disciplinary investigation of a member of staff) meant that the complaint process had to be paused.

- 8.77 The 2017-2018 internal audit⁸⁰ demonstrated that recording of complaints was inconsistent and incomplete, and it is impossible to estimate the number of families or advocates who raised concerns about care in MAH. When concerns were raised, either formally or informally, investigations were often inconclusive as there was no supporting evidence, or staff disputed the complainant's version of events.
- 8.78 Developing a proportionate response to concerns and complaints remains a challenge throughout the health and social care system. Patient-facing staff are the first line of contact, and it is important, on the one hand, that any complaint management process is efficient and does not reduce patient contact time and, on the other hand, that concerns are properly investigated.
- 8.79 Too many complaints were not resolved in a timely manner and insufficient information was given to families in relation to the complaints process.
- 8.80 There was a lack of understanding about support and advocacy services that could have been provided to assist people in raising a concern or making a complaint.

⁸⁰ Gordon Symth Statement (Organisational Modules) – 07/06/24 – Page 52 (Exhibit Tab 6) – HSCT Adult Social and Primary Care Services Directorate Risk audit – Management of Complaints and Incidents at Muckamore 2017/18

Recommendations

R38	People with learning disabilities and autistic people and their families should be provided with clear, written information outlining the available pathways for raising concerns. This information should clearly distinguish between an enquiry, a concern and a complaint. Individuals should then be asked to select the option that they feel best aligns with their needs. This selection should be recorded at ward or residential level and confirmed with the individual raising the issue.
R39	People with learning disabilities and autistic people and their families should be provided with a short description of how best to record and present concerns so as to be effective.
R40	In HSCTs all complaints, regardless of whether they are resolved immediately at ward level, should be recorded in the Trust's electronic complaints management system. In private and third sector facilities the Registered Home Manager should be informed of all concerns raised and must record such concerns and any action taken.
R41	Complainants should immediately be informed of how their complaint will be managed (locally or through the corporate complaints process) along with a clear explanation of the corresponding level of investigation and oversight this entails.
R42	Complainants must be regularly updated and informed of the progress of any investigation, including when the process concludes without a specific finding.
R43	All complaints managed at corporate level and rated as red (using the red, amber and green (RAG) rating matrix) should be shared with all non-executive directors (NEDs) on the Board.
R44	Complaints alone are a poor indicator of quality of care, particularly in a vulnerable population such as those admitted to MAH. A low volume or absence of complaints does not necessarily indicate that care provided is good or satisfactory. Organisations must find proactive approaches to assure themselves and the public that high standards of care are being provided, such as using a validated system to explore the experience of people with learning disabilities and autistic people on a quarterly basis, including regular person and family surveys or interviews. In a learning disability setting, interviewers must be trained in effective methods of communication. Complaints should be analysed for themes quarterly and triangulated with themes from incident reporting and RQIA inspection reports, and displayed on a public dashboard as well as online.

Patients are people first

'My son really loves colours. He notices when people have colourful mobile phones. During lockdown, because of the restrictions one of the few things that we could do with my son was to go to Superdrug. Here my son would like to look at the bright colours in the nail varnishes. My son always likes different hair dyes'

'Even though my nephew has always had special needs, we would have been able to send him to the shops on his own'

'He would have been stubborn but full of fun. He wouldn't have been scared or afraid. However, after a while in Muckamore he totally changed in all those ways. It was like he became a totally different person'

Chapter 9

Previous Concerns, Previous Investigations and Warning Signs

- 9.1 In this chapter we will look at what signals and signs there were, and whether anyone should have considered them globally or thematically, to indicate impending issues with the way in which patients with challenging behaviours were cared for, managed and looked after at Muckamore Abbey Hospital (MAH) prior to the 2017 revelations and thereafter. We will consider previous investigations, including the 2012 investigation of the hospital's Ennis Ward, and consider their consequences.
- 9.2 Unfortunately, in the UK, reports of abuse of people with learning disabilities, both children and adults, have repeatedly appeared over the years. One of the earliest inquiries into such abuse was in 1969 and related to the care of adults with learning disabilities in Ely Hospital in Wales.¹ That led to a UK Government White Paper 'Better Services for the Mentally Handicapped' (1971), which signalled the start of a closure programme for hospitals for people with learning disabilities and the transfer of services to the community. Nevertheless, cases of abuse continued to occur in multiple patient settings, for example, Longcare in England, concerning two large privately run residential homes for people with learning disabilities in Buckinghamshire (1998)², as well as hospitals and community-based homes in Cornwall (2007)³ and Ralphps Close in Northern Ireland (2012).⁴
- 9.3 The abuse investigated in these settings comprised significantly of staff-on-patient abuse. Reports of abuse in a number of small hospital settings run by independent

¹ Department of Health and Social Security (1969) Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other irregularities at the Ely Hospital, Cardiff. – <https://sochealth.co.uk/national-health-service/democracy-involvement-and-accountability-in-health/complaints-regulation-and-enquiries/report-of-the-committee-of-inquiry-into-allegations-of-ill-treatment-of-patients-and-other-irregularities-at-the-ely-hospital-cardiff-1969>

² Article reference 'Law and learning Disability' <https://www.emerald.com/tldr/article-pdf/4/1/28/2353598/13595474199900007.pdf>

³ J. Snell (2007) 'Cornwall learning disabilities scandal: has the tide turned?', Community Care – <https://www.communitycare.co.uk/2007/06/27/cornwall-learning-disabilities-scandal-has-the-tide-turned/>

⁴ Northern Ireland Assembly (2014) Ministerial statement: Department of Health, Social Services and Public Safety – Ralphps Close Residential Care Home – <https://www.niassembly.gov.uk/assembly-business/official-report/written-ministerial-statements-2011-2016/departments-of-health-social-services-and-public-safety--ralphps-close-residential-care-home/>

healthcare providers followed: Winterbourne View in Gloucestershire (2011),⁵ Whorlton Hall in Durham (2019)⁶ and Yew Trees hospital in Essex (2020).⁷

- 9.4 It is worth therefore examining the findings of the reports into those scandals (and others) in order to discover if there are common themes and common factors. We have briefly summarised the background to those inquiries and their findings in Appendix 3 (Page 657). We set some of those issues out here, but only by way of example. Those inquiries found common themes and that factors in many cases were: lack of oversight of what was happening on the ward; poor leadership; poor infrastructure; a badly thought-out patient mix; lack of advocacy; poor staff training for the specific patient group; overuse of restraint; and overuse of ‘pro re nata’ (PRN) medication. A consideration of what had happened in those cases and a review of those previous reports, even on summary reading, would have alerted the diligent reader to warning signals present at MAH before 2017.
- 9.5 Even without the background of such infamous scandals, the abuse of autistic people and those with learning disabilities has long been recognised as a risk in healthcare settings. A recent systematic review of abuse in care settings reported a number of risk factors, including victim characteristics (such as having a more severe learning disability, being female, having challenging behaviour or being on medication to manage behaviour), perpetrator characteristics (such as being male, staff believing people to be very different from them or ‘too disabled’ or ‘to have no skills’) and a whole raft of environmental characteristics (such as those related to staffing and restrictive practices).⁸
- 9.6 Organisational factors also featured in the studies reviewed, such as inadequate monitoring of services, a lack of managerial support for frontline staff, negative relationships between staff, poor staff training, poor engagement with family

⁵ South Gloucestershire Safeguarding Adults Board (2012) Winterbourne View Hospital: A Serious Case Review by Margaret Flynn – <https://sites.southglos.gov.uk/safeguarding/adults/i-am-a-carerrelative/winterbourne-view>

⁶ Social Care Institute for Excellence (2022) Safeguarding Adults Review on Whorlton Hall – <https://www.anncrafttrust.org/wp-content/uploads/2022/12/WhorltonHallSafeguardingAdultsReviewExecutiveSummaryDecember2022.pdf>

⁷ M. Samuel (2020) ‘Staff abused women at learning disability unit, finds CQC’ – <https://www.communitycare.co.uk/2020/09/23/staff-abused-women-learning-disability-unit-finds-cqc/>

⁸ J. Collins and G.H. Murphy (2021) ‘Detection and prevention of abuse of adults with intellectual and other developmental disabilities in care services: a systematic review’, *Journal of Applied Research in Intellectual Disability*, 35(2), pp. 338-383 – <https://doi.org/10.1111/jar.12954>

members, poor community participation, isolated and poorly maintained environments, poor-quality care plans, staff shortages, high staff turnover, use of restrictive practices, staff collusion and downgrading of incidents.

- 9.7 Given that many of these risk factors were present at MAH prior to 2017 it is difficult not to conclude that there was a failure to react to warning signs readily available to the management of the Belfast Health and Social Care Trust (BHSCT), had a holistic view been taken. Whether or not such recognition would have resulted in change, there could and should have been closer scrutiny of the circumstances in which patients were being cared for at MAH well before 2017.

Early reports of abuse – reports of abuse occurring before 1999

- 9.8 Several members of staff who had long service at MAH told the Inquiry that there had always been a process for reporting and disciplining staff who had behaved inappropriately. When an allegation was made, the staff involved would be moved to a different clinical area, or a different part of the ward, while an investigation was ongoing.⁹
- 9.9 In 1996, a former patient at MAH alleged that he had been physically and sexually abused while he was in MAH. The patient had been a resident in MAH between 1970 and 1982, when he was aged 12 to 24 years old. The case was brought to the Director of Public Prosecutions (DPP), where it was decided that the case was not strong enough to proceed for various reasons. Nevertheless, in 2004 the patient received an out-of-court financial settlement from the Eastern Health and Social Services Board (EHSSB), which was responsible for MAH at the time.¹⁰
- 9.10 As part of this case, EHSSB requested that MAH undertake a review of the patient's records and the records of those patients and staff mentioned in his records. A total of 64 patient records were reviewed in what was termed 'Phase 1'.¹¹ They found 18 incidents of peer-on-peer sexual abuse by adult males against minors (four of these involved the patient who made the original claim).

⁹ Eilish Steele Statement – 21/05/24 – Page 96

¹⁰ Sensitive PSNI Case Review Report Operation SELK (16/06/08) furnished to Inquiry

¹¹ Sensitive PSNI Case Review Report Operation SELK (16/06/08) furnished to Inquiry

The actions by ward managers included imposing a loss of privileges for both victims and alleged perpetrators, and 'no real investigative action'. A number of other possible offences were discovered, such as: five clearly non-consenting sexual acts between adult male patients, in which the victim was held down (in two cases the victim was held down by three men); nine sexual acts between possibly consenting adults; and 15 where it was not possible to be certain if the victims were minors or not consenting. There were also nine incidents of physical abuse. Phase 2 followed, during which a further 296 case files were reviewed by social services.

- 9.11 These historic claims of sexual abuse came to the attention of the Police Service of Northern Ireland (PSNI) at the end of 2005, which triggered an investigation named Operation Selk. According to the PSNI, the records demonstrated a significant amount of sexualised behaviour between patients, some of which could be clearly defined as 'sex offending'. Interviews with patients in both phases of the review provided insufficient evidence to support any prosecutions and there was a lack of any corroborative evidence.¹²
- 9.12 No further court cases ensued. The alleged abuse took place outside the Terms of Reference (ToR) of the Inquiry (the incidents reviewed date from the early 1960s to the early 1980s) and the Inquiry has not sought to investigate these further. Nevertheless, the material available does seem to indicate that some staff at MAH were aware of abusive and inappropriate behaviour and had not taken effective action to prevent it. These allegations should have raised further awareness of the risk of abuse after their emergence in the mid-1990s.
- 9.13 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

¹² Sensitive PSNI Case Review Report Operation SELK (16/06/08) furnished to Inquiry

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 2006.¹³

- 9.14 In 1997, the Northern Health and Social Services Board (NHSSB) conducted a review of how it dealt with untoward events across all services. This concluded that there was no clear understanding within trusts, at either board or departmental level, as to which incidents should be reported and how.¹⁴

1999 to 2010

- 9.15 The Inquiry heard from the Assistant Director of Learning Disabilities at North and West Belfast Health and Social Services Trust (NWBHSST) from 2001 to 2004 that he was aware of families of patients at MAH raising concerns about bruises and other injuries,¹⁵ but where there was no witness this was often categorised as ‘unexplained injury’ and recorded through the local complaints system. This approach was confirmed by the evidence of family members who were often told that injuries they noticed were likely to be ‘self-inflicted’.
- 9.16 Peer-on-peer abuse or cases of taking patients’ possessions were dealt with informally on wards up until 2008 without going through the formal complaints or incident procedures,¹⁶ reflecting a general assumption at all levels (ward, safeguarding and policymaking) that peer-on-peer incidents were not regarded as ‘abuse’. This meant that these incidents did not trigger a review of the systems and processes (including consideration of the mix of patient needs in the wards). Given that NWBHSST was responsible for the safety of all its patients throughout their stay at hospital this was an unwise, if common, approach.
- 9.17 In 2000, regional guidance on reporting serious incidents and how they should be investigated was issued by the Mental Health Commission (MHC). This was updated in August 2005 and it set out a list of the types of incident that were required to be reported.¹⁷ These included:

¹³ Eilish Steele Statement – 21/05/24 – Page 62 (restricted)

¹⁴ Seamus Logan Statement – 10/08/22 – Page 3

¹⁵ Oscar Donnelly Statement (Organisational Modules) – 08/06/24 – Page 28

¹⁶ H298 Transcript – 12/09/24 – Pages 83-84

¹⁷ MAHI – Additional Materials Referenced – Page 188 (Letter from Mental Health Commission - Monitoring of Untoward Events)

- The death of a patient other than from natural causes;
- Suspected suicides in the hospital or community;
- Sexual assaults or allegations of sexual assaults in hospital or the community;
- Actual or alleged physical assaults by members of staff;
- Serious assaults by patients on other patients or staff;
- Allegations of gross professional misconduct or serious deficiencies in standards of care;
- Any other incidents the provider 'feels should be brought to the attention of the commission, for example serious unexplained injury'.

9.18 In 2004 the Department of Health Social Services and Public Safety (DHSSPS) introduced interim guidance on the method of reporting and follow-up by investigation of serious adverse incidents (SAIs).¹⁸ Initially the reporting was to the DHSSPS but from 2010 SAIs were monitored by the Health and Social Care Board (HSCB). This included three stages of review – Level 1, Level 2 and Level 3 – depending on the risk of harm incurred. The levels referred to the depth and extent of the investigation undertaken. Level 1 led to a significant event audit (SEA) by the organisation reporting the incident and a report by the investigator to the HSCB. Level 2 meant a root cause analysis (undertaken internally) leading to a report to HSCB. Level 3 led to an independent (external) investigation.¹⁹ From 2005 all organisations were required to inform the DHSSPS immediately of any serious incidents.²⁰

9.19 A 2007 Regulation and Quality Improvement Authority (RQIA) review of safeguards for children and vulnerable adults in learning disability hospitals reported that according to the trust's own self-assessment at MAH there had been no child protection referrals in 2004/05, one unsubstantiated referral in 2005/06 and two unsubstantiated in 2006/07. There was one substantiated adult

¹⁸ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Page 58

¹⁹ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 6

²⁰ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Page 5492 (Exhibit MMcG/123) – Circular HSS (PPM) 05/05

safeguarding referral and six unsubstantiated in 2004/05, ten unsubstantiated in 2005/06 and two substantiated with seven unsubstantiated in 2006/07.²¹

- 9.20 In May 2010, the DHSSPS delegated the review of SAs to the HSCB²² and introduced 'early alerts'.²³ The circular 'Establishment of an Early Alert System' provided guidance to ensure that the DHSSPS was made aware in a timely fashion of significant events occurring within health and social care organisations.²⁴ Since 2012 these early alerts have been known as 'safety and quality alerts'.²⁵ Alerts were a way of ensuring the DHSSPS was made aware of potential issues but there was no expectation that it would take any immediate action, having delegated the monitoring of the investigation to the HSCB, so, in themselves, such alerts provided no reassurance that action would be taken.
- 9.21 Consideration of the MAH Core Group minutes between 2002 and 2016 makes it clear that many of the risk factors mentioned above were present in MAH, particularly in some wards. For example, challenging behaviour was a common occurrence in certain wards (for example, Cranfield 1 and 2, Sixmile and the Psychiatric Intensive Care Unit (PICU)) and the rate of incidents, seclusions and restraints recorded in these wards was high.²⁶ Other wards seemed less at risk, for example, we heard that wards such as Rathmullan and Rathmore housed residents who had very severe physical disabilities, which presumably meant they exhibited less challenging behaviours.²⁷
- 9.22 In addition, MAH was certainly geographically isolated and a number of witnesses spoke about the lack of visits from senior managers from the BHSCT.²⁸ It seemed that some wards were in bad repair (another risk factor already mentioned), such as Ennis Ward and Erne Ward, according to Brendan Ingram (a former nurse who

²¹ MAHI – Additional Materials Referenced – Page 192 (RQIA Review of Mental Health and Learning Disability Services: 2007)

²² Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 44

²³ Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 51; Page 6744 (Exhibit BW106) – Circular HSC (SQSD 10/10)

²⁴ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Page 61

²⁵ Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 52

²⁶ Inquiry analysis of data provided by BHSCT

²⁷ Brendan Ingram Statement – 25/07/24 – Page 5

²⁸ A6 Transcript – 19/02/24 – Page 111 – Line 15

was the MAH Business Manager in 2016).²⁹ It is likely that some wards varied in their condition, but H112 described Erne Ward as it was in October 2016 as follows:

'Initially I was horrified as I had not seen a ward like it before. The physical environment was appalling due to the smell of urine and there were infection control issues. There was dark lighting, and it was a depressing ward. Some of the day rooms had curtains, others did not. The bathrooms were disgusting and there was a lack of personal care items in the toilets like towels and bed linen. Overall, it was a horrendous physical environment, and I found it very distressing that patients were being nursed in this environment. It was very clear to me that there was a lack of external oversight by any senior management and a clear lack of governance afforded to this ward'.³⁰

9.23 The RQIA inspected Erne Ward in July 2016 and found 12 areas for improvement, including various aspects of the environment and levels of staffing.³¹

9.24 John Veitch (former Co-Director of Learning Disability) told the Inquiry that he could find no evidence that between 2012 and 2017 much attention had been given by the BHSCT Board to MAH. He told the Inquiry:

'I mean certainly in 2017 the Trust gave the site their full attention in every possible way, but we couldn't find the evidence that between 2012 and '17 there was much attention given'.³²

9.25 It is impossible to identify accurately the number of historical incidents of abuse given different reporting systems and cultures in the past. Some have suggested that concerns may have been under-reported.

2010 to 2017

9.26 There were repeated concerns about staff shortages (another risk factor for abuse) voiced in MAH Core Group meeting minutes, some as early as 2003 and 2004 and then particularly from 2012 onwards (for example, 30/09/03; 18/05/04; 15/05/12; 12/06/12; 21/08/12; 18/09/12; 08/01/13; 30/04/13; 28/10/14; 17/02/15; 13/03/15 and 01/03/16) and confirmed by individual staff members.³³ Staffing was always a concern but it reduced considerably over the years, and particularly by 2010, as

²⁹ Brendan Ingram Transcript – 11/09/24 – Page 131 – Line 17

³⁰ H112 Transcript – 10/09/24 – Page 37 – Line 13

³¹ RQIA – Unannounced inspection, Erne Ward – 19-21/07/16

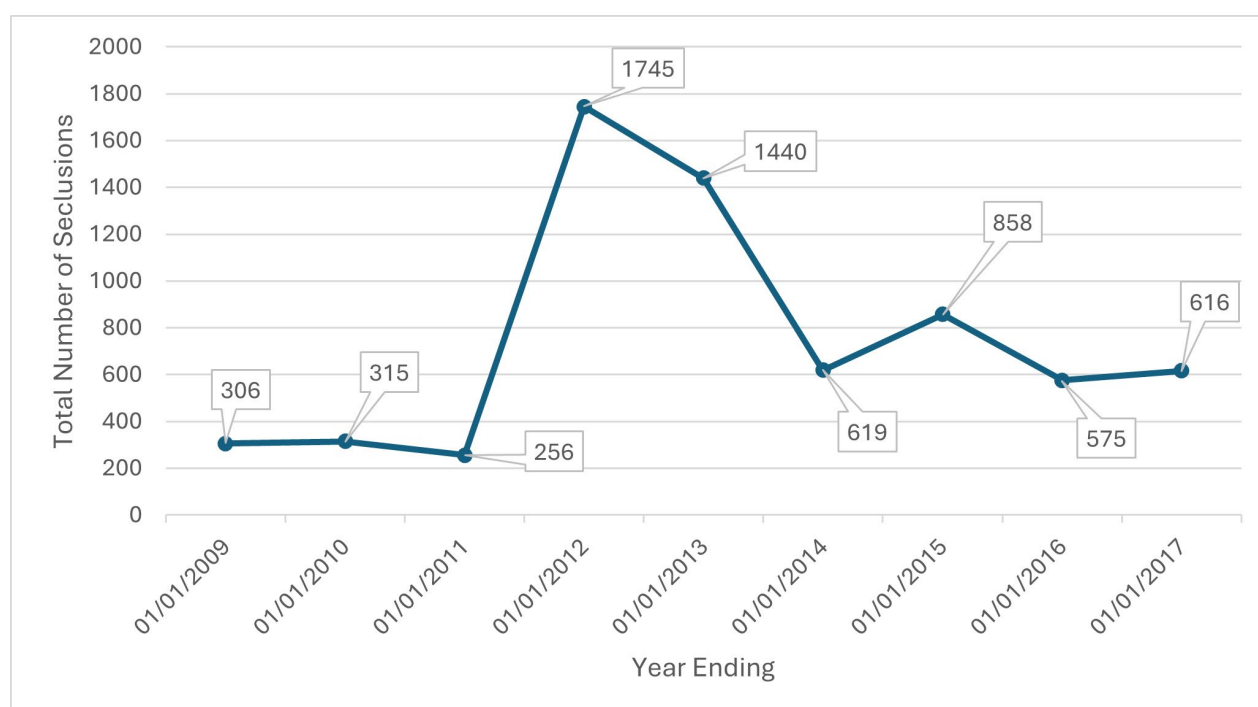
³² John Veitch Transcript – 18/06/24 – Page 93 – Line 19

³³ Brendan Ingram Transcript – 11/09/24 – Page 113 – Line 28; MAH Core Group meeting minutes

seen in Chapter 12 (Staff and Ward Management), it was a serious concern and was reported as such, for example by A12 on Ennis Ward,³⁴ and noted by the RQIA.³⁵ Certainly in 2010 the turnover of staff was high. Moreover, many families described poor relationships with staff, not knowing from whom to seek information and feeling very unwelcome on wards when they visited their relatives (see Chapter 1 (The Patient Experience)).

- 9.27 From 2011 (and as the ward staffing shortages became more acute), the number of seclusions increased significantly. See Figure 9.1 for details.

Figure 9.1 Reported incidents of seclusion 2009-2017



- 9.28 Esther Rafferty (former Service Manager and Associate Director of Nursing for MAH) told the Inquiry that she was notified of an alleged assault of a patient by a staff member on her first day as Service Manager in 2012. The staff member was sent home and later suspended. He accepted a formal police caution and was subsequently disciplined. She also recalled that a staff nurse was dismissed for slapping an elderly patient's hand (although an appeal reinstated the nurse with a

³⁴ A12 Statement – 28/03/24 – Pages 30-32

³⁵ Module 6b Ennis Bundle – Page 114 – RQIA Unannounced Inspection Ennis Ward MAH

final warning) and a healthcare worker pushed a patient, causing him to fall, and was dismissed, although a criminal charge was dismissed in court.³⁶

- 9.29 Her recollections are supported by a contemporaneous note of a meeting in 2012 when Esther Rafferty told the Public Health Agency (PHA) that from the beginning of 2012 she had suspended eight healthcare assistants. One had been dismissed and two received cautions from the PSNI. She noted that six months prior to the November 2012 allegation by Bohill staff, a support worker from Ennis had been suspended. PSNI had investigated but no charges were brought, and the staff member resigned.³⁷
- 9.30 MAH had a high number of vulnerable patients at risk of abuse, either from other patients, permanent or visiting staff. Concerns and allegations have been subject to Vulnerable Adult (later called Adult Safeguarding) processes since 2003.³⁸ Because of the high risk, there is a low threshold for referrals and between 01 January 2012 and 31 December 2012 there were 565 adult safeguarding referrals at MAH and between 01 January 2013 and 31 December 2013 there were 804.³⁹
- 9.31 A referral does not necessarily mean abuse had occurred but that an incident needs scrutiny. Not all referrals result in a full investigation, but a significant number do.
- 9.32 P1's Sister told the Inquiry how her family was informed that her brother had been assaulted on 18 May 2014, and staff had been suspended. The PSNI charged a member of staff, but she was acquitted.⁴⁰ In June 2014 they were informed of a further incident where water had been thrown over her brother 'for a laugh'. The staff member received a police caution.⁴¹

³⁶ Esther Rafferty Statement (Organisational Module) – 27/06/24 – Page 31

³⁷ MAHI – Additional Materials Referenced – Page 311 (Briefing Notes Regarding Allegations of Abuse at Muckamore Abbey Hospital – 15/11/12)

³⁸ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Page 34

³⁹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 7

⁴⁰ P1's Sister Transcript – 28/06/22 – Pages 19-20

⁴¹ P1's Sister Transcript – 28/06/22 – Page 21 – Line 8

- 9.33 Also in 2014, another healthcare assistant was charged with assaulting a patient, but the case was dismissed in the magistrate court.⁴²
- 9.34 The Inquiry heard numerous examples where the police had charged a suspect but the suspect had ultimately been acquitted in the criminal courts. The criminal standard of proof is of course far higher than that applied in civil cases or in disciplinary processes where generally the standard, known as ‘the civil standard’, is applied. In simple terms the test applied in civil and disciplinary cases is: is it more likely than not, on the balance of probabilities that the event happened and the individual acted in the way alleged? In criminal cases the test is, can the jury/tribunal be ‘sure’. Many cases are brought which end in a ‘Not Guilty’ finding, this does not mean that the police were wrong to take the case to court nor that the individual did not do the act alleged.
- 9.35 Alleged assaults were not confined to MAH staff. In 2014 there was ‘serious concern’ about the PSNI use of handcuff and leg restraints on a young person who was subsequently taken to a seclusion room. The RQIA noted the limited knowledge of staff concerning the management of behaviours. Among the RQIA’s 35 recommendations was the drafting of a protocol ‘to define the circumstances in which the police should be required to assist staff to manage challenging behaviour’.⁴³
- 9.36 In February 2015, two incidents at MAH met the criteria for SAIs and were reported to the HSCB. The members of staff accused of abuse had been suspended and the incidents reported to the PSNI. There was no prosecution, and the cases were managed through the Trust disciplinary procedures. The staff members did not return to the same ward and were placed on supervised practice for six months.⁴⁴

⁴² P68’s Brother Statement – 25/04/22 – Pages 2-5 (restricted)

⁴³ Margaret Flynn’s Statement (Evidence Modules) – 24/04/23 – Page 71 (Exhibit MF/1) – A Way to Go - Final Report Appendix 5 Themes arising from Regulation and Quality Authority (RQIA) Reports 2012-2017

⁴⁴ Jacqui Austin Statement (Organisational Modules) – 08/05/24 – Pages 16-17

9.37 Between October 2013 and March 2015, the PHA received 4 SAIs from BHSC in relation to learning disabilities services (of a total across all BHSC services of 154).⁴⁵

9.38 Between 08 February 2013 and 21 April 2021, 15 SAIs involving abuse by a member of staff were reported, 3 of the SAIs involved a patient assaulting another patient with 2 SAIs involving a patient assaulting a member of staff.⁴⁶

9.39 P1's Sister told the Inquiry that by 2015 her family were noticing a real change in the service at MAH and had written to the Health Minister, copied to the Deputy First Minister.⁴⁷ She told the Inquiry:

'One of the things we were trying to get to the bottom of, because no one else seemed to be, was why this was happening, why was it happening now -- because we didn't hear anything about abuse for 16 years and then, suddenly, he's getting abused every couple of weeks. You know, it was like 'What is happening?!', and that was the carers, and the nurses had identified that to us, by saying 'There's a lot of agency nurses'. Just to put it in context about what was happening at this time, Muckamore was shutting down, so they were -- they had closed -- they were closing down the wards. They were closing the swimming pool, all the social activities. Patients were really being confined to wards. And when you have patients with very complex disabilities and behavioural problems changing their routine and making them confined to wards, it's going to create a stressor event, and it's going to create a stressor event for staff as well. So, if you have that in the context, then you had unbelievable sick leave that was happening, which again is indicative of something wrong within the structure. The use of agency nurses coming in. Staff had expressed to my parents that they were worried about their jobs as the wards were closing. So, you have all this happening and it's creating like a perfect storm of -- and the abuse was thriving within this, as far as we could see. So that's why we had raised those issues'.⁴⁸

9.40 This account chimes with the evidence that ward staffing was on the service unit risk register from 2012⁴⁹ and on the BHSC risk register from 2014.⁵⁰ As described in Chapter 13 (Senior Management and Trust Board Governance), risk registers are developed at the point closest to the patient (the service unit) and described the highest risks and the actions taken to manage them. The risk

⁴⁵ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Pages 371-375

⁴⁶ Inquiry analysis of material provided by BHSC

⁴⁷ P1's Sister Transcript – 28/06/22 – Pages 116-117

⁴⁸ P1's Sister Transcript – 28/06/22 – Page 123 – Line 1

⁴⁹ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 32

⁵⁰ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 20

registers for all the service units within a larger organisational grouping (division or directorate) are reviewed and a register is created for the highest risks within the division or directorate. This means that some of the risks on the service unit register are not the highest risks for the division or directorate. The process is repeated and the registers for all the directorates are reviewed and the highest risks across the whole Trust to create the Principal Risk Register

- 9.41 The notes of the regional Directors of Nursing meeting in January 2013 record that across Northern Ireland 421 people with learning disabilities had adult safeguarding care and protection plans.⁵¹ In January 2013 Esther Rafferty reported that in MAH there were approximately 60 to 65 safeguarding referrals a month, including peer-on-peer abuse.⁵² A later review of safeguarding files found that between April 2012 and September 2017 there were 128 allegations of abuse concerning staff at MAH.⁵³ This period incorporated the start of the period of the CCTV revelations, and some have inferred that there were, prior to this period, significantly more incidents that might be classified as abuse than had previously been reported.
- 9.42 Whilst the reporting of staff abuse of patients remained relatively low, compared to peer-on-peer abuse, there was clear evidence of the increasing levels of aggressive and violent behaviours at MAH. The Trust supplied the Inquiry with a retrospective analysis of Datix incidents. They aggregated a number of incident subcategories into a single category which they called inappropriate/aggressive behaviour. Their analysis shows that there was a rise in reported peer-to-peer inappropriate/aggressive behaviour from 343 incidents in 2011, to 704 in 2014 (after which it fell to 539 in 2016). These figures need to be interpreted with the numbers of patients in mind: there were approximately 200 patients in 2011, 160 in 2014, and 100 in 2016, implying that proportionately peer-on-peer abuse was rising across those years (from a ratio of 1.7 per patient in 2011, to 5.4 per patient in 2016). There was also a rise in patient-to-staff inappropriate aggressive

⁵¹ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 711 - Meeting with Directors of Nursing to discuss Learning Disability Nursing issues, Wednesday 30/01/13

⁵² Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 711 – Meeting with Directors of Nursing to discuss Learning Disability Nursing issues, Wednesday 30/01/13

⁵³ Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Page 22 - Way to Go Report

behaviour from 416 incidents in 2011 to 1571 in 2016 (again these figures should be interpreted with the fall in the number of patients in mind).⁵⁴ It is not clear whether the Trust's Clinical Governance processes registered this significant rise at the time. However the staff appeared to be well aware, and the Inquiry heard from a member of staff that by 2016 the increased number of peer-to-peer and patient-to-staff incidents to be reported meant staff were required to complete Datix forms in their own time after their shift had ended.⁵⁵ On one occasion a patient was prosecuted for assaulting a member of staff and received a suspended sentence.⁵⁶

- 9.43 Mairead Mitchell (then Head of Learning Disability Services at BHSCT) went on to describe the series of things she had noted (and listed in July 2017), including the RQIA report on Erne ward (and the lack of improvement in that ward for months), many concerns raised by staff in walkabouts, and requests for meetings from families, regarding concerns about patient care and safety. Staff absence rates were high (10%) and there were a very large number of incidents per month (e.g. 369 in May 2017 alone including abusive and violent behaviour between patients and between patients and staff) as well as safeguarding incidents (54 in May 2017). These incidents, as well as seclusions, use of Pro Re Nata (PRN), physical interventions, and complaints were reported at weekly ward manager meetings by the hospital resource nurse (and this had been longstanding practice since about 2000):

'Regular reports were received by senior managers and the ward managers which included all of the above as well as incidents/accidents and patients on special observations on a weekly basis. These were discussed at the Core Group meeting and latterly at the combined hospital/community management group meeting. These reports were also sent to the consultants for learning disability'.⁵⁷

- 9.44 In addition, these reports were sent to governance meetings, chaired by the Director. The reasons for incidents and how to reduce them were considered, and following a successful pilot in Killead Ward, Positive Behaviour Support was

⁵⁴ Chris Hagan Statement (Evidence Modules) – 20/03/23 – Page 5490 (Exhibit T05.06) – MAH Behavioural Incidents by selected Incident Type Tier Two Jan 2009 to Dec 2022

⁵⁵ A14 Statement – 20/05/24 – Pages 8-9

⁵⁶ H298 Transcript – 12/09/24 – Page 92 – Line 18

⁵⁷ Mairead Mitchell Transcript – 16/09/24 – Page 116 – Line 14

introduced in 2016, led by Psychology, as one way to reduce the numbers of incidents. Ms Mitchell also said she introduced more management walkabouts, increased day activities, began to improve co-production, with a carer's forum and a user consultant, such that by mid-2017 she felt MAH was more positive and less 'closed'.

- 9.45 Senior MAH managers visited the wards and neither saw any abuse or behaviour that worried them during 2016/2017 or later. Nevertheless, the Service Manager was aware of a number of incidents where disciplinary hearings had taken place.⁵⁸

[Counsel]: *'I am wondering, given those incidents, do you ever have concerns that they weren't simply isolated incidents but actually evidence of a wider culture within the hospital?'*

[Ms Rafferty]: *'I discussed, when we had these incidents, they would have been discussed at various levels both within our own team at the hospital but with my co-director, but also at nurses in difficulty and with the senior nursing team. Certainly, in those, you know, I would have said look, what else should I be doing and I felt the actions I was taking were appropriate at the time and I wasn't given further advice as in, well, do I need to do something else at this point'.*⁵⁹

- 9.46 However, she did not feel this reflected widespread poor practice:

[Counsel]: *'But did the Core Management Group never think of suggesting some wider review of practice within the hospital, given the number of incidents that were being reported and of which the Core Management Group became aware?'*

[Ms Rafferty]: *'No, I don't think we discussed a broader review of culture or, I don't recall that being discussed.'*

[Counsel]: *'Do you think that might have been a missed opportunity looking back?'*

[Ms Rafferty]: *'I think part of our reasoning around implementation of CCTV was very much around safeguarding because the feedback that we had got from staff very much was lots of people are making accusations, but actually we are delivering good care here and we would like a tool that would support us and exonerate us from harm or from having done harm. So staff very much, I think, viewed the CCTV in the initial discussion as in this would be useful for us. So it was almost like we want to prove to you that we're treating patients well.'*

[Counsel]: *'Were you in favour then of the installation of CCTV?'*

[Ms Rafferty]: *'Yes'.*⁶⁰

⁵⁸ Esther Rafferty Transcript – 15/10/24 – Page 145 – Line 29

⁵⁹ Esther Rafferty Transcript – 15/10/24 – Page 147 – Line 2

⁶⁰ Esther Rafferty Transcript – 15/10/24 – Page 148 – Line 2

The Ennis Ward investigation 2012

- 9.47 Ennis Ward was a 17-bed resettlement adult ward for female patients with learning disabilities who presented with challenging behaviour.⁶¹ In November 2012, in-reach staff from a community placement (Bohill) went to Ennis Ward to become familiar with a patient who was to be discharged to their care. Some of these staff raised concerns about the way certain MAH staff had interacted with patients on the ward on 07 November 2012.
- 9.48 On 08 November 2012, a member of staff from Bohill (care home) reported that she had witnessed staff verbally and physically abusing four patients the day before. This included one incident when a patient was pulled off a sofa onto the floor and another of a patient being pushed so hard into a chair that they hit their head on the back of it. She reported that she tried to contact both the BHSCT directorate and corporate safeguarding teams the following morning, but on receiving no reply she contacted the RQIA.⁶² The RQIA immediately contacted MAH, and the joint protocol (See Chapter 11 (Safeguarding)) was instigated.⁶³
- 9.49 The initial allegations were also recorded as an incident on Datix and given a risk grade of 'medium'.⁶⁴ An early alert was sent to DHSSPS on 09 November 2012 by the Co-Director of Nursing for Governance⁶⁵ and copied to the HSCB, the BHSCT Director of Nursing, the BHSCT Medical Director, the BHSCT Director of Adult Social and Primary Care and the BHSCT Co-Director of Risk and Governance.⁶⁶
- 9.50 A joint protocol strategy meeting was set up for the following day, with senior nurse managers, social workers, medical staff, the police and RQIA represented. The strategy meeting of 09 November 2012 records that:

'A care assistant working on the ward from the Priory Group, Bohill Care Home, alleged that whilst working on Ennis Ward, Muckamore Abbey Hospital on the 7/11/2012, she witnessed staff being verbally and physically abusive to four

⁶¹ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 373 (Exhibit MD2 T03.14) – RQIA Report 13/11/12

⁶² Module 6b Ennis Bundle – Page 222 – Ennis Ward Adult Safeguarding Investigation (Page 248)

⁶³ Moira Mannion Statement – 19/09/23 – Page 7

⁶⁴ Brenda Creaney Supplementary Bundle – Ref 115 – Pages 38-42 – LD Governance Lead – Various Records, Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 38

⁶⁵ Module 6b Ennis Bundle – Page 82 – Early Alert Communication

⁶⁶ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 12

named patients. Only one patient's surname was provided but the Christian names provided for the other three allowed the hospital to identify these individuals. Three of the patients are from the BHSCT and one from the NHSCT [Northern Health and Social Care Trust]'.⁶⁷

- 9.51 The RQIA held an unannounced inspection of Ennis Ward on 13 November 2012⁶⁸ and the main concern raised was the staffing level on the ward,⁶⁹ and that staffing levels had not changed even though patient needs had increased.
- 9.52 In accordance with the BHSCT adult protection policy and procedures, three members of staff were suspended pending investigation, and the relatives of the four patients who had been named were informed about the events that had been reported. Additional staff from other wards were rostered onto the ward and the ward manager moved to a different ward. Early in the investigation, the PSNI asked for the BHSCT's view on installing covert CCTV on Ennis Ward, but Aine Morrison (then operations manager for the community adult disability teams) informed the Inquiry that she was told that the PSNI later decided against this approach.⁷⁰ This was contrary to the evidence of DS Elaine McCormill (a former public protection detective sergeant, including safeguarding vulnerable adults, from 2011 to 2022), who told the Inquiry that BHSCT management did not give authorisation for the use of covert surveillance.⁷¹
- 9.53 Safeguarding allegations relating to a member of staff in MAH were supposed to be investigated by someone outside the hospital line-management team. The operations manager for community learning disability services (who was a social worker), was appointed as the investigating officer to review the referral.⁷² Following a conversation with the PSNI, it was agreed that an adult safeguarding investigation and a police investigation would be simultaneously undertaken. The first joint protocol case conference/strategy meeting requested a forensic examination of the four patients, although MAH medical staff reported that all four

⁶⁷ Module 6b Ennis Bundle – Page 5 – Minutes of Strategy Review Meetings

⁶⁸ Module 6b Ennis Bundle – Page 28 – Minutes of Strategy Review Meetings; Module 6b Ennis Bundle – Page 135 – RQIA Inspection Records regarding Ennis

⁶⁹ Martin Dillon Statement (Evidence Modules) – 26/04/23 – Page 21

⁷⁰ Aine Morrison 2nd Statement (Evidence Modules) – 02/02/24 – Page 8

⁷¹ Elaine McCormill Statement Organisational Module – 20/09/24 – Page 9

⁷² Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 5

patients were known to be self-injurious, so determining non-accidental injury would be difficult.⁷³

Background leading to complaint

- 9.54 While resettlement had been a goal for the DHSSPS since the 1980s, by the late 2000s rates of discharge had slowed. A push to stimulate the process was evident from 2010 onwards and Ennis Ward had been redesignated as a resettlement ward. Shortages of staff were immediately apparent and the RQIA review of Ennis Ward in 2010 criticised the moving of staff between wards to meet day-to-day shortages as this impinged on patient care. It also recommended that clerical support should be provided to release nurses to care for patients.⁷⁴
- 9.55 This was not the first time concerns had been raised about staffing, including the lack of psychology and allied health therapists, as well as nursing and healthcare assistant (HCA) hours. However, there was a tension between increasing staffing and the ambition of closing beds, and the problems persisted. The new service manager raised concerns almost immediately after she commenced in January 2012. An MAH Workforce Strategy Steering Group was convened during February 2012.⁷⁵
- 9.56 In May 2012, the Ennis Ward manager started raising concerns about the impact of staff shortages on patients by completing incident reports on Datix, sending emails and highlighting duty rosters.⁷⁶ The pressure was particularly intense in the mornings due to the number of patients with a high need for assistance with personal care, but despite this Ennis Ward staff were still being deployed to cover other wards, compounding the problem.⁷⁷ Incidents were reported on 18 September 2012 and 23 October 2012.⁷⁸
- 9.57 In September 2012, the service manager escalated her concerns about staffing to the Co-Director for Learning Disabilities, the Assistant Director of Nursing and the

⁷³ Module 6b Ennis Bundle – Pages 4-7 – Minutes of Strategy Review Meetings

⁷⁴ MAHI – Creaney, B – Supplementary Bundle – Page 2 (Ennis Ward Inspection Report 10 November 2010)

⁷⁵ John Veitch Statement (Evidence Modules) – 23/02/24 – Pages 14-15

⁷⁶ A12 Statement – 28/03/24 – Pages 30-33

⁷⁷ A12 Statement – 28/03/24 – Page 31

⁷⁸ John Veitch Statement (Evidence Modules) – 23/02/24 – Pages 17-18

RQIA,⁷⁹ including the fact that staff were anxious about job security as MAH contracted.⁸⁰

- 9.58 In October 2012, a staffing review reduced the number of staff on Ennis Ward by two on morning shifts⁸¹ and personal care was therefore not being undertaken. The Ennis Ward safeguarding investigation team⁸² noted that the majority of staff they spoke to had raised the issue of staff shortages which, among other consequences, meant patients prescribed one-to-one supervision could not receive it, and at times each member of staff was supervising three patients instead of just one. This was confirmed by staff from Bohill.

Staffing

- 9.59 The Co-Director of Nursing who was brought in to support the safeguarding investigation identified staffing levels at all times of the day as a concern.⁸³ On 27 October 2012 the Ennis Ward manager had notified BHSCT's corporate nursing department that Ennis could no longer take nursing students as there were insufficient staff to supervise them and the university was notified.⁸⁴ They also reported their concerns about the ability to supervise the Bohill staff; indeed, one of the complaints later investigated was that Bohill staff did not receive adequate supervision.⁸⁵ It is clear that senior management (including those outside MAH) were aware of the problems on Ennis before November 2012, but this was not recognised as being a precursor to an increase in challenging behaviour and potential serious issues for patient safety.
- 9.60 The RQIA held an unannounced inspection of Ennis Ward on 13 November 2012⁸⁶ and its main concern was the staffing levels on the ward and that patient needs

⁷⁹ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Pages 6-7; Pages 24-31 (Exhibit 1) – Report to RQIA

⁸⁰ John Veitch Statement (Evidence Modules) – 23/02/24 – Pages 14-15

⁸¹ A12 Statement – 28/03/24 – Page 33

⁸² Martin Dillon Statement (Evidence Modules) – 26/04/24 – Page 240 (Exhibit T03.01) – Ennis Ward Adult Safeguarding Investigation

⁸³ Martin Dillon Statement (Evidence Modules) – 26/04/24 – Page 316 (Exhibit T03.05) – Multi-Agency Strategy Group Meeting

⁸⁴ A12 Statement – 28/03/24 – Page 35

⁸⁵ A12 Statement – 28/03/24 – Page 32

⁸⁶ Module 6b Ennis Bundle – Page.28 – Minutes of Strategy Review Meetings; Module 6b Ennis Bundle – Page 114 – RQIA Inspection Reports regarding Ennis

had increased.⁸⁷ The RQIA visited again in December 2012, January 2013⁸⁸ and May 2013,⁸⁹ each time expressing concerns about staffing. In January 2013, the RQIA wrote to the BHSCT Chief Executive Officer (CEO) about the poor environment, low staffing and lack of behavioural support on Ennis.⁹⁰

Adult safeguarding protocols

- 9.61 In 2012, the regional procedures for adult safeguarding were relatively new and all health and social care trusts (HSCTs) were reporting issues with the interpretation of the joint protocol.⁹¹ BHSCT noted these concerns in its 2012 'Trust Delegated Statutory Functions (DSF) Interim Report'⁹² and this may have had an impact on the conduct of the safeguarding investigation, although it is not explicit in the report or evidence given to the Inquiry.

The adult safeguarding investigation

- 9.62 Aine Morrison, who was the lead investigator of the Bohill allegations, gave evidence to the Inquiry on 11 June 2024. She was, when asked to investigate as designated officer, the operations manager for the community adult learning disability services. She told the Inquiry it was a large-scale and complex investigation, which she undertook with two assistant investigators.⁹³ Its report was eventually delivered in October 2013.⁹⁴ Ms Morrison explained that the investigation had taken longer than it would otherwise have done because of the contemporaneous police investigation.

- 9.63 She described her initial unease when first entering Ennis Ward. She told the Inquiry:

'It's difficult to describe exactly because it was an unease rather than anything very definite, and I would also say that it was the first time I had been on that ward and, indeed, it had probably been quite some time since I had been on any of the older-style wards, of which Ennis was one. So, I certainly was entering into a ward environment that was quite old-fashioned and where the

⁸⁷ Martin Dillon Statement (Evidence Modules) – 26/04/24 – Page 21

⁸⁸ Module 6b Ennis Bundle – Page 145 – RQIA Inspection Reports regarding Ennis; Module 6b Ennis Bundle – Page 163 – RQIA Inspection Reports regarding Ennis

⁸⁹ Module 6b Ennis Bundle – Page 183 – RQIA Inspection Reports

⁹⁰ Module 6b Ennis Bundle – Page 209a – Correspondence between BHSCT and RQIA

⁹¹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 18

⁹² Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Pages 18-19

⁹³ Aine Morrison Transcript – 11/06/24 – Page 113 – Line 17

⁹⁴ Module 6b Ennis Bundle – Pages 221-292 – Ennis Ward Adult Safeguarding Investigation

*environment, you know, was not what you would have wanted, so that probably contributed to my unease. But I think, in particular, I had some concerns about how the ward manager was, I suppose, interacting with the patients; as I was being shown round, a lot of patients were coming up to us and attempting to engage, and I felt that the ward manager, I suppose, was not particularly responsive to the efforts to engage’.*⁹⁵

- 9.64 The initial incident reporter and a further eight members of Bohill staff were interviewed between 15 November and 22 November 2012 by adult safeguarding investigators, led by the investigating officer.⁹⁶ They identified 22 incidents relating to the physical treatment of four patients. Ten of the incidents related to the way three members of MAH staff spoke to these four patients, including shouting at a patient and being verbally condescending to the patients. A total of 16 incidents related to the management of the patients’ behaviours, including threatening to remove a treat or a meal if they behaved in a certain way, telling one patient to hit another patient back if they assaulted them, and advising Bohill staff to disengage if the patient’s behaviour was ‘bad’ and not to give too much attention to patients as they would then ‘want it all the time’. In addition:

*‘Concerns were raised about the atmosphere on the ward ... lacking stimulation and warmth. Very set routines ... also a lack of staff engagement and interaction with patients’.*⁹⁷

- 9.65 A number of incidents related to a single patient, including placing things out of their reach or the patient being secluded outside in the rain.⁹⁸ As the investigation progressed, a number of other allegations were recorded, including more general issues, such as lack of MAH staff and lack of induction for, and supervision of, Bohill staff.⁹⁹ Bohill staff were clear that they had no concerns about other wards.¹⁰⁰
- 9.66 Interviews with family members also raised concerns, including poor staffing levels and lack of sufficient supervision.¹⁰¹

⁹⁵ Aine Morrison Transcript – 11/06/24 – Page 128 – Line 10

⁹⁶ Module 6b Ennis Bundle – Page 225 – Ennis Ward Adult Safeguarding Investigation

⁹⁷ Module 6b Ennis Bundle – Page 227 – Ennis Ward Adult Safeguarding Investigation

⁹⁸ Module 6b Ennis Bundle – Page 227 – Ennis Ward Adult Safeguarding Investigation

⁹⁹ Module 6b Ennis Bundle – Page 227 – Ennis Ward Adult Safeguarding Investigation

¹⁰⁰ John Veitch Statement – 23/02/2024 – Page 14

¹⁰¹ Module 6b Ennis Bundle – Page 232 – Ennis Ward Adult Safeguarding Investigation

9.67 The investigation interviewed 34 members of staff.¹⁰² Ward staff also considered the staffing levels needed improvements, but did not feel the culture of the ward was problematic:

'Most staff reported significant staff shortage on Ennis Ward at various points and were concerned about the impact of short-staffing on patient care and on staff well-being'.¹⁰³

9.68 Ms Morrison said that she was 'immediately concerned about potential widespread abuse on Ennis Ward' and that was partly because the MAH staff had behaved in the way that was reported, in front of external staff from another organisation.¹⁰⁴ She said that:

'I felt that I didn't have enough information or evidence to conclusively prove that the abuse had been more widespread. However, I felt there was enough evidence to justify a suspicion about that, and certainly not a sort of an outcome that said no, we had not found institutional abuse'.¹⁰⁵

9.69 She did not feel that this was an issue on other wards however:

[Counsel]: *'Even where the possibility was considered, just to be clear, it was considered only in respect of Ennis Ward, isn't that right, it wasn't considered in respect of potential issues in the wider Muckamore site?*

[Ms Morrison]: *Largely, yes. There was, you know, certainly from my point of view in terms of safeguarding investigation, that there was nothing leading me to other wards'.¹⁰⁶*

9.70 She also noted, however, that nursing assistant staff were reporting that they felt unsupported in the management of challenging behaviours and that it was largely the unregistered staff who were doing most of the hands-on care.¹⁰⁷

9.71 Despite the shortage of staff who had direct contact with patients, the investigating officer requested that supernumerary nursing staff be rostered to monitor ward practices for four to six weeks, led by the Co-Director for Nursing, Education and Learning. In order to achieve this, 10 staff of Band 6 or above were redeployed from other areas of MAH, leaving those areas without senior cover. The ward manager was on sick leave, and the investigating officer appeared to be attempting

¹⁰² Aine Morrison Transcript – 11/06/24 – Page 132 – Line 26

¹⁰³ Aine Morrison 2nd Statement (Evidence Modules) – 02/02/24 – Page 16

¹⁰⁴ Aine Morrison Transcript – 11/06/24 – Page 124 – Line 8

¹⁰⁵ Aine Morrison Transcript – 11/06/24 – Page 174 – Line 17

¹⁰⁶ Aine Morrison Transcript – 11/06/24 – Page 176-177

¹⁰⁷ Aine Morrison Transcript – 11/06/24 – Page 136 – Line 10

to manage the staff as well as the investigation. An unintended consequence was less engagement from staff in the investigation process. Concerns were raised about the impact external monitors and bank staff were having on the patients, who were reacting badly to the presence of so many strangers.

- 9.72 The agreed six weeks of monitoring reports showed no evidence of a culture of abuse on the ward¹⁰⁸ and the Co-Director for Nursing requested on 20 December 2012 that the monitors be stood down, but the investigating officer did not support this. Monitors remained (at a cost to BHSCT of approximately £500,000) until 05 July 2013, when the draft report was presented.¹⁰⁹
- 9.73 The safeguarding investigators interviewed four patients on the ward who were deemed to have capacity, none of whom expressed any concerns about their care, nor did their families.¹¹⁰ The joint protocol team then agreed that families of all the patients on the ward should be informed that allegations had been made. Following this, one family reported that their relative told them they had been held by the scruff of the neck. A family member expressed concerns about staffing on the ward and a lack of supervision of patients.¹¹¹ Another family reported concerns about the number of assaults of their relative by other patients. No other families expressed concerns.¹¹² MAH staff not associated with the allegations were interviewed and reported concerns about staff shortages meaning some care and activities could not be done, but none of them (including medical staff) had any concerns about abuse by staff.¹¹³ However, the investigating officer was concerned that some of the MAH staff described by Bohill staff had not been identified¹¹⁴ and therefore were not interviewed, so the investigation continued to pursue identification.
- 9.74 The joint protocol case conference received a briefing report on 09 January 2013 from the Co-Director for Nursing (who had had no previous experience in MAH),

¹⁰⁸ Module 6b Ennis Bundle – Page 95 – Action Plan Material

¹⁰⁹ Module 6b Ennis Bundle – Page 48; Module 6b Ennis Bundle – Page 70; Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 7 and Page 14

¹¹⁰ Module 6b Ennis Bundle – Pages 229-230 and Page 232 – Ennis Ward Adult Safeguarding Investigation

¹¹¹ Module 6b Ennis Bundle – Page 229 – Ennis Ward Adult Safeguarding Investigation

¹¹² Module 6b Ennis Bundle – Page 702 – A Review of Leadership & Governance at Muckamore Abbey Hospital

¹¹³ Module 6b Ennis Bundle – Page 251-273 – Ennis Ward Adult Safeguarding Investigation

¹¹⁴ Module 6b Ennis Bundle – Page 72 – Adult Safeguarding Case Conference Minutes 28/10/13

based on reviews of patient records and 118 monitoring reports. While highlighting problems with the ward environment and some practice issues, it concluded that there was 'no evidence that there is a culture tolerant of behaviours that could be defined as abusive or support systemic abuse'.¹¹⁵ As the agreed six weeks of monitoring reports showed no evidence of a culture of abuse on the ward, the Co-Director for Nursing had requested on 20 December they be stood down, but the investigating officer did not support this. By the meeting of 29 March 2013 there was still no evidence of institutional abuse.¹¹⁶ The monitors did not observe a culture of abuse at any point in the eight months while staff were being monitored. It is important to note that this does not prove either that there was or was not a culture of abuse, nor that individual staff may have behaved differently if not under observation.

- 9.75 The RQIA had recommended in November 2012 that staffing on Ennis Ward be increased to seven staff per shift (two to undertake enhanced observations), but the service manager was not able to fulfil this as MAH had 30 whole-time equivalent (WTE) Band 3 and eight registered nurse – learning disability WTE vacancies.
- 9.76 Adult safeguarding referrals from June to November 2012 were reviewed by the investigating officer and found to be appropriate, as were the actions taken.¹¹⁷ In March 2013, the Co-Director for Learning Disabilities (himself a social worker and by this time, the investigating officer's line manager) decided that insufficient evidence had been discovered to support the continuing suspension of one of the staff and they were reinstated but on a different ward.¹¹⁸
- 9.77 It is the policy of BHSCT (and indeed across the NHS) that vulnerable adult/adult safeguarding investigations and disciplinary investigations are conducted separately and by different personnel¹¹⁹ and are conducted according to the Trust's disciplinary procedures. Following PSNI approval, in June 2013 the MAH

¹¹⁵ John Veitch Statement (Evidence Modules) – 23/02/24 – Pages 9-10

¹¹⁶ John Veitch Statement (Evidence Modules) – 23/02/24 – Pages 9-10

¹¹⁷ Module 6b Ennis Bundle – Page 280 – Ennis Ward Adult Safeguarding Investigation internal page 59

¹¹⁸ Module 6b Ennis Bundle – Page 66 – Ennis Ward Investigation Meeting Minutes – 29/03/13

¹¹⁹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 51

service manager set the terms of reference for the disciplinary investigation.¹²⁰ One of the investigators was an occupational therapist from a different division in order to be independent from MAH.

9.78 Meanwhile, the adult safeguarding investigation report concluded that the allegations made by some Bohill staff were not evidenced in any of the BHSCT staff interviews or records. It noted that Bohill staff were consistent in their accounts but also that they were new to the care of people with complex learning disability needs. The investigation also acknowledged the 'genuineness and caring attitude shown by MAH staff'. The investigation was unable to draw definitive conclusions but felt that there was evidence to support the allegations against two members of staff who remained suspended.¹²¹

9.79 The report recommended that a disciplinary investigation take place. The report expressed the difficulty that the investigators faced in weighing up the very different evidence produced by the Bohill team and the staff from MAH. The investigation felt it was unlikely that Bohill staff would report falsely but recognised the apparent genuineness of, and the caring attitude shown by, MAH staff. There was general agreement that the Ennis Ward environment was unsatisfactory, and concerns included maintenance issues, lack of privacy and a lack of space and overcrowding. The report recognised that management had made significant environmental improvements. Recommendations were made in relation to:

- Staffing of the ward (including the line management by members of the same family, although this was not related to the allegations of abuse);
- Environmental changes;
- Improvements to induction of visiting staff;
- Improvements in relation to the management of specific patients;
- Improvements to the training of all staff in relation to safeguarding;
- Improvements to the access of resettlement patients to a full range of professionals.¹²²

¹²⁰ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 52; Module 6b Ennis Bundle – Page 321 – Ennis Investigation Reports

¹²¹ Module 6b Ennis Bundle – Page 287 – Ennis Ward Adult Safeguarding Investigation

¹²² Module 6b Ennis Bundle – Pages 290-292 – Ennis Ward Adult Safeguarding Investigation

- 9.80 The draft safeguarding investigation report was discussed at a joint protocol adult safeguarding case conference on 05 July 2013.¹²³ At that point, the Public Prosecution Service (PPS) had not decided whether to prosecute the two suspended members of staff. Ms Morrison told the meeting that although no evidence had been uncovered to substantiate the allegations, she felt the Bohill staff were credible. She stated that there were no safeguarding concerns about the Ennis Ward manager. A further meeting on 28 October 2013 approved the amended report.¹²⁴ The investigation officer and the Co-Director for Learning Disabilities (both social workers) disagreed on whether there had been institutional abuse, and the investigation was formally closed.¹²⁵ It was noted that no concerns had been raised since 08 November 2012.
- 9.81 The safeguarding investigation took a protracted time because the investigation officer was searching diligently for evidence but did not find it. She was line-managed by the Co-Director for Learning Disabilities (who was also a social worker, experienced in child protection) and professionally managed by the Co-Director for Social Work.¹²⁶ If she had felt constrained by the operational management at MAH, she could have raised her concerns through her professional line manager, but there is no evidence that she did so. Given her extensive efforts, it is unclear what other routes to establish that the allegations were true could have been taken, or what any organisation could have done in the absence of any supporting evidence. Meanwhile the suboptimal conditions in which care was being delivered were frequently being evidenced by the RQIA, the ward manager and the service manager, but to no avail. Attention was focused on 'bad apples' (for which it was hard to find evidence) rather than poor systems (for which there was extensive evidence).
- 9.82 The BHSC's disciplinary investigation concluded in February 2015.¹²⁷ Only four of the nine Bohill staff who had given statements for the adult safeguarding

¹²³ Module 6b Ennis Bundle – Page 67 – Adult Safeguarding Case Conference Minutes – 05/07/13

¹²⁴ Module 6b Ennis Bundle – Page 71 – Adult Safeguarding Case Conference Minutes – 28/10/13

¹²⁵ Module 6b Ennis Bundle – Page 792 – A Review of Leadership and Governance at MAH

¹²⁶ Module 6b Ennis Bundle – Page 582 – Teleconference by Marie Heaney and Carol Diffin with Aine Morrison & Jackie McIlroy – Thursday 16th January 2020

¹²⁷ Module 6b Ennis Bundle – Page 309 – Ennis Investigation Reports

investigation engaged with the disciplinary investigation.¹²⁸ Those that did presented different accounts from those recorded by the adult safeguarding investigation. One, who was recorded as the source for an allegation that a care assistant would remove a patient's shoes if she was on the ground and throw them across the floor, told the disciplinary investigators that she had not referred to this as a criticism of MAH staff, but intended it as a positive example of staff behaviour and had mentioned it as such during her interview with the PSNI.¹²⁹ The disciplinary investigation also interviewed BHSCT staff who were on the ward at the time of each allegation but who were not interviewed by the PSNI or the adult safeguarding investigators.¹³⁰

9.83 The disciplinary investigation team met with Ms Morrison in June 2015 to discuss their differing conclusions, when it was acknowledged that some evidence given to the adult safeguarding team in December 2012 differed from evidence given to the internal investigation team when individuals were re-interviewed in June 2014.¹³¹ While Ms Morrison acknowledged that she could not find supporting evidence for the claims by some Bohill staff, she believed they were credible and consistent witnesses. However, the Bohill staff either gave different evidence to the disciplinary investigation or did not participate in it and did not support the criminal prosecution.

9.84 The disciplinary investigation team was not able to find evidence to support formal disciplinary action in relation to the allegations against two of the Ennis Ward staff who had been suspended.¹³² The disciplinary investigation findings were reviewed by the MAH service manager, the Co-Director for Learning Disabilities and BHSCT Human Resources, who concluded there was not enough evidence to proceed with a formal disciplinary process.¹³³ The PPS had recommended prosecution of the two staff who remained suspended after March 2013. Both were charged; one was acquitted and the other was found guilty, but the conviction

¹²⁸ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 53

¹²⁹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 54

¹³⁰ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 55

¹³¹ Module 6b Ennis Bundle – Page 309 – Ennis Investigation Reports

¹³² Module 6b Ennis Bundle – Page 317 – Ennis Investigation Reports; Module 6b Ennis Bundle – Page 339 – Ennis Investigation Reports

¹³³ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 14

was quashed on appeal, meaning ultimately both staff members were found not to be guilty of criminal conduct.¹³⁴

- 9.85 Following the allegations, Bohill managers concluded that the identified patients on Ennis Ward were not suitable to be resettled into Bohill.¹³⁵

Changes at MAH

- 9.86 The term ‘institutional abuse’ was not defined in Northern Ireland until July 2015, when the DHSSPS and Department of Justice (DoJ) guidance ‘Adult Safeguarding: Prevention and Protection in Partnership’ defined it as:

*‘The mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use ... Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts, or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place’.*¹³⁶

- 9.87 The team that led the 2020 independent leadership and governance review of MAH considered, in their view, the Ennis Ward allegations ‘to be an example of institutional abuse’.¹³⁷ They appear to have accepted the allegations as being true and the investigating officer’s belief that absence of supporting evidence was not sufficient to dismiss them. While it can be true that evidence is hard to find, it is also true that organisations cannot act without evidence. There appears to have been insufficient evidence upon which the leadership and governance review team could properly make a finding of ‘institutional abuse’. Indeed, the investigating officer herself considered she did not have sufficient evidence to come to that conclusion. Nevertheless, the investigation should have alerted people to the high risk of institutional abuse.

¹³⁴ Moira Mannion Statement – 19/09/23 – Page 23

¹³⁵ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 8

¹³⁶ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 60

¹³⁷ Module 6b Ennis Bundle – Page 591 – A Review of Leadership and Governance at MAH

- 9.88 Both investigations identified significant challenges on Ennis Ward and led to a number of changes within MAH, many before the adult safeguarding report was published. Most of the recommendations for improving the buildings and environment were implemented and induction processes for visiting care staff were reviewed. Additional training on restrictive practices was delivered to all staff.¹³⁸ One of the alleged incidents related to pulling a patient up from a chair and the Co-Director for Nursing observed that the actions staff took to assist may have been misinterpreted when in fact the problem was the seating. An assessment was carried out by the BHSCT manual handling assessor, who found that the chairs were not fit for purpose and they were replaced.¹³⁹
- 9.89 Two additional full-time senior social workers provided training for all MAH staff on the reporting of safeguarding incidents¹⁴⁰ and new guidance regarding family members who worked together on the same wards recommended members of staff from the same family should not work with the same patients. Wards were required to review family connections and discuss with their senior nurse manager how to deploy the staff to reduce the risk of members of the same family working on the same shifts on a ward.¹⁴¹

Governance – how the allegation was handled

- 9.90 The initial allegations were also recorded as an incident on Datix¹⁴² and given a risk grade of 'medium'.¹⁴³ An early alert was sent to DHSSPS on 09 November 2012 by the Co-Director of Nursing for Governance¹⁴⁴ and copied to the HSCB, the BHSCT Director of Nursing, the BHSCT Medical Director, the BHSCT Director of Adult Social and Primary Care and the BHSCT Co-Director of Risk and Governance.¹⁴⁵ It was not considered as an SAI as, at the time, the procedure governing whether an SAI was instigated was the HSCB's SAI procedure from 2010, which did not explicitly include alleged abuse of a patient by a member of

¹³⁸ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 13

¹³⁹ Module 6b Ennis Bundle – Page 329 – Ennis Reports; Moira Mannion Statement – 19/09/23 – Page 15

¹⁴⁰ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 14

¹⁴¹ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 15

¹⁴² Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 115

¹⁴³ Brenda Creaney Supplementary Bundle – Ref 115 – Pages 38-42 – LD Governance Lead; Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 38

¹⁴⁴ Module 6b Ennis Bundle – Page 82 – Follow-Up Proforma for Early Alert Communication

¹⁴⁵ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 12

staff when there was no serious injury. The HSCB SAI procedure was updated in 2013 to include serious assault by a member of staff.¹⁴⁶ Neither version referred to institutional abuse (which was not formally defined until 2015). However, on 07 September 2015 the BHSCT accepted it was in breach of both the 2010 and 2013 SAI procedures but noted that the safeguarding investigation had not substantiated the allegations.¹⁴⁷

- 9.91 The service manager acted promptly on receiving the allegations via the RQIA on 08 November 2012. The assigned investigating officer acted promptly in initiating the joint protocol procedures, with the first multi-agency strategy meeting held on 09 November. The ward manager completed an incident report that triggered an early alert on 09 November 2012 to the DHSSPS, copied to the HSCB, the BHSCT Director of Nursing, the BHSCT Medical Director, the BHSCT Director of Adult Social and Primary Care and the BHSCT Co-Director of Risk and Governance. Three staff were immediately suspended and the two who were registered nurses were also referred to the national Independent Safeguarding Authority, and a Chief Nursing Officer (CNO) alert was requested through the 'nurses in difficulty' process.¹⁴⁸
- 9.92 On 01 February 2013 the Chief Executive of RQIA wrote to the BHSCT Chief Executive about the Ennis abuse allegations, copied to the Chief Executive of the HSCB and the DHSSPS Chief Medical Officer.¹⁴⁹ The investigating officer assigned to lead the safeguarding investigation was consulting with the Co-Director for Social Work, demonstrating a direct line of professional accountability that was required for any adult safeguarding investigation.¹⁵⁰
- 9.93 In line with the regional joint protocol procedures, the establishment of multi-agency case conferences (also known as strategy meetings) was the primary governance mechanism for adult safeguarding investigations.¹⁵¹ This multi-

¹⁴⁶ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Pages 38-40

¹⁴⁷ Module 6b Ennis Bundle – Pages 624-625 – A Review of Leadership & Governance at Muckamore Abbey Hospital 31 July 2020

¹⁴⁸ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 12

¹⁴⁹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 14

¹⁵⁰ John Veitch Statement (Evidence Modules) – 23/02/24 – Page 7

¹⁵¹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 20

agency group oversaw and directed the investigation. From January 2013, the Co-Director for Learning Disabilities attended all the Ennis Ward case conferences¹⁵² and provided the BHSCT Director of Adult Social and Primary Care (who attended the BHSCT Board meetings) with regular reports,¹⁵³ discussing the investigation at their monthly meetings.¹⁵⁴

- 9.94 There was nothing in the regional guidance about who should receive a vulnerable adult/adult safeguarding report (if created) other than the members of the joint protocol strategy meeting/case conference or equivalent,¹⁵⁵ with no mention of how it would progress through any assurance framework.
- 9.95 The final version of the Ennis Ward adult safeguarding investigation report was shared with all agencies involved in the joint protocol case conference, including the PSNI, the RQIA, South Eastern Health and Social Care Trust (SEHSCT) and the NHSCT, as well as BHSCT's Co-Director for Learning Disabilities and Co-Director of Nursing.¹⁵⁶ While others were aware of the final report, there is no evidence that it was presented to any assurance committee, either within or outside BHSCT.
- 9.96 Adult safeguarding is assured through two channels; safeguarding partnerships and DSF reports as discussed in more detail in Chapter 11. Local adult safeguarding partnerships (LASPs) were established by the 2010 'Adult Safeguarding in Northern Ireland – Regional and Local Partnership Arrangements'.¹⁵⁷ The Belfast LASP (also known as the Vulnerable Adults Protection Panel), was accountable to both BHSCT and the Northern Ireland Adult Safeguarding Partnership (NIASP).¹⁵⁸ In 2012 Belfast LASP was a subcommittee of the BHSCT Social Care Steering Committee, which in turn reported to the

¹⁵² Module 6b Ennis Bundle – Page 611 - Teleconference by Marie Heaney and Carol Diffin with Aine Morrison & Jackie McIlroy – Thursday 16th January 2020

¹⁵³ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 13

¹⁵⁴ John Veitch Statement (Evidence Modules) – 23/02/24 – Page 8

¹⁵⁵ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 20

¹⁵⁶ Module 6b Ennis Bundle – Page 71 – Minutes of Adult Safeguarding Case Conference - 28/10/13

¹⁵⁷ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Page 3620 (Exhibit MMcG-71) – Adult Safeguarding in Northern Ireland Regional and Local Partnership Arrangements – March 2010

¹⁵⁸ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Pages 23-24

Assurance Committee of the BHSCT Board. The NIASP was chaired by the HSCB Director of Social Work in 2012.¹⁵⁹

- 9.97 LASPs are accountable for the implementation of the NIASP strategic plan, policy and operational procedures locally¹⁶⁰ rather than the management of individual safeguarding investigations. Thus, as long as the procedures were followed properly, there would be no reason to discuss each case. However, if the Executive Director of Social Work at BHSCT had been informed of the case by the Co-Director for Social Work (who was providing advice and support to the investigating officer) they could have raised any outstanding concerns at the Belfast LASP. If the HSCB had concerns, the HSCB Executive Director of Social Work could have raised them at the NIASP.
- 9.98 The DSF annual report is the annual report on statutory functions delegated from the HSCB to the individual HSCTs. While child protection is a statutory function, adult safeguarding currently is not, however it has become custom and practice to include a section on adult safeguarding.¹⁶¹ The 2010 scheme for DSF reports provided a pro forma structure requiring completion of a predetermined dataset and compliance with key performance measures. A free-text section required a general statement of controls assurance and exception reporting of areas where the HSCT had not met standards, together with a progress report in relation to remedial action highlighted in the previous year. It also should have included a narrative on any financial issues that meant the HSCT believed it could not adequately discharge statutory functions and any emerging trends.¹⁶² The DSF therefore is a vehicle for reporting prevalence and broad themes, rather than itemising individual safeguarding cases.¹⁶³
- 9.99 The lack of mention of the Ennis Ward adult safeguarding report does not mean that the DHSSPS was unaware of the investigation. The Chief Executive of RQIA had copied the DHSSPS Chief Medical Officer into its February 2013 letter to the

¹⁵⁹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 23

¹⁶⁰ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Pages 34-35

¹⁶¹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 29; Colm Donaghy Statement (Organisational Modules) – 14/06/24 – Page 90 (Trust Board Minutes 06 June 2013)

¹⁶² Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Pages 28-29

¹⁶³ Cecil Worthington Statement (Organisational Modules) – 18/07/24 – Page 10

BHSCT Chief Executive regarding the allegations¹⁶⁴ and the DHSSPS had received the early alert in November 2012. However, a further route might have been through the SAI procedures. Initially BHSCT felt that the incident did not meet the HSCB SAI procedure set out in April 2010, which did not explicitly include alleged abuse of a patient by a member of staff when there was no serious injury or 'serious assault', although it did include an unexpected serious risk to a service user. But the HSCB was receiving the case conference notes¹⁶⁵ and does not seem to have suggested the incident should have been an SAI until 06 March 2014.¹⁶⁶

- 9.100 Even if it had been reported as an SAI, it is unclear how it would have been managed differently. The allegations made on 08 November 2012 were promptly reported on an incident report and graded as medium, which might at most have triggered a Level 1 SAI, which is a SEA, a structured process to assess what happened, why it happened and what can be learned. The adult safeguarding investigation superseded this and conducted such an assessment in its draft report in July 2013, and an improvement plan had already been executed, making a Level 1 SAI unnecessary. HSCB was aware of the safeguarding investigation and could have requested that its report look for the learning points that technically the HSCB would have received through the SEA.
- 9.101 The specific details of individual SAIs were not usually discussed at BHSCT Board level; instead, the Board received trend data,¹⁶⁷ which (if presented as trends in themes rather than simple frequencies, and then considered and acted upon) is arguably most useful. Five directors on the BHSCT Board were aware of the allegations by February 2013, and the Executive Director of Finance would presumably be aware of the £500,000 overspend for monitoring the ward. Three directors (Executive Director of Nursing, Executive Director of Social Work and Director of Adult Social and Primary Care) were actively involved in the management of the situation. It is hard to argue that the Board was not aware of this investigation and that an SAI would have made a material difference.

¹⁶⁴ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 14

¹⁶⁵ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 38

¹⁶⁶ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Pages 37-38

¹⁶⁷ Cecil Worthington Statement (Organisational Modules) – 18/07/24 – Page 10

9.102 It is clear that senior staff at DHSSPS, HSCB, PHA and BHSCT were all aware of the Ennis Ward allegations. Given that neither the safeguarding investigation nor the disciplinary investigation could find evidence to support the suggestion of systemic or institutional abuse, it is unclear what action, if any, could have been taken against ward staff. However, identification of the potential of a high risk of institutional abuse could have led to the earlier introduction of CCTV.

Warning signs – a ward in crisis

9.103 However, both the safeguarding investigation and the disciplinary process identified a ward in crisis, with a poor environment and low ward staffing. There was little therapeutic input from psychologists and allied health professionals (AHPs) and few activities to stimulate the patients. There was a high incidence of peer-on-peer abuse. High peer-on-peer abuse indicates an unmanaged situation that creates an environment with an even higher risk that staff will abuse patients. Peer-on-peer abuse may be considered to be a proxy indicator, as staff are more likely to report that than staff-on-patient abuse. There was therefore in our view a very high risk of abuse by staff and, while an improvement plan was put in place, there appears to have been no ongoing monitoring to ensure the improvement was sustained, or to assess whether other wards at MAH were carrying the same risks. Ennis was a red flag, not because institutional abuse was demonstrated, though it had been suspected, but because the situation in which care was being provided was so widely known by senior staff across the HSCT and there was no action or follow-up.

9.104 One of the reasons for the lack of action was that change is not made on the basis of a single case. The approach to safeguarding was to focus on single cases. Reporting serious but ultimately unproven allegations through any governance structure would not have led to the system change that was required. What was missing, however, was the aggregation of risks factors across the (very many) safeguarding referrals. This should have included the peer-on-peer safeguarding referrals, as the factors that allow this type of incident to take place are similar (low staffing, lack of therapy, lack of supervision). The recommendations from the Ennis Ward safeguarding investigation should have been to raise awareness of

the risk factors for abuse and to develop metrics that measure those risks to provide a dashboard-style trend analysis of the change in risk.

- 9.105 It transpired after a lengthy and thorough investigation, which included having 24-hour monitoring staff on the ward for about nine months (November 2012 to July 2013), that senior staff in BHSCT disagreed about the significance of what had been observed and reported by the Bohill staff. John Veitch (then Co-Director of Learning Disability) said in a letter to Theresa Nixon (Director of Mental Health and Learning Disabilities at RQIA) on 06 June 2013:

*‘As you should be aware a number of Strategy meetings have been held to progress the ongoing investigation into the allegations. This investigation has not only focused on specific allegations but has equally explored any potential of institutional abuse. Action included putting in place a protection plan which involved independent daily monitoring of staff interventions and the quality of care delivered on the ward. This protection plan continues to be reviewed at each Strategy meeting and currently remains in place. I can also confirm that these monitoring arrangements remain in place ... I am pleased to confirm that these measures have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture’.*¹⁶⁸

Post Ennis

- 9.106 Esther Rafferty was service manager at MAH and Associate Director of Nursing from 2012 until 2018. She was managerially responsible for nursing and social work/social care staff on the MAH site (but not responsible for medical staff, AHPs or admin staff at MAH). She had a major role in resettlement from MAH and had previous experience on resettlement in mental health. Later (in 2016) her role was expanded to include supported living and residential community services.
- 9.107 Mairead Mitchell was Head of Learning Disability at the BHSCT from 2016 to 2019 (including MAH, the Iveagh Centre and community services, as well as community learning disability teams). She had previously been the lead for quality improvement at NWBHSCT and was involved in the modernisation project (the new build for MAH) from 2005 to 2007.

¹⁶⁸ Module 6b Ennis Bundle – Pages 219-220 – Ennis Ward Adult Safeguarding Investigation

9.108 Ms Rafferty described the shortcomings in community services, listing a lack of resources in the community generally, no specific self-harm services, no home treatment team options, limited behaviour management services, large caseloads held by community professionals, a very limited number of community learning disability nurses, a limited number of vacancies in staffed supported housing options, a limited number of respite beds or services to support carers or reduce carer fatigue, and pressure in the approved social worker rota.¹⁶⁹ She noted that equally there was a lack of professional resources in MAH: in January 2012 there were about 150 patients but only one psychologist (dedicated to the forensic ward), 1.5 speech and language therapists (SALTs), 1.5 physiotherapists and no occupational therapists (OTs) at all. Two OTs were then appointed in 2012 and one more psychologist was appointed in 2015-2016.¹⁷⁰

9.109 In addition, both of them were concerned about the shortage of nursing staff: Ms Rafferty had put this issue on the Directorate Risk Register in 2012, and it remained there in 2016, even before the events of 2017. Managers were aware that many staff were working bank shifts to try to cover gaps in staffing. Both Ms Rafferty and Ms Mitchell also agreed that sometimes training was not attended because of the shortage of staff leading to concerns about ward safety, and this became more acute after the 2017 events.¹⁷¹

9.110 Both were aware that there were large numbers of incidents in MAH and Mairead Mitchell did have a number of concerns. For example she was shocked at the lack of activity for patients who remained in Muckamore:

'When I then had the managerial role in 2016, I was slightly shocked that there wasn't people coming in or patients going out for day care, it was very insular. Ehm, many patients didn't go off the wards for day care because staffing issues, or the day care was closed because of staffing. So, when I walked the wards, you know, patients would just be sitting and very little activity'.¹⁷²

¹⁶⁹ Esther Rafferty Transcript – 15/10/24 – Pages 33 – Line 23

¹⁷⁰ Esther Rafferty Transcript – 15/10/24 – Pages 45 – Line 1

¹⁷¹ Esther Rafferty Transcript – 15/10/24 – Pages 106, 110, 114 and 125

¹⁷² Mairead Mitchell Transcript – 16/09/24 – Page 107 – Line 22

9.111 She also noted that there was a lack of senior manager presence on the wards:

[Counsel:] *'And whenever you say that staff told you they never saw anyone, is that they were telling you that whenever you were taking up the post as Head of Learning Disability?*

[Ms Mitchell:] *Yes, yes. Whenever I went out on the wards, people, you know, a lot of people would have known me because I had been in the Trust, and then some didn't, and they would just say, you know, "We never see any senior managers here"'.¹⁷³*

9.112 Ms Mitchell went on to describe a series of things she had noted (and listed in July 2017),¹⁷⁴ including the 2016 RQIA report on Erne Ward (and the lack of improvement in that ward for months), as well as complaints about the service manager's abrasive attitude and poor communication skills, many concerns raised by staff in walkabouts and requests for meetings from families regarding concerns about patient care and safety. Staff absence rates were high (10%) and there were a very large number of incidents per month (for example, 369 in May 2017 alone, although this included a wide range of incidents not limited to inappropriate or aggressive behaviours and could have included broken equipment and lack of staff) as well as safeguarding incidents (54 in May 2017). These incidents, as well as seclusions, use of PRN sedation, physical interventions and complaints, were reported at weekly ward manager meetings by the hospital resource nurse (this had been long-standing practice since about 2000):

[Ms Mitchell:] *'Regular reports were received by senior managers and the ward managers which included all of the above as well as incidents/accidents and patients on special observations on a weekly basis. These were discussed at the Core Group meeting and latterly at the combined hospital/community management group meeting. These reports were also sent to the consultants for learning disability'.¹⁷⁵*

9.113 In addition, these reports were sent to governance meetings, chaired by the Director of Adult and Social Care. The reasons for incidents and how to reduce them were considered, and following a successful pilot in Killead Ward, positive behaviour support was introduced in 2016, led by psychologists, as one way to reduce the numbers of incidents. Ms Mitchell also said she introduced more management walkabouts, increased day activities and began to improve co-

¹⁷³ Mairead Mitchell Transcript – 16/09/24 – Page 113 – Line 22

¹⁷⁴ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Pages 15-17 (Exhibit 1)

¹⁷⁵ Mairead Mitchell Transcript – 16/09/24 – Page 116 – Line 14

production with a carer's forum and a user consultant, such that by mid-2017 she felt MAH was more positive and less 'closed'.

- 9.114 Despite these major areas of agreement, there were tensions between the MAH core management team, to the extent that the leadership team was called 'dysfunctional'¹⁷⁶ and it was admitted that communication between them was poorer than it should have been.

What did the BHSCT Board and hospital management know?

- 9.115 Even if the BHSCT Board was not aware of the number of incidents and safeguarding referrals, it is clear that it was aware of the risks at MAH from 2011. In January 2011 the Governance Steering Group received the Board Assurance Framework (BAF) principal risk document dated October 2010, which noted 'risk to the quality of outcomes for patients at MAH due to discharge being delayed and resettlement ceasing. Risk to reputation of Organisation'. The September 2011 Board meeting received the June 2011 principal risk document, which included 'Management of Aggression and Violence (possible harm to staff, patients/clients should physical intervention be necessary. Ongoing physical and verbal violence against staff and their property)'. Despite the lack of evidence of mitigation of these risks (and the increased incident reporting via Datix from 2011 onward), the risks at MAH dropped out of the Board assurance agendas until 2018. In the circumstances, the Panel found this a worrying omission.
- 9.116 The April 2013 BHSCT Board meeting noted that PSNI had investigated two staff at MAH regarding 'abuse of patients on Ennis in 2012'. The non-executive directors (NEDs) were advised that the trust had safeguarding policies and procedures in place and no further consideration was given to the matter.¹⁷⁷ In evidence Brenda Creaney (former Executive Director of Nursing) told the Inquiry that this was a matter being brought to the attention of the Board rather than asking for proactive consideration, and she said that the process in relation to the allegations had already started.¹⁷⁸ Nevertheless, this might be regarded as a

¹⁷⁶ Esther Rafferty Transcript – 15/10/24 – Page 137 – Line 11

¹⁷⁷ Brenda Creaney 3rd Statement (Evidence Modules) – 30/08/24 – Page 100 (Trust Board Confidential Minutes 11th April 2013)

¹⁷⁸ Brenda Creaney Transcript – 11/06/24 – Pages 30-32

missed opportunity to consider the issues raised on Ennis Ward through a site-wide review (we discuss the role of Board members in Chapter 13). Other PSNI investigations of alleged abuse by staff given to the Inquiry do not appear in the Board's or its assurance committees' minutes. Safeguarding incidents at MAH continued to be investigated on an individual basis and the Inquiry saw no evidence of any analysis of themes across incidents.

9.117 Adult safeguarding stood outside BHSCT's clinical governance system and safeguarding investigations (including the 2012 Ennis investigation) were not integrated into its clinical governance and assurance mechanisms.¹⁷⁹ Prior to October 2018, SAIs were not routinely reported directly to the BHSCT Board and only presented if escalated by a relevant director, meaning that even if a safeguarding incident had also been reported as an SAI, the Board would not automatically be notified.¹⁸⁰

9.118 The 2018 Level 3 SAI review ('A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go') acknowledged the potential impact on staff of repeated exposure to chronic and low-level allegations, outbursts of distressed behaviour and to violence directed at peers and staff being perceived as 'normal' at the hospital,¹⁸¹ but it is unclear how this was managed by the BHSCT.

Conclusions

9.119 In common with other institutions providing care for people with learning disabilities, there is evidence of persistent allegations of staff abusing patients since at least the 1970s.

9.120 While witnesses gave examples of cases in the 1980s and 1990s, changes in the policy for reporting concerns from the late 1990s occurred at the same time as the philosophy and culture of care changed, which crystallised in the Bamford Review report 'Equal Lives' in 2005 and may in part explain the increase in reports in later

¹⁷⁹ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital – Page 32. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

¹⁸⁰ Cathy Jack Statement (Organisational Modules) – 14/06/24 – Page 50

¹⁸¹ Margaret Flynn Statement – 24/04/23 – Page 36 (Exhibit MF/1) – A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go

years. BHSCT Governance Steering Group minutes from 2011 demonstrate that Board members were aware of the risks to patients both from delayed resettlement and the risks associated with management of aggression and resettlement. The Inquiry did not hear any evidence of the Board's plans to mitigate these risks and the trajectory of reported aggressive and/or violent incidents began a steep rise from 2011, particularly peer-on-peer incidents and patient-on-staff incidents.

- 9.121 Even before the Ennis Ward alleged abuse took place in 2012, and certainly before 2017, there were numerous signs that should have alerted staff at MAH, managers and the Board that the quality of care was poor and that abuse was a possibility. Examples of this included: the persistent shortages of ward staff; the lack of AHPs; the high levels of bank and agency shifts; the very high levels of incidents; physical interventions and seclusions; the family complaints; the family relationships between staff; and the closed culture in MAH as a result of its geographical location. It seems that some staff were much more alert to these factors than others, but even so the abuse that was revealed on CCTV in 2017 was a shock to most staff and to managers alike.
- 9.122 Between 2013 and 2021 the PHA received three SAls relating to staff abuse of learning disability patients at BHSCT and two relating to patients assaulting staff. However, neither the BHSCT Board, nor the PHA Board, nor the HSCB were receiving aggregated information on incidents and SAls. The Inquiry was given examples of six staff who were either prosecuted or who accepted police cautions for abusing patients before 2017. There were also numerous adult safeguarding investigations and at least two SAI Level 3 reviews of safeguarding concerns, but it was not routine practice to inform the Board of these individually. After the revelations on CCTV in 2017, allegations of abuse continued, and the risks remained unmitigated. Safeguarding processes were not always clear and adult safeguarding files were found to be unsatisfactory even in 2022.
- 9.123 There was more than sufficient data in the system to alert BHSCT and its commissioners to the increase in violence and aggression at MAH from 2011 onwards. This data came from incident reporting, SAls (including Ennis) and adult safeguarding referrals. However, each incident was investigated and managed in

isolation, with no attempt to see the bigger picture. This was true of each process independently (for example, no one appeared to notice the trends in the Datix reports) but was further impeded by the lack of integration of different systems. This meant that no one had an overview of the emerging picture that is plain to see in retrospect. All of this information should have been a red flag for the potential for abuse by staff, even if abuse was not proved in individual cases.

Recommendations

R45	Incident reports of any violent or aggressive behaviour by either people with learning disabilities and autistic people or staff should be analysed and trend data reported on every HSCT Board's quality and safety dashboard. In private and third sector care a similar system must be in place.
R46	Where people with learning disabilities can participate, the provider should actively seek their lived experience feedback in relation to staff attitudes and behaviours on a quarterly basis through an external and independent agency (perhaps to be undertaken by the PCC), and report this to a public part of a Board-level committee and also publish it on the provider's website.
R47	The provider should actively seek family or carer feedback on the service user's experience on a quarterly basis via an external agency and report the findings to the public part of a Board-level committee minutes (where these exist) and publish them on the provider's website.
R48	HSCTs must review and improve governance of safeguarding to ensure that findings from different safeguarding investigations are considered holistically, synthesised and presented to the public part of a Board-level committee.

Do you see me?

'My son loved relaxing in the evenings at home and we had good quality family time. We could go for walks in the summer, to the beach or forest or to the shops. He loved to help with the groceries. He loved music and singing.... he would go to bed with his favourite toys, including Barney and Tigger, and we would sing the Barney song.'

'Before being admitted to MAH, my daughter loved going to the swimming pool. She cannot swim but she loves being in water. She refused to go to the swimming pool at MAH. When I asked her why, she said 'They are bad in there'

Chapter 10

CCTV, 2017 Revelations and the Response

Introduction

- 10.1 Closed-circuit television (CCTV) played a defining role in uncovering abuse of patients at Muckamore Abbey Hospital (MAH). The decision to install CCTV was initially driven by concerns around patient and staff safety and the need for greater oversight of incidents. What was initially a safeguarding measure became the key evidentiary tool in exposing serious mistreatment of vulnerable individuals. Without access to CCTV footage, it is unlikely that abuse would have been uncovered at MAH or that this public inquiry would ever have been commissioned.
- 10.2 This chapter traces the trajectory of CCTV at MAH, beginning with the drivers behind its installation. It then examines the subsequent management and handling of CCTV records. We pay close attention to the role played by MAH staff and designated adult protection officers (DAPOs). The role of the Police Service of Northern Ireland (PSNI) in the analysis and actions following the viewing of CCTV is discussed briefly in this chapter and in more detail in Chapter 14 (External Agencies Inspection and Oversight).
- 10.3 Our own engagement with the CCTV material prefaces this chapter. At the outset of this Inquiry, the Panel dedicated four days to viewing selected parts of the CCTV footage provided by the PSNI. A second viewing by the Panel took place in August 2024. Given that criminal proceedings remain ongoing against several defendants, proceedings in which the CCTV evidence is critical, it is not appropriate here to disclose any detail as to what was revealed on the footage itself. It is sufficient to note that the Panel observed a number of examples of the types of abuse alleged. It is also worth repeating at this juncture that the reporting of evidence in relation to witnesses' commentary upon the actions viewed on the CCTV footage does not entail an adjudication or determination by the Panel in respect of the lawfulness or otherwise of individual conduct viewed on CCTV and reported by others.

- 10.4 Operation Turnstone, to which some reference is made in this report, is a major investigation by the PSNI into alleged abuse by members of staff at MAH, based on the CCTV material captured between March and September 2017. The investigation is continuing and so the Inquiry has had to be sensitive to ensuring, consistent with our Terms of Reference (ToR), that our process does not interfere with that investigation. Our terms of reference are however far wider than the period covered by that police operation.

The push for CCTV installation at MAH

- 10.5 The chronology of installation of CCTV at the hospital was examined in some detail by the 2020 independent leadership and governance review. The Inquiry also asked the Belfast Health and Social Care Trust (BHSCT) to assist with the history of installation and operation of CCTV within the hospital.¹
- 10.6 The earliest recorded discussion of CCTV for the wards at MAH appeared in the minutes of a Core Group meeting, held on 01 May 2007; CCTV already existed at the hospital perimeter, to assist if patients absconded. The discussion of CCTV arose from review of an incident at Conicar Ward. In the incident's aftermath there was an allegation of threatening behaviour towards staff by a family member of a 12-year-old patient (P363) at MAH. The family member believed that his son had been injured during a restraint, although no bruising was found. In response, some staff expressed concern for their own safety and advocated for the installation of CCTV. The minutes of 08 May 2007 record:
- 'Dr MacPherson has again requested CCTV be installed, as she believes there is a need to have something in place for staff protection'.²*
- 10.7 There was discussion regarding the expense of installing CCTV and the need for guidelines to be in place around its use. However, the possibility of CCTV was not pursued further at this time. The imminent move of the children's service to another site (Iveagh Centre) seems to have been the reason for the issue not being pursued. In addition, there is evidence that the installation of CCTV was considered in the design of the new 'core hospital' wards. Eilish Steele (former

¹ MAHI – Additional Materials Referenced – Pages 376-380 (DLS Correspondence of 30/09/22 and 10/01/23 re History of CCTV Installation & Operation)

² Core Group Meeting Minutes – 08/05/07 – Page 2

nurse and ward manager at MAH) recalled that senior staff at MAH (including psychiatrists) were not in favour of CCTV at the time, on the grounds that it might adversely affect patients with paranoia or delusions and would not be conducive to patients' dignity.³

- 10.8 The issue of CCTV resurfaced again in 2010 in relation to the newly opened Iveagh Centre, and thereafter on 09 August 2011. The Core Group, which had been formed to address increasing patient-on-patient and patient-on-staff incidents of aggression, opted not to pursue CCTV installation.⁴ However, staff member H92 repeatedly raised the issue with the Core Group, including on 21 August 2012, 16 October 2012 and 13 November 2012. The context provided for raising this again was linked to staffing issues, with rising patient-on-patient and patient-on-staff incidents, and poor staff morale:

'H92 requested consideration be given to CCTV being installed in the hospital. The group discussed the advantages/disadvantages, legal implications, costs, staff morale and patient's privacy. Dr Milliken agreed to further discussions on this and Mrs Mitchell agreed to look at the Policy and Procedures for CCTV'.⁵

- 10.9 The August 2012 minutes record that the Senior Manager for Service Improvement and Governance agreed to look at existing policies around CCTV, to enquire with the Directorate of Legal Services (DLS) and check which mental health services used CCTV. The process of securing the necessary funding then followed in 2013, with a business case being prepared for the installation of CCTV in communal areas in Sixmile and Cranfield male, female and intensive care wards.
- 10.10 At the Core Group meeting on 18 February 2014, Esther Rafferty (former service manager and Director of Nursing for MAH) confirmed that there was now sufficient funding (from the Corporate Capital Spending Group) to install CCTV on the Cranfield and Sixmile wards. The Core Group agreed that this proposal should be advanced. Barry Mills was tasked with following up with other mental health services within the BHSCT that were also considering CCTV installation. Brendan

³ Eilish Steele Transcript – 04/06/24 – Page 64 – Line 13

⁴ Core Group Meeting Minutes – 09/08/11 – Page 4

⁵ Core Group Meeting Minutes – 21/08/12 – Page 3

Ingram (then a nurse) subsequently investigated the associated costs.⁶ These were presented by Esther Rafferty to a June 2014 Core Group meeting. At that meeting, the group agreed in principle to proceed with CCTV installation on several wards, and installation work commenced in February 2015 in Cranfield and Sixmile.⁷

10.11 The formal handover from the contractor to the BHSCT occurred on 09 July 2015 and it would appear that the cameras were functional from that point. That is not to say, however, that staff or patients were aware that the system was operational. From the time of installation there followed a lengthy period (an ‘inexplicably long time’ as the leadership and governance review commented) during which the policy for usage was drafted by multiple committees within BHSCT, amended and considered for approval.

10.12 The draft CCTV policy for Cranfield and Sixmile wards was tabled for discussion on 13 September 2016. The minutes record:

*‘Mrs Rafferty tabled the above (CCTV policy for Cranfield and Six Mile) for discussion. She explained that Mr Mills, Brendan Ingram and DWSR Brennan had been working on this policy along with Orla Barron in Equality, they have consulted the patients’ group, staff side and the Society of Parents and Friends. Mrs Rafferty highlighted that the CCTV still hasn’t been switched on, access rota has been put in place so that not just anyone can access it or the cameras’.*⁸

10.13 Brendan Ingram (then Business Manager) confirmed that a lengthy consultation process had taken place with patients, families and staff. While the vast majority of staff and families supported the installation of CCTV, patient views were more mixed.⁹ He was responsible for procuring and sourcing the funding for the installation of the system. He was asked during the Inquiry about the hiatus between the installation of the system and the ultimate approval of the policy. He accepted that it had taken a ‘mammoth amount of time to get the policy to the point

⁶ Brendan Ingram Transcript – 11/09/24 – Page 144 – Line 5

⁷ Core Group Meeting Minutes – 10/06/14 – Page 2

⁸ Core Group Meeting Minutes – 13/09/16 – Page 2

⁹ Brendan Ingram Transcript – 11/09/24 – Pages 150-156

of being signed, sealed and signed off'.¹⁰ When asked how conceivably it could have taken so long, he replied:

'Well, undoubtedly I believe it took that length of time ... because this was such an unprecedented thing to happen within the hospital, the introduction of CCTV ... And there was so many different people to consult with, agree with, we had to be absolutely sure what we were putting into it was legal, viable ... And then in the end it had to go through an equality impact assessment, and that took ages and ages'.¹¹

- 10.14 Mr Ingram was also asked whether the delay could be explained by resistance from the Core Group in the hospital. He said that was not the case:

'No ... It's not - it certainly wasn't resistance. I wouldn't use that term whatsoever. It was just really fine tuning it. It really was fine tuning it. But the thing about -- and I think it's fair to say, certainly within the Trust, you know, it would never take two years to get a policy past through ... This one, because I don't believe it ever existed anywhere else within the Trust, because it was such a unique policy, and there were so many different people involved in it, and it had to go from one group, to another group, to another group, and sometimes I believe the delay was that it was sat on. Now, I don't know if that was intentional or not intentional, I can't vouch for that'.¹²

- 10.15 The policy was eventually approved by the Executive Team in June 2017, and it was ultimately agreed that the system would 'go live' in September 2017. As we now know, however, the response to the complaint in August 2017 revealed that the system was in fact in operation before that date and footage dating back to March 2017 was recovered. It is that footage that has resulted in criminal proceedings against a number of individuals and provided the impetus for this Inquiry.

- 10.16 Following on from the CCTV being installed in Cranfield and Sixmile wards, the chronology of installation of CCTV in other wards was more straightforward. CCTV was installed in Killead and Donegore wards by March 2018 and in the Moyola day-care unit and the general areas of the MAH swimming pool in early May 2018, although not initially connected and functioning. Further work enabled

¹⁰ Brendan Ingram Transcript – 11/09/24 – Page 164 – Line 4

¹¹ Brendan Ingram Transcript – 11/09/24 – Page 164 – Line 22

¹² Brendan Ingram Transcript – 11/09/24 – Page 166 – Line 16

it to become functional by early September 2018. The last area to have CCTV installed was Erne Ward, in which the system went live in October 2018.¹³

CCTV revelations

- 10.17 According to Brendan Ingram, it was envisaged that CCTV footage would be used in the following way (as was to become the policy):

*‘The initial concept was that the CCTV footage would only be reviewed when an incident was reported, so that a recording of the reported incident could be viewed and to clarify what had happened’.*¹⁴

- 10.18 On 21 August 2017, a staff member reported witnessing an incident in the Psychiatric Intensive Care Unit (PICU) in which another staff member had allegedly struck a patient.¹⁵ PICU is located within the Cranfield building at MAH. The incident was said to have occurred approximately 10 days earlier. There had, however, had been a delay in reporting as the deputy charge nurse wished to take advice on whether it was a reportable incident. On the day of the incident, a different staff member informed the nurse in charge, who had subsequently emailed the deputy ward manager. The relevant information was then passed onto the ward manager when he came back on duty. Following this a number of actions were taken: adult safeguarding procedures were initiated, the staff member in question was put on precautionary suspension, and the police were informed.¹⁶

- 10.19 The following day, Esther Rafferty was informed by Brendan Ingram and Barry Mills (then Hospital Services Manager) that CCTV footage of the incident might exist. Esther Rafferty asked Brendan Ingram to look at CCTV footage to determine if the incident had indeed been recorded.¹⁷ Brendan Ingram reported back to her that this was indeed the case. She told the Inquiry that she felt extremely upset and had a ‘gut reaction of disbelief’.¹⁸

¹³ MAHI – Additional Materials Referenced – Pages 376-380 (DLS Correspondence of 30/09/22 and 10/01/23 re History of CCTV Installation & Operation)

¹⁴ Brendan Ingram Statement – 25/07/24 – Page 9

¹⁵ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Page 36; and Page 159 (Exhibit 17) - Strategic Multi-Agency Group Meeting in response to Safeguarding Concerns at Muckamore Abbey, 30 October 2027

¹⁶ Esther Rafferty Transcript – 15/10/24 – Page 150 – Line 2

¹⁷ Brendan Ingram Statement – 25/07/24 – Page 9

¹⁸ Esther Rafferty Transcript – 15/10/24 – Page 152 – Line 15

10.20 While reviewing the CCTV footage, Brendan Ingram noticed that the CCTV equipment had been recording continuously for some while. He subsequently contacted the installers to ask about this:

'They advised that they had turned the cameras on to make sure they were working and that the recordings were retained in accordance with the period of time promised under the contract'.¹⁹

10.21 It transpired that there was about six months' worth of CCTV footage retained; it would appear that CCTV footage was overwritten by the system after six months. This archive began to be referred to as the 'historical CCTV recordings of 2017'.

10.22 Mairead Mitchell (BHSCT Head of Learning Disability from 2016 to 2019) was informed of the incidents of alleged abuse by the MAH service manager 'about 3 weeks after they happened', as she had been on holiday at the time.²⁰ Reflecting on the incidents that began to emerge from the CCTV footage, she commented:

[Counsel]: '... in becoming aware of the issues that were captured on CCTV, did you or have you since reflected on how that could have happened in a situation where you were implementing the measures that you have described to us?'

[Mairead Mitchell]: I mean all I can say is CCTV is a wonderful thing, you know you do walk abouts and you don't see any of this, you're told things and whatever but I from (when) I took up post in 2016 there were a series of things that alerted me that something wasn't right on-site and I think I have given you that information and I never ever thought it would be what has transpired. I never would have thought that. Shocking'.²¹

10.23 Esther Rafferty reflected similarly:

[Counsel]: 'I'm sure you have reflected on this but do you have any thoughts on how inappropriate treatment of patients could seemingly have been happening in the hospital without being detected?'

Esther Rafferty: If some of the incidents that I viewed had been in areas that were isolated you could understand how some of that was hidden. Unfortunately, what I was viewing on CCTV was instances of people abusing or staff abusing patients in full view of registrants and non-registrants. And the disregard that I witnessed was unbelievable because it seemed to be in the open. But yet when people walked through the ward, including myself, there was no obvious actions that were taken in front of us that would lead you to believe that someone was being hurt. And I think that's what shocked me more was how open it was'.²²

¹⁹ Brendan Ingram Statement – 25/07/24 – Page 9

²⁰ Mairead Mitchell Transcript – 16/09/24 – Page 155 – Line 19

²¹ Mairead Mitchell Transcript – 16/09/24 – Page 156 – Line 25

²² Esther Rafferty Transcript – 15/10/24 – Page 156 – Line 9

Management of the historical CCTV recordings of 2017

Organising the viewings

- 10.24 Initially, when viewing of CCTV footage commenced in August 2017, three separate incidents were seen. These related to two patients. However, only one incident had been reported at the time. In response, the PSNI and the Regulation and Quality Improvement Authority (RQIA) were notified, a serious adverse incident (SAI) was notified and an early alert was sent to the Department of Health (DoH). The staff member involved was placed on precautionary suspension. An adult safeguarding strategy meeting was convened on 25 September 2017 to review actions taken and to plan next steps.²³
- 10.25 Initially, the process involved Esther Rafferty requesting Brendan Ingram to check CCTV footage whenever a new incident was reported. He would then conduct a targeted review. However, several more incidents soon came to light, including a complaint from a patient on Sixmile Ward and a staff complaint regarding incidents at the swimming pool. This led to further staff being placed on precautionary suspension.
- 10.26 As the number of reported incidents captured on CCTV continued to grow, BHSCT decided in October 2017 to conduct a review. It was agreed that a 25% sample of all the historical CCTV recordings would be examined to assess the extent of the concerns.²⁴
- 10.27 According to Brendan Ingram, the Core Hospital Group:
- 'Discussed what dates would be reviewed, how the cameras would be selected, the time period that would be looked at and who would conduct the reviewing of the CCTV. I recall a decision was taken by the Core Hospital Group that we would initially review daytime hours. This was on the basis that there was likely to be more activity on the wards during the day than at night time'.²⁵*

²³ A11 Statement – 31/05/24 – Page 11 (restricted)

²⁴ Brendan Ingram Statement – 25/07/24 – Page 10

²⁵ Brendan Ingram Statement – 25/07/24 – Page 10

10.28 Brendan Ingram was asked to organise the viewing of incidents. He explained to the Inquiry that:

'Viewers were appointed to conduct the CCTV review. These tended mainly to be retired social workers, working on an ad hoc basis. I do not know how these viewers were recruited, but I believe they came from a variety of Trusts, not only the Belfast Trust. My role was to manage the review of the CCTV footage by these viewers. I did not review the CCTV myself. I trained the viewers on how to use the reviewing equipment and gave them an induction. At the start, I sat in with the viewers when they reviewed the CCTV just to show them how to operate the equipment. It was a complex system; some viewers felt that they could view a number of cameras at the one time and the speed of the recordings could also be enhanced or slowed down. There could also be a number of cameras in the one area which showed different angles. I provided the viewers with the clips that were to be reviewed in accordance with what was agreed at the Core Hospital Group meetings. The viewers reviewed the CCTV and completed forms detailing what they had viewed in terms of camera, date, time and whether or not they had observed any untoward incidents, giving as much detail on the incident that they had observed on the form as possible'.²⁶

10.29 During what was later referred to as Phase 1, the viewing of CCTV clips was carried out by the external viewers (as it was in Phase 2). They worked in pairs within an office in MAH's administration building. The footage was reviewed in four-hour segments. Brendan Ingram told the Inquiry that this followed a chronological order, from the earliest recordings onwards, in line with a 25% dip sample.²⁷ The approach was selected to ensure that no material was inadvertently overlooked.

10.30 The external viewers completed viewing forms for each session. These were put into sealed envelopes and delivered by the viewers to Brendan Ingram's office (they were put under his door if he was not in). He then reviewed the forms and passed them to Esther Rafferty, who in turn submitted them to the Adult Safeguarding (ASG) Team. Brendan Ingram noted:

'The volume of incidents being recorded on the forms completed by viewers indicated a high frequency of untoward incidents. I was advised that a decision had been taken by the Belfast Trust and the Department of Health and we needed to increase the percentage of CCTV being viewed to fifty percent of the total footage. I managed and implemented this as I had done for the viewing of twenty-five percent of the recordings. At some time, I cannot recall

²⁶ Brendan Ingram Statement – 25/07/24 – Page 10

²⁷ Brendan Ingram Transcript – 11/09/24 – Pages 177-178

when, I was advised that we needed to now review all of the CCTV footage and I put a system in place to do so'.²⁸

- 10.31 Once incidents of concern were identified by external viewers and documented on viewing forms, the forms were passed to Esther Rafferty, investigating officers and DAPOs. These officers were responsible for reviewing the relevant CCTV extracts to determine whether the incidents constituted safeguarding events.
- 10.32 If an incident was deemed a safeguarding matter, the DAPO was required to complete an ASP1 form. Where the incident was potentially criminal in nature, an AJP1 form was submitted to refer the matter to the PSNI. In accordance with the adult safeguarding policy and joint protocol for investigating cases, DAPOs were also responsible for informing the families of the individuals involved.²⁹ The process was complicated by the fact that DAPOs, although employees of BHSCT, did not work in MAH. As a result, they relied on Brendan Ingram to assist in identifying the names of staff and patients for each incident.
- 10.33 The decision to review only 25% as a 'dip sample', however, caused concerns elsewhere. The Inquiry was shown correspondence which demonstrated that the Chief Nursing Officer and the Chief Social Work Officer from DoH wrote to the Chief Executive of BHSCT on 20 October 2017 indicating growing concern as to the handling of the response to the safeguarding incident. A further letter on 30 November 2017 indicated further concern as to the decision only to view 25% of the footage and requested that 100% be viewed.
- 10.34 For families, being informed by DAPOs that their relative had been the subject of a safeguarding incident was deeply distressing. There was anger, hurt and disbelief at what had occurred as well as guilt that they had let their loved ones down in some way.³⁰ Many struggled to understand why they had not been notified of safeguarding incidents involving their patient relatives in chronological order. Brendan Ingram maintained that this stemmed from the initial decision in

²⁸ Brendan Ingram Statement – 25/07/24 – Page 11

²⁹ Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 8794 (Exhibit BW/140) – Protocol for Joint Investigation of Adult Safeguarding Cases

³⁰ Geraldine O'Hagan Transcript – 15/05/24 – Page 28 – Line 6

October 2017 by BHSCT to review a 25% sample, which was later expanded to a 50% sample and ultimately to 100% by January 2018 as per the request from the DoH. This meant that earlier incidents that had not been included in the initial 25% sample were only identified and reviewed at a later stage.³¹ Consequently, families who had already been informed of one incident were later notified of additional, earlier events. This caused significant upset and confusion.

- 10.35 Brendan Ingram also facilitated the viewing of CCTV recordings by the PSNI, providing copies of the footage as required by them:

'And I suppose just to clarify that when the downloading was being done on to the CD-ROM, there were always two copies made. One for the PSNI and one for the Trust. And the reason for that was that were there to be any follow-up disciplinary proceedings, the evidence would still be there. Bearing in mind what I said earlier that the system only had capacity for X amount of recording and would have then began overwriting'.³²

- 10.36 However, according to Brendan Ingram he was informed by Mairead Mitchell that the PSNI intended to remove the CCTV footage from the hospital. Mairead Mitchell explained that she had been advised of this development by the Co-Director of MAH:

'The police had taken a decision, and I don't -- obviously I have no idea about that -- but they had taken a decision that they wanted a complete copy of the CCTV system, and they were going to come to the hospital to make that copy, and I was actually there on the day that they came to do it and they had brought the wrong obviously IT technical people and so on with them to do that. But during the process of them trying to obtain a copy of what was on the system, there was some sort of malfunction. Now, we were never made aware of what that malfunction was. And, in essence, no CCTV could be viewed, because it seemed to have disappeared. Now, the system was then removed from the hospital and sent to Dublin to be, for the want of better words, rebuilt'.³³

- 10.37 Brendan Ingram described the situation to us:

'Now, I can't honestly remember the exact length of time, but I think it was probably a couple of months where there was no CCTV viewing, for that very reason, because we had nothing to view. And when it was retrieved, it was not brought back to the hospital. The police then actually held on to it but did make a copy of it to give back to us, but it was -- there was a whole different way of managing it thereafter'.³⁴

³¹ Brendan Ingram Transcript – 11/09/24 – Page 182 – Line 5

³² Brendan Ingram Transcript – 11/09/24 – Page 192 – Line 23

³³ Brendan Ingram Transcript – 11/09/24 – Page 194 – Line 15

³⁴ Brendan Ingram Transcript – 11/09/24 – Page 195 – Line 8

PSNI involvement

- 10.38 Detective Chief Inspector Jill Duffie (Public Protection Branch) provided a statement to the Inquiry dated 25 October 2024. In her evidence, she confirmed that a meeting took place on 01 February 2019 to discuss the extent and completeness of BHSCT's viewing of the CCTV footage. She told the Inquiry:

'During this meeting it was confirmed that the Trust had not viewed as much CCTV as had been previously communicated to Police. I took the decision that police would seize the CCTV hard drives as I was unable to rely on assurances from BHSCT that all footage had been viewed ... I was not content following the above mentioned meeting that the original evidence/CCTV footage remained on site at Muckamore Abbey Hospital and wished to ensure that it was secure'.³⁵

- 10.39 On 07 February 2019, police officers visited MAH accompanied by technical staff.³⁶ Their purpose for being there was to clone the CCTV footage so that a copy could be retained by the hospital. However, this was unsuccessful, with police attributing this failure to a fault in the Sixmile digital video recorder. Officers returned to MAH on 08 February, seizing both Cranfield and Sixmile CCTV drives.

- 10.40 According to Brendan Ingram, the PSNI subsequently took over the viewing of the CCTV footage and would refer incidents to the DAPOs for further review. At one stage, all viewing reportedly took place at Antrim Police Station. In Brendan Ingram's view:

'I think also part of the reason for them (PSNI) removing it was they were quite concerned about the security ... Of the system being at Muckamore ... And I think they thought that perhaps they could offer better levels of security for it than where it was located in the hospital'.³⁷

- 10.41 On 01 April 2019, the police returned copies of the Sixmile footage to Marie Curran (then Human Resources (HR) Senior Manager) to allow BHSCT staff to recommence viewing.³⁸ The DAPOs' recollections were that external viewers continued to be used until December 2019.³⁹ The PSNI complained that it did not

³⁵ Jill Duffie Statement – 25/10/24 – Page 3

³⁶ Jill Duffie Statement – 25/10/24 – Page 4

³⁷ Brendan Ingram Transcript – 11/09/24 – Page 203 – Line 27

³⁸ Jill Duffie Statement – 25/10/24 – Page 6

³⁹ A5 Statement – 25/01/24 – Page 20 (restricted)

receive Management of Actual or Potential Aggression (MAPA) expert opinions on events on CCTV footage. This was eventually rectified in 2020.⁴⁰

Designated adult protection officers' views

- 10.42 From the perspective of the investigating officer and the DAPOs, the early days of reviewing CCTV footage were challenging. They found the office space inadequate and the operation of key equipment problematic, and they required assistance in identifying staff and patients. They also sought guidance from H189 and others to determine whether observed actions constituted recognised MAPA techniques.
- 10.43 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.⁴¹ 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.
- 10.44 In general, DAPOs reported that they found the CCTV challenging to watch and difficult to do coterminously (they were often tasked with watching the product of six to eight cameras). When untoward incidents were observed, an ASP1 form was completed. These were sent directly by DAPOs to Mairead Mitchell to enable protection plans to be put in place. Families were at this point informed. If a crime was suspected, DAPOs then completed AJP1 forms. These were forwarded to the PSNI, as per the joint protocol.⁴² In summary, one DAPO said:

'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

⁴⁰ A5 Statement – 25/01/24 – Page 22 (restricted)

⁴¹ A7 Statement – 09/02/24 – Page 12 (restricted)

⁴² Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 8794 (Exhibit BW/140) – Protocol for Joint Investigation of Adult Safeguarding Cases

*stimulation for the patients on the wards by the MAH staff. Staff ignored the patients which appeared to lead to escalation’.*⁴³

10.45 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.⁴⁴ At times footage showed that this resulted in patient distress, which led to self-injury and thereafter seclusion of the patient by staff. DAPOs reported that there were times when incident reports completed by staff did not align with what was seen on CCTV footage.

10.46 It was also noted that when certain staff were working a shift together, they appeared to form a clique and an incident was more likely to occur, whereas when the same individuals worked separately, they behaved differently.⁴⁵

10.47 DAPOs tasked with viewing CCTV footage from PICU became concerned that staff may have been behaving in a similar way on other wards. They raised this concern with managers. CCTV footage from cameras on the Sixmile and Cranfield wards were subsequently examined, leading to identification of further concerning conduct. The Inquiry heard evidence from a DAPO who said that as time went on they felt able to predict that if certain staff were on duty they would see safeguarding incidents:

*‘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’.*⁴⁶

10.48 DAPOs were also concerned that incidents identified on CCTV often involved staff who had observed the incidents but who had not reported them. Neither were the incidents logged on Datix:

⁴³ A7 Statement – 09/02/24 – Pages 12-13 (restricted)

⁴⁴ A7 Statement – 09/02/24 – Page 13 (restricted)

⁴⁵ Geraldine O’Hagan Transcript – 15/05/24 – Page 21 – Line 1

⁴⁶ A7 Transcript – 20/02/24 – Page 61 – Line 18 (restricted)

'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'.⁴⁷

- 10.49 Increasingly, as the number of identified incidents via CCTV footage rose, DAPOs felt that tensions were rising in MAH. DAPOs were unclear why the CCTV they were given was not chronological and they felt that their job was being made unnecessarily difficult:

'We were made very unwelcome at Muckamore when attending to review the CCTV footage. We were given the CCTV footage in a bizarre way. For example, we were provided with footage from March 2017 and the next recording would be from September 2017. There was no continuity'.⁴⁸

- 10.50 They 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.⁴⁹ Following the PSNI intervention, CCTV viewing was subsequently moved to a health centre in Belfast, ensuring that viewing took place outside MAH.⁵⁰

- 10.51 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.⁵¹ Viewing sheets were passed from external viewers to Brendan Ingram, who then disseminated them to DAPOs. DAPOs reported that viewing sheets were of variable quality. Brendan Ingram told the Inquiry that:

'The viewer was required to record both positively if an incident had been seen on a recording, or in the negative if no incident was seen. These forms were then placed into sealed envelopes and left in my office'.⁵²

- 10.52 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

⁴⁷ A11 Transcript – 08/10/24 – Page 16 – Line 23 (restricted)

⁴⁸ A4 Transcript – 14/11/23 – Page 17 – Line 21

⁴⁹ A7 Statement – 09/02/24 – Page 19 (restricted)

⁵⁰ A5 Statement – 25/01/24 – Page 24 (restricted)

⁵¹ A7 Statement – 09/02/24 – Page 8 (restricted)

⁵² Brendan Ingram Transcript – 11/09/24 – Page 185 – Line 15

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.⁵³ When asked about this, Brendan Ingram told the Inquiry that he viewed the content of the sheets given to him, separating them into incident or no incident piles. He denied ever offering a view as to whether something amounted to a safeguarding incident or not.⁵⁴ He told the Inquiry that his role had effectively been purely to facilitate viewing of footage by DAPOs.

- 10.53 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.⁵⁵ On 08 February 2019 PSNI removed the CCTV footage, causing some further delay to the DAPOs' review.⁵⁶ 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.⁵⁷ DAPOs objected that they had not viewed night-time footage.
- 10.54 It was not until 25 February 2019 that CCTV viewing restarted, now at Antrim Police Station.⁵⁸ There was an inevitable backlog of footage to review. This amounted to 80 to 90 viewing sheets.⁵⁹ 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.⁶⁰ They described the Phase 1 DAPO team as working under 'immense pressure' with very limited support and resources from BHSCT.⁶¹

⁵³ A5 Statement – 25/01/24 – Pages 45-48 (restricted)

⁵⁴ Brendan Ingram Transcript – 11/09/24 – Page 190 – Line 5

⁵⁵ A7 Statement – 09/02/24 – Page 19 (restricted)

⁵⁶ A7 Statement – 09/02/24 – Page 19 (restricted)

⁵⁷ A7 Transcript – 20/02/24 – Page 42 – Line 10 (restricted)

⁵⁸ A7 Statement – 09/02/24 – Page 22 (restricted)

⁵⁹ A7 Transcript – 20/02/24 – Page 45 – Line 3 (restricted)

⁶⁰ A13 Statement – 17/05/24 – Page 4 (restricted)

⁶¹ A13 Statement – 17/05/24 – Page 7 (restricted)

- 10.55 At times there were disagreements between DAPOs and managers about what should be referred to the PSNI, leading to stressful meetings. Some DAPOs left their posts, citing the traumatic nature of the work, the poor support offered to them and the problems associated with both reviewing CCTV footage and communicating with families. A new adult safeguarding team was appointed.
- 10.56 This second set of DAPOs were appointed between April 2019 and April 2020. This group was later referred to as the Phase 2 team. The Phase 2 team viewed the CCTV at a new location, Musgrave Park Hospital,⁶² was managed by a new BHSC 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.⁶³ It was felt that a decision had been made to keep the two teams very separate.⁶⁴ The process used for reviewing footage nevertheless appeared to remain the same. External viewers screened CCTV footage before passing flagged incidents to DAPOs. There was a team of 17 external viewers in summer 2019.⁶⁵
- 10.57 Phase 2 DAPOs sought to maintain links with HR (which was responsible for disciplinary processes for BHSC staff). However, the DAPOs told the Inquiry that they were instructed to keep three separate databases: one for the adult safeguarding team with all relevant information, another for HR and a third for the PSNI.
- 10.58 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.⁶⁶

⁶² A5 Statement – 25/01/24 – Page 13 (restricted)

⁶³ A5 Statement – 25/01/24 – Page 14 (restricted)

⁶⁴ A5 Statement – 25/01/24 – Page 27 (restricted)

⁶⁵ A5 Statement – 25/01/24 – Page 62 (restricted)

⁶⁶ A13 Statement – 17/05/24 – Page 13 (restricted)

They also felt that on occasions they were being asked by BHSCT managers to minimise the extent of the abuse suffered by patients.⁶⁷ The FLO described a tangible atmosphere of mistrust, secrecy, control and unprofessional conduct with the management of Phase 2.

- 10.59 Another DAPO brought in during 2019, Geraldine O'Hagan (a former family liaison social worker for BHSCT), was an experienced social worker. She described how challenging the task was to view the footage, quite apart from the distressing nature of the contents of it. She told the Inquiry:

'The big challenge for me was the speed at which I was asked to view the footage, as well as how I was being asked to view the footage and this was all coming from the senior management. At the start of my work with the team, I was encouraged in my induction to take my time and become familiar with this type of work. However, the person who gave me the induction had very different views from the senior management when it came to this and, once I got into the work, it was very different from the induction. Looking at CCTV to try and figure out harm to patients was not as straightforward as you might imagine, because you had to identify the staff, as well as what was going on for the patient before, during and after the incident, so you could not rush through it. The emphasis from the senior managers was speed and getting our weekly statistics to be as high as possible, and it did not matter if this was harmful to working out what happened to the patient'.⁶⁸

- 10.60 In the early stages of the CCTV investigation, staff were identified by senior management. Eventually, as Marie Curran explained to the Inquiry, a master file was created to assist DAPOs in identifying staff:

[Counsel]: '... you were asked if HR took any steps to ensure that DAPOs were able to identify those appearing on CCTV, and you outline at paragraph 46 that HR did provide assistance in respect of identifying staff, but in the early stages of the investigation it was Senior Management who identified staff during the CCTV investigation and, you then say that a master file was created by management with staff photographs and ID from HR records. Now, the Inquiry has heard evidence that there were difficulties at times for some staff being able to identify those on CCTV and being able to get information to be able to ascertain who they were. Do you know when that master ID file that you've referred to was made available to the DAPO or the Adult Safeguarding Team? [Ms Curran]: I don't have the specific date, but it was relatively early on in the process, so probably 2018/19'.⁶⁹

⁶⁷ A13 Statement – 17/05/24 – Page 18 (restricted)

⁶⁸ Geraldine O'Hagan Transcript – 15/5/24 – Page 16 – Line 23

⁶⁹ Marie Curran Transcript – 18/09/24 – Page 90

However, as Marie Curran then went on to explain, the numerous suspensions of ward staff and rapid changes of ward staff still made identification difficult for DAPOs.

- 10.61 A number of witnesses spoke about the tensions between the various groups of staff during the historical CCTV investigations. The Inquiry asked Marie Heaney (former Director of Adult Social and Primary Care) about these tensions:

[Prof Murphy]: *'When you were talking earlier on in your statement about realising the size of the task for CCTV viewing, you were talking about needing to expand the team to do the viewing, you said that you decided to appoint more social workers to the DAPO roles, did it worry you at all that you might be setting up professions to feel that they were in some way operating against each other? We've heard nursing saying they felt social workers were against them, we've heard social workers saying they felt nurses were against them, I just wonder what you thought about that and whether you thought in retrospect it could have been done differently?'*

[Ms Heaney]: *'Yes, I think we were very aware that it created division between social workers involved in this and the nursing staff at Muckamore. If it could have been done differently, I mean in retrospect I think it should have been done or could have been done differently. I think it was difficult to identify the forum where you could think through these issues in more detail. I suppose looking back, I mean the police should have just taken the hard drive, did the analysis and contacted us for a discussion about actions as opposed to us engaging in this major viewing and identifying, it was outwith our experience and created, I think, unintended consequences. We were following the Adult Safeguarding policy as was the police, but it was insufficient for this task, for this major institutional investigation. So it wasn't fit for purpose in retrospect'.⁷⁰*

- 10.62 Following a critical unannounced inspection report from the RQIA in 2019, some DAPOs reported an adult safeguarding policy change.⁷¹ This related to what should be referred to the adult safeguarding team. The change meant that instead of some staff-on-patient incidents being resolved at ward manager level, all incidents were now to be referred to DAPOs:

'The new procedures dictated that every small incident that could possibly be interpreted as safeguarding should be reported and that every referral be accepted as a potential safeguarding incident'.⁷²

⁷⁰ Marie Heaney Transcript – 26/09/24 – Page 119-120

⁷¹ RQIA - Unannounced Inspections -26/02/19 to 01/03/19, 15/04/19 to 17/04/19

⁷² A3 Transcript – 15/11/23 – Page 87 – Line 1

10.63 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: ⁷³

‘The Safeguarding Team was swamped with very paperwork-heavy, process-driven, task ... endless reporting and recording and we had little resource to do that’. ⁷⁴

10.64 One DAPO reported that staff at MAH were suspicious of the FLO role and questioned how, as a BHSCCT employee, they could challenge Muckamore staff on the basis of advocating for families. It was felt there was some sort of conflict of interest and the FLOs repeatedly had to defend their position.⁷⁵

10.65 Moreover, DAPOs felt criticised by senior management, and this led to high staff turnover:

*‘On several occasions senior management of MAH made it clear that they disagreed with our decisions and were unhappy with our approach’.*⁷⁶

*‘Trying to do the job was completely overwhelming and I did not feel professionally safe. I felt that I needed to move as the job was completely unmanageable and I was not supported’.*⁷⁷

10.66 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 BHSCCT’s HR team.⁷⁸ 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.⁷⁹

⁷³ A11 Transcript – 08/10/24 – Page 29 – Line 4 (restricted)

⁷⁴ A3 Transcript – 15/11/23 – Page 89 – Line 22

⁷⁵ Geraldine O’Hagan Transcript – 15/05/24 – Pages 35-36

⁷⁶ A3 Transcript – 15/11/23 – Page 91 – Line 1

⁷⁷ A3 Transcript – 15/11/23 – Page 93 – Line 4

⁷⁸ A5 Statement – 25/01/24 – Page 21 (restricted)

⁷⁹ A5 Statement – 25/01/24 – Page 22 (restricted)

10.67 From the DAPOs' view there were a number of other noteworthy issues:

- DAPOs found it very difficult to get the assistance required in identifying relevant staff members on CCTV footage.⁸⁰
- BHSCT seemed unable to assist in the identification process, providing no access to staff photos. This was despite the fact that staff name badges at MAH included staff photographs.
- 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.⁸¹
- There were statements that PICU viewing had been completed by August 2019, when DAPOs knew that this was not the case. This concern was also flagged by Esther Rafferty.⁸²
- There was pressure to speed up viewing, such that some DAPOs adopted the practice of 'skimming'. This involved running 11 hours of CCTV footage through review processes in 20 minutes. Some DAPOs articulated concerns that this risked missing recorded incidents on CCTV footage.
- 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.⁸³

10.68 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.

⁸⁰ A5 Statement – 25/01/24 – Page 53 (restricted)

⁸¹ A5 Statement – 25/01/24 – Page 54 (restricted)

⁸² Esther Rafferty Transcript – 15/10/24 – Page 160 – Line 5

⁸³ A5 Statement – 25/01/24 – Pages 31-32 (restricted)

- 10.69 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.⁸⁴ 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.⁸⁵
- 10.70 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.⁸⁶ While DAPOs responded to these historical forms they were often too late to be included in criminal processes, as suspects had already been interviewed.⁸⁷
- 10.71 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.⁸⁸ A13 also described how, when staff realised the CCTV was operational, they changed their presentation and their behaviour.
- 10.72 A new collective leadership team in June 2022 offered fresh oversight.⁸⁹ However, one DAPO told the Inquiry:
- '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'.⁹⁰*
- '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'.⁹¹*

⁸⁴ A5 Statement – 25/01/24 – Page 71 (restricted)

⁸⁵ A5 Statement – 25/01/24 – Page 88 (restricted)

⁸⁶ A5 Statement – 25/01/24 – Page 84 (restricted)

⁸⁷ A5 Statement – 25/01/24 – Page 85 (restricted)

⁸⁸ A13 Statement – 17/05/24 – Page 64 (restricted)

⁸⁹ A5 Statement – 25/01/24 – Page 112 (restricted)

⁹⁰ A5 Statement – 25/01/24 – Page 13 (restricted)

⁹¹ A5 Statement – 25/01/24 – Page 151 (restricted)

- 10.73 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.⁹²

Trust meeting on 06/01/22 about DAPO and FLO Involvement in this Inquiry

- 10.74 During the latter months of 2021, the Inquiry held a number of engagement sessions at hotels around Northern Ireland to provide information to families and other interested parties about its work. The Chair, Senior Counsel to the Inquiry, the Solicitor and Secretary to the Inquiry all attended each of those sessions and introduced themselves and gave a short summary of the work the Inquiry was undertaking. The purpose of these was to encourage participation in the Inquiry's work from anyone affected by the events at MAH. FLOs attended some of those sessions to support families who were attending.
- 10.75 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.⁹³ They were told to wait for a staff meeting, scheduled for 06 January 2022.⁹⁴
- 10.76 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.
- 10.77 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.⁹⁵ It was also emphasised that any staff member was free to assist the Inquiry if they felt they

⁹² A13 Statement – 17/05/24 – Page 34 (restricted)

⁹³ A5 Statement – 25/01/24 – Page 96 (restricted)

⁹⁴ A5 Statement – 25/01/24 – Page 96 (restricted)

⁹⁵ A5 Statement – 25/01/24 – Page 100 (restricted)

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.⁹⁶ 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. 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'.

- 10.78 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.⁹⁷
- 10.79 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.
- 10.80 Whatever the motivations and intentions behind these warnings given at the meeting, it appears that they had a chilling effect. They were received by at least one of those present as a discouragement to be open and engaging with a public inquiry commissioned to investigate abuse within the Trust. Fortunately for the Inquiry the individual was not dissuaded and with considerable courage gave evidence to the Inquiry, as did other FLOs.

⁹⁶ A5 Statement – 25/01/24 – Page 105 (restricted)

⁹⁷ A5 Statement – 25/01/24 – Page 104 (restricted); A5 Transcript – 08/02/24 - Page 47 - Line 5 (restricted)

The view from Human Resources

10.81 Marie Curran was appointed Senior Human Resources (HR) Manager in 2017 and had a significant role in managing disciplinary outcomes of the emerging issues at MAH. In December 2018 she was appointed Interim Services Manager in HR for the MAH investigation team.⁹⁸ She retained that role until a promotion in May 2023. She described the difficulties that arose in relation to the disciplinary process and the need to show staff CCTV footage in support of the case against them. This was difficult to navigate with respect to the role of the PSNI and its concerns about the sharing of CCTV footage potentially prejudicing police investigations.⁹⁹ There were also issues around the level of detail that could be shared with staff. Marie Curran described how the police held primacy in viewing CCTV footage. However, those cases that did not reach a criminal threshold would nevertheless follow BHSCT processes, including potential disciplinary processes.¹⁰⁰

10.82 Marie Curran was able to confirm that Sixmile Ward had the least number of safeguarding incidents identified.¹⁰¹ She also confirmed that there was no specific standard or protocol applied in identifying behaviour that should or should not be referred to disciplinary processes. There was therefore no way of ensuring the consistency of approach in flagging potentially significant incidents:

[Dr. Maxwell]: *'Was there any way of quality assuring that the same standard was being applied through all the viewings?*

[Ms Curran]: *Not in a prescriptive way to quality assure I suppose. The concerns and incidents that have been identified do span lots of different areas of concern. You know, we will have very direct and overt incidents, and then we will have, as you describe, practice or conduct matters that need to be addressed, and I suppose, yes, it's dependent on the person and their assessment of that, and possibly some of their own experience and skills.*

[Dr. Maxwell]: *So there may have been some variability on how people viewed things?*

[Ms Curran]: *Possibly, yes'.¹⁰²*

⁹⁸ Marie Curran Transcript – 18/09/24 – Page 60 – Line 14

⁹⁹ Marie Curran Transcript – 18/09/24 – Page 62 – Line 5

¹⁰⁰ Marie Curran Transcript – 18/09/24 – Page 75 – Line 2

¹⁰¹ Marie Curran Transcript – 18/09/24 – Page 84 – Line 13

¹⁰² Marie Curran Transcript – 18/09/24 – Page 86 – Line 8

10.83 Marie Curran told the Inquiry that although there were no prescribed thresholds for supervision or suspension of staff, the decision was broadly based on risk to patients. Moreover, if a staff member appeared via reviewed CCTV footage to have been directly involved in mistreatment of a patient, they would be suspended. If they had been recorded as witnessing mistreatment, and nevertheless failed to intervene, they may have been placed on supervision or training. It was emphasised these were not hard and fast rules.¹⁰³

10.84 Marie Curran told the Inquiry:

*'Because a decision to suspend is based on a number of factors and, you know, you have to consider the arrangement, what is the job that the person undertakes, what are their responsibilities, what is the level of actual or potential risk to either themselves, others, the process of the organisation? So it is - it would be really, really challenging to have a list of prescribed actions, or incidents, or scenarios where a suspension -- now there's clearly obvious incidents, you know, of a very serious nature, where it would result in precautionary suspension decisions'.*¹⁰⁴

Management of contemporaneous CCTV (after 2017)

10.85 The Phase 1 adult safeguarding team also viewed what was referred to as the 'contemporaneous CCTV' at MAH. This fell outside of the scope of Operation Turnstone (which was concerned only with the historical CCTV up to and including August 2017). However, in Phase 2 the contemporaneous CCTV team was separated from the historical CCTV team.

10.86 The processes followed by the two teams were similar. An external viewing team also worked on the contemporaneous CCTV, with clips drawn at random, prior to clips being given to DAPOs.¹⁰⁵ 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.¹⁰⁶ 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

¹⁰³ Marie Curran Statement – 26/08/24 – Page 23

¹⁰⁴ Marie Curran Transcript – 18/09/24 – Page 106 – Line 27

¹⁰⁵ A3 Transcript – 15/11/23 – Page 100 – Line 7

¹⁰⁶ A5 Statement – 25/01/24 – Page 117 (restricted)

identifying staff on CCTV.¹⁰⁷ Frequent staff turnover of DAPOs also made workload difficult to manage.¹⁰⁸

- 10.87 There were numerous meetings about safeguarding. These included: daily ward meetings, weekly governance meetings, weekly safeguarding meetings, monthly safeguarding forums, monthly assistant service managers meetings and monthly ward managers meetings.¹⁰⁹ Nevertheless, some members of the adult safeguarding team felt that the meetings were ineffective and far too numerous. One category of meeting took place 25 times a week:

[Counsel]: ‘... Are you saying that the meetings themselves were ineffective? Are you saying there is an issue with the volume of them?’

[A3]: *I think the meetings in themselves were ineffective. Probably an issue with the volume as well because I think you can become saturated with meetings and people switch off, it is just meetings for the sake of meetings. But I don't think they were effective probably because they weren't particularly well attended and because not everybody necessarily understood the point or understood their role. I think very much safeguarding was seen as something that belonged to the social workers and other people didn't necessarily see their role in it.*¹¹⁰

- 10.88 DAPOs also felt that MAH staff were defensive:

[Counsel]: ‘And you think that that defensiveness arose from the ongoing investigations, is that what you're linking it to?’

[A3]: *To the staff's misunderstanding about the ongoing investigations, the very senior staff obviously would have known exactly what the investigations were about. And I understand that they also had a job to do with trying to stabilise a hospital that was in crisis and had huge staffing difficulties and trying to improve the staff morale. But there seemed to be a real struggle to do that with safeguarding as part of it. It seemed to be, you could do one or the other but you couldn't do both.*¹¹¹

Informing the families

- 10.89 Families of the patients who had been seen to have been involved in incidents of abuse by staff had a number of reactions to what happened. Although they praised the FLOs assigned to keep them informed, the process was difficult for all. For many the effect upon them has been extremely damaging.

¹⁰⁷ A5 Statement – 25/01/24 – Page 122 (restricted)

¹⁰⁸ A5 Statement – 25/01/24 – Page 122 (restricted)

¹⁰⁹ A3 Statement – 02/11/23 – Page 14

¹¹⁰ A3 Transcript – 15/11/23 – Page 126 – Line 15

¹¹¹ A3 Transcript – 15/11/23 – Page 144 – Line 1

- 10.90 In 2017 many families learnt that CCTV showed incidents involving their loved ones and felt guilty about not having questioned the staff more at the time. They felt guilty for misplacing their trust in staff:

'Anything can set off P18's temper. Sometimes he is bored and wants entertainment and the staff usually try to calm him down verbally before restraining him. I never thought the staff at Muckamore would do anything like that to harm P18. You have no choice but to send your loved ones to places like Muckamore to be looked after. I trusted the staff at Muckamore'.¹¹²

'On one occasion when my mum was collecting Greg from the ward, a member of staff told my mum not to worry about the reports as the abuse hadn't happened on Greg's ward, Cranfield 2. I do not know the date or the staff member's name. That is why we were very shocked when we were contacted by the family liaison officer in July 2020 regarding the two CCTV in July and August 2017. She asked us if the police had been in touch, which they hadn't at the time, and advised us that Greg had been mistreated. This came as a huge shock to me and my family and I find it hard to believe that this was allowed to happen to vulnerable adults in the care of MAH'.¹¹³

- 10.91 There was concern that the abuse could have taken place in areas not covered by CCTV:

'I am particularly concerned about the places in MAH that did not have CCTV such as bathrooms and bedrooms and, given the extent of abuse it has been acknowledged has occurred in MAH, P105 could have been abused in those areas. I am aware that abuse continued to be caught on CCTV at MAH even though it was known that CCTV was operational. I think that staff should wear body cameras. I also think that something should apply to all facilities where people with serious mental issues or severe learning disabilities are being cared for, given their vulnerability and the level of abuse that has been identified in such places in the past'.¹¹⁴

'Not long after I became aware of the allegations of abuse, I remember one Friday when P113's father and I were getting P113 ready to take him out for the day a nurse called H457 came into his bedroom. I cannot recall her surname. H457 was crying and she looked at P113's father and said she was sorry about everything. At this stage, we were not aware that P113 was involved, so I remember P113's father and me saying to each other that it was an odd thing for H457 to say. We put it down to her having a bad day, or perhaps she was stressed as the press were reporting on the abuse claims. In hindsight, I wonder if she may have known that P113 had been mistreated and that we would eventually find out. I can clearly recall the day that I was told P113 was a victim of abuse from staff on PICU. It was a Friday in May 2018 and I had taken P113 to the Tower Centre in Ballymena. We were walking through the centre and P113 was linking me as we walked. I missed

¹¹² P18's Mother Transcript – 21/09/22 – Page 16 – Line 5

¹¹³ P13's Sister Transcript – 05/07/25 – Page 67 – Line 9

¹¹⁴ P105's Mother Transcript – 14/09/23 – Page 58 – Line 7

a call from an unknown number and picked up a voicemail from H283, social worker of safeguarding with Belfast Trust. I remember saying to P113's father that something must have happened to P113 at MAH. I did not return the call as I could not speak privately. I received a further call from H283 when we were walking through the centre. She told me she was reviewing CCTV footage as part of the investigation into allegations of abuse against staff at MAH and that she could see from the footage that P113 was involved in one or two incidents. I felt completely numb and sick'.¹¹⁵

'Finding out that P113 was abused has affected my life dramatically. In June 2019 I took sick leave from work for one month, as processing what I was told happened to P113 was too much for me to cope with. This affected my husband and sons. I do not talk about this experience to anyone outside my immediate family. I want to protect my sons from the reality of what P113 has suffered. When I talk about what happened to P113, I feel physically sick and very emotional, which causes me to lose my appetite and feel depressed'.¹¹⁶

Conclusions

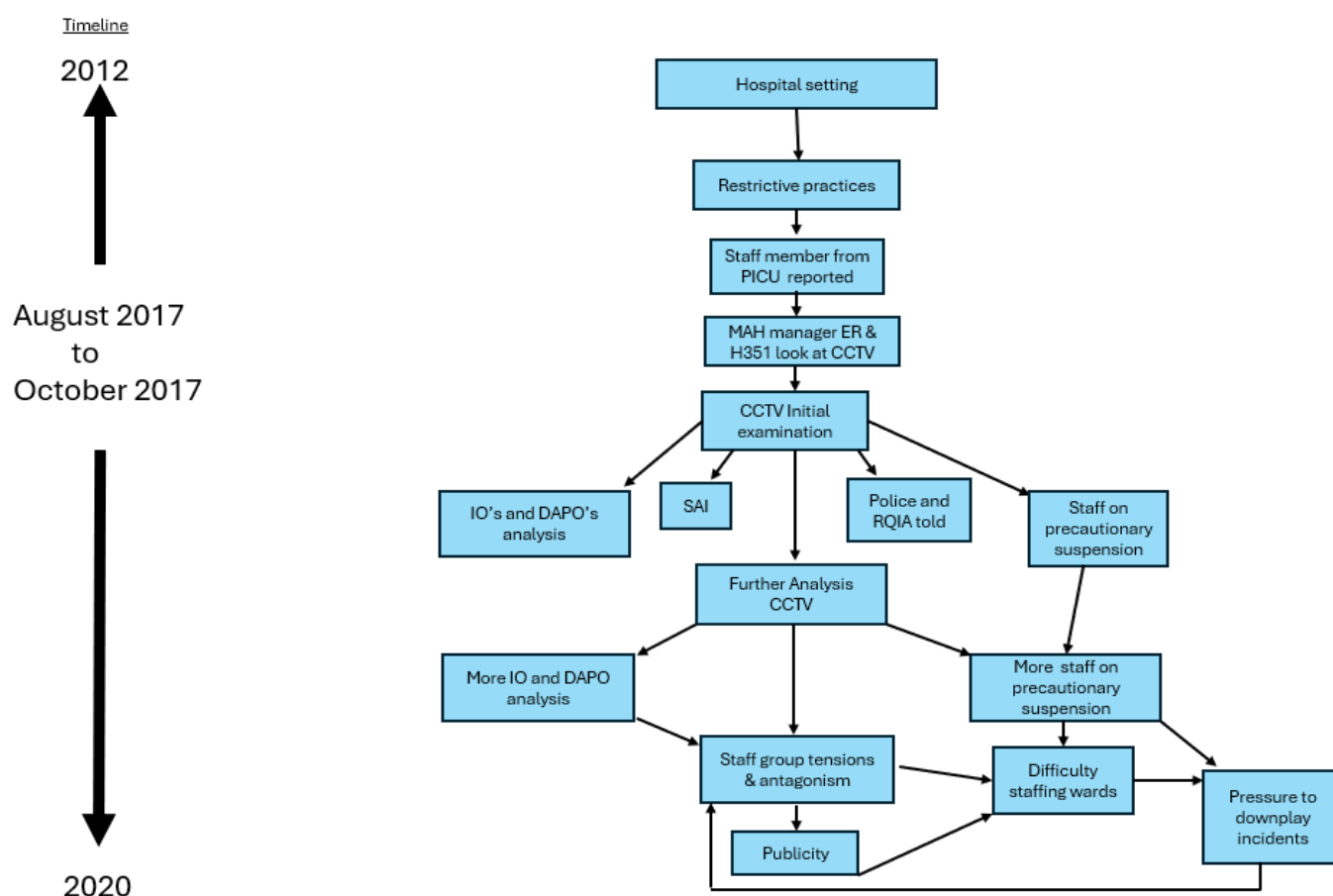
- 10.92 The system was ill-equipped to deal with the scale of the abuse uncovered and, in retrospect, analysis of the 'historic' 2017 CCTV footage was not well managed. There was a failure to identify and take action to mitigate any appearance of interference in the DAPOs' task of viewing CCTV (and identifying safeguarding concerns) by ensuring any oversight of their task was undertaken by someone external to the immediate MAH management, given the widely acknowledged familial relationships and a culture of insular loyalty that rendered it a 'closed' environment.
- 10.93 There needed to be clearer guidance defining which incidents warranted referral to the PSNI so that disciplinary outcomes would not lead to inconsistent outcomes.
- 10.94 Senior managers should have been quality assuring the referrals to ensure consistency and appropriateness.
- 10.95 DAPOs responsible for viewing the CCTV were under-supported and over-tasked, as were HR staff responsible for implementing the actions arising from the CCTV viewing.

¹¹⁵ P113's Mother Transcript – 26/09/23 – Page 53 – Line 16

¹¹⁶ P113's Mother Transcript – 26/09/23 – Page 74 – Line 21

- 10.96 Management failed to adequately address a poor working relationship between all staff during the process of CCTV viewing and consequent actions. This resulted in significant stress for all involved.
- 10.97 Without the discovery of CCTV footage, it is very unlikely that the abuse of patients at MAH would have been uncovered in 2017, if at all. This fact is surely the strongest argument for the introduction of CCTV in all hospitals and placements housing vulnerable people. However, as we heard during the resettlement sessions (see Chapter 15 (Resettlement)), views differed on the appropriate extent of CCTV coverage. It remains essential to protect the rights of all patients and those with learning disabilities in spaces where they might expect there to be privacy.
- 10.98 The scale of poor practice and abuse uncovered through CCTV footage, and the extremely large numbers of staff suspensions required, severely disrupted MAH operations and further fractured staff relationships. This created a vicious circle, as illustrated in Figure 10.1.

Figure 10.1: Disruptive consequences of CCTV revelations



Recommendations

R49	Hospital settings for people with learning disabilities and autistic people are very high-risk environments for abuse and poor practice, partly because those admitted tend to show high rates of challenging behaviour. Therefore, all such settings (including community-based settings for those with challenging behaviour) should consider the installation of CCTV in the public areas, for the protection of vulnerable individuals and for staff. There should be appropriate consultation with families and the service users themselves as to the installation and use of CCTV in any facility where those with learning disabilities and with challenging behaviours are resident.
R50	Guidelines should be agreed in relation to providing CCTV systems in residential and day services where requested. Guidelines should be agreed by HSCTs, resettlement service providers, families and people with learning disabilities about the use of CCTV in public areas and in some circumstances in private areas such as bedrooms and bathrooms, alongside strict controls on access to the footage.

R51	The installation of CCTV in non-public areas should be considered only where this will be in the best interests of the individual service user and following full consultation taking the views of relevant carers, service users (where possible) and relatives fully into account.
R52	Policies governing the use of CCTV should be agreed only after consultation with staff, residents and their families using the service.
R53	Policies should include careful consideration of the circumstances in which the CCTV should be viewed; for example, that it should be viewed when concerns are raised by residents, families or staff about abuse or maltreatment.
R54	Viewers of the CCTV should be independent of the setting, i.e. not involved in day-to-day care of the residents.
R55	Oversight of the CCTV analysis should sit outside the setting in which the CCTV is recording, and should include audits of referrals and outcomes.
R56	Policies should include clear guidance and definitions of behaviour and circumstances in which information should be passed to PSNI about possible offences.
R57	Policies should be clear about the circumstances in which a regulator, such as RQIA, could access the CCTV.
R58	Those drafting the policy should consider whether CCTV could ever be used for staff training and, if so, how this would be done.
R59	All service users and their families should have the CCTV explained to them in easily understood language and with easy access materials, so that they are aware that it is for their protection, and so that they understand when it can be accessed and by whom.
R60	All staff should receive training on the reasons for the use of CCTV and the processes for its analysis.

(This page is intentionally left blank)

Patients are people first

'My son is six-foot six inches tall and 14 stone. He is a happy, contented young man...' '...He is like a big child. He is very touchy-feely and always wants to shake hands. He wants to touch people by touching buttons on their clothes, for example. He is big in stance and people tend to be scared of him, but he is a big gentle giant'

'My brother's pride and joy was his Massey Ferguson tractor. He was heavily involved in the community delivery turf. He would have been considered a gentle giant in and around the area where we lived.'

'Well, before my brother went into Muckamore, he had washed, bathed every day. He had taken great pride in his appearance and his dress sense'

Chapter 11

Safeguarding

Introduction

- 11.1 Safeguarding vulnerable persons is a basic responsibility within health and social care (HSC). It encompasses both preventive measures and proactive interventions to protect individuals at risk of harm through neglect, exploitation or abuse. In settings such as Muckamore Abbey Hospital, where care is provided to some of society's most vulnerable members, who are at particularly high risk, the implementation of robust safeguarding practices is central to upholding principles of safety, dignity and human rights.
- 11.2 This chapter examines the safeguarding systems in place at MAH, evaluating their effectiveness in principle and practice. We recognise evolving attitudes towards the rights of vulnerable adults and children from 1949, when MAH opened, and the shifting boundaries of acceptable practice among HSC staff. Since 1999, policy in Northern Ireland has increasingly adopted an individual human rights-based approach to protection, supported by regional guidance and structural reforms.¹ However, despite these advancements, Northern Ireland remains the only UK jurisdiction without dedicated adult safeguarding legislation. This is a gap which the proposed Adult Protection Bill seeks to address.

Legislative context

- 11.3 Safeguarding, formerly referred to as 'protection', is underpinned by a range of legislative instruments. These include the Health and Personal Social Services (Northern Ireland) Order (HPSS) 1972. Notably, Article 37 of the HPSS Order permits removal to suitable premises of persons in need of care and attention. Other relevant legislation includes the Criminal Law Act (Northern Ireland) 1967 and the Mental Health (Northern Ireland) Order 1986 (MHO).² We have not focused on the protection of children who from 2010 were looked after at the Iveagh Centre.

¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 33

² Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 33

- 11.4 Between 1997 and 2016, a series of adult safeguarding guidance documents were introduced.³ In 2002, the Department of Health, Social Services and Public Safety (DHSSPS) supported the establishment of a regional adult protection forum to promote, develop and improve arrangements for the protection of vulnerable adults.⁴ Through the forum's work it became increasingly clear that effecting further significant progress in safeguarding arrangements lay in the production of regional policy and procedures. This was reinforced by the degree of organisational change that was being proposed at that time by the Review of Public Administration in Northern Ireland.⁵ This was followed by the DHSSPS policy on safeguarding vulnerable adults in 2006. This introduced the concept of a 'vulnerable adult' and set out procedures for identifying and responding to the risk of harm.⁶ The 2010 policy, 'Safeguarding Vulnerable Adults: A Shared Responsibility', extended safeguarding guidance to the voluntary and community sectors.⁷ Over time, reporting and investigation processes were refined, including the introduction of standardised referral forms.⁸
- 11.5 The 2015 DHSSPS policy 'Adult Safeguarding in Northern Ireland: Prevention and Protection in Partnership' introduced a key distinction between: (i) adults at risk of harm who required preventative measures; and (ii) adults at risk of harm and in need of protection.⁹ All the patients at MAH, by virtue of their learning disability and their inpatient status, automatically fell into the first definition. The adult at risk of harm and in need of protection definition is engaged where there is a concern that another person is causing 'deliberate' harm and intervention is needed to protect that patient. Where this was suspected, a referral to adult safeguarding

³ Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in Muckamore Abbey Hospital (North and West Belfast Health and Social Services Trust, December 2005) – Page 62; Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 8794 (Exhibit BW/140) – Protocol for joint investigation of adult safeguarding cases, August 2016; Department of Health, Social Services and Public Safety (2015) Adult Safeguarding: Prevention and Protection in Partnership. DHSSPS, Belfast – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>; Volunteer Now (2010) Keeping Adults Safe: A Shared Responsibility. Volunteer Now, Belfast – <https://www.volunteernow.co.uk/training-and-standards/keeping-adults-safe-a-shared-responsibility>

⁴ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 - Page 34

⁵ Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, February 2012

⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3373 (Exhibit MMcG/69) – Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance' 2006

⁷ Volunteer Now (2010) Safeguarding Vulnerable Adults: A Shared Responsibility)

⁸ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 19

⁹ DHSSPS (2015) Adult Safeguarding: Prevention and Protection in Partnership – Page 10

was required. In hospitals, ward managers managed incidents where no deliberate harm was suspected.

- 11.6 Significant changes in safeguarding management followed the introduction of the joint protocol for investigation with the Police Service of Northern Ireland (PSNI) in 2003, updated in 2009 and 2016.¹⁰ While not all harmful actions constitute criminal offences, the protocol aimed to clarify how such allegations should be handled.¹¹ Under the agreement between Health and Social Care Trusts (HSCTs) and the PSNI, Trusts lead safeguarding investigations unless a crime is suspected. If this is the case, the PSNI will take over and lead an investigation.
- 11.7 The protocol also guides HSCT social workers in determining whether to refer cases to joint agency consultation with the PSNI's Central Referral Unit (CRU).¹² This manages allegations of abuse, exploitation or neglect constituting a potential criminal offence.¹³
- 11.8 The joint protocol introduced a more formalised process for reporting concerns within HSCTs. However, neither the regional guidance nor the joint protocol required a written report to be produced for each safeguarding referral, nor did they mandate that investigation outcomes be shared through governance systems.¹⁴ This gap was evident in 2013, when the safeguarding investigation into allegations of abuse on Ennis Ward was not reported to, or reviewed by, any governance committee. This is described in more detail in Chapter 9 (Previous Concerns, Previous Investigations and Warning Signs). At MAH however, all complaints and potential safeguarding incidents were discussed weekly by both the clinical multidisciplinary team (MDT) and the hospital management team.¹⁵

¹⁰ Lindsay Fisher Statement (Organisational Modules) – 27/08/24 – Pages 233-239 (Exhibit 7) Joint Protocol August 2016

¹¹ Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, February 2012 – Page 31

¹² Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 8794 (Exhibit BW/140) – Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016

¹³ Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 8794 (Exhibit BW/140) – Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016

¹⁴ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 20

¹⁵ Miriam Somerville Statement (Evidence Modules) – 27/04/23 – Page 15

Structures for implementation and oversight

- 11.9 In 2010, the Northern Ireland Adult Safeguarding Partnership (NIASP) was established.¹⁶ Chaired by the Health and Social Care Board (HSCB) Director of Social Care and Children's Services, its role was to ensure robust governance arrangements were in place for implementing regional safeguarding policies and procedures. Five Local Adult Safeguarding Partnerships (LASPs), aligned with each HSCT, were created to oversee local implementation; however, the Inquiry was unclear as to the extent of oversight of practice. LASPs were also responsible for appointing designated adult protection officers (DAPOs) and establishing HSCT adult protection gateways. The PSNI's CRU manages allegations of abuse, exploitation, or neglect constituting a potential crime. Under the 2012 joint protocol, the CRU consults with the DAPO to determine whether criminal investigation is appropriate. If so, the PSNI Public Protection Branch (PPB) conducts a criminal investigation.¹⁷ Following screening, the adult protection gateway service could task an investigating officer within the relevant directorate (see Chapter 13 (Senior Management and Trust Board Governance)) to investigate.¹⁸
- 11.10 The Inquiry heard conflicting evidence on the quality assurance of safeguarding records. Evidence was unclear regarding who received the 2013 Ennis Ward safeguarding investigation report and whether safeguarding record-keeping standards were ever formally audited. Responsibility for oversight also appeared unclear. Some witnesses suggested that this fell to the LASP, rather than the directorate or division's clinical governance structures.¹⁹ However, the DHSSPS Chief Social Work Officer (CSWO) (from 2010 to 2022) stated that ongoing concerns arising from safeguarding investigations should be managed through the HSCT's internal systems and not by LASPs.²⁰ LASPs were described as strategic bodies focused on themes and system-wide issues rather than interrogating safeguarding at an operational level.²¹

¹⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3620 (Exhibit MMcG/71) – Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements, March 2010

¹⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3726 (Exhibit MMcG/73) – Protocol for Joint Investigation of Adult Safeguarding Cases (2016)

¹⁸ Eilish Steele Transcript – 04/06/24 – Page 70 – Line 13

¹⁹ John Veitch Transcript – 18/06/24 – Page 42 – Line 22

²⁰ Sean Holland Transcript – 21/10/24 – Page 102 – Line 5

²¹ Brendan Whittle Transcript – 21/10/24 – Page 162 – Line 7

- 11.11 Although the LASP Committee was chaired by the Belfast Health and Social Care Trust (BHSC) Executive Director of Social Work, its remit did not include reviewing individual cases.²² It was unclear whether its work informed BHSC's clinical governance or risk management structures. A 2016 organogram showed that the Adult Safeguarding Committee reported to a Social Care Steering Group, itself a subcommittee of the Assurance Committee, which in turn reported to the BHSC Board. A separate Social Care Committee also reported to the Board but met only twice a year. The Inquiry heard that its time was largely spent on the required corporate parenting report and the annual delegated statutory functions report, rather than safeguarding.²³
- 11.12 While the Inquiry saw evidence that the MAH Core Group received data on the number of safeguarding referrals and discussed certain cases (particularly if the PSNI was involved), this appeared to be a performance management function rather than a quality assurance exercise. For example, the minutes of the meeting of 08 December 2015 record:
- 'ADULT SAFEGUARDING*
Mr Creaney joined the group to discuss the above.
Mr Creaney informed the group that the hospital safeguarding issues continues to be proactively managed.
Mr Creaney tabled the safeguarding figures for discussion. All pending investigations are complete.
Mrs Rafferty raised concern about an incident in Donegore involving two female patients, Mr Creaney advised that advice was sought from DLS [Directorate of Legal Services] and there is now a court case due.
Mr Creaney spoke about meeting with HR [Human Resources] for support for staff, situation remains the same, Mrs Mitchell advised that if we are going to court on behalf of the Trust the DLS will provide the support.
Mr Veitch spoke about a meeting with HR this week, he asked Mr Creaney to attend so he could raise this issue.
Mrs Rafferty acknowledged how successful the Designated Officer Role has been'.²⁴
- 11.13 The Inquiry saw a note in the Belfast LASP Report 2012/13 that the learning disabilities service area completed audits of safeguarding practice every six months, and that an audit on 04 April 2013 had shown good practice in responding

²² Sean Holland Transcript – 21/10/24 – Page 102 – Line 6

²³ Cecil Worthington Transcript – 16/10/24 – Page 21 – Line 8

²⁴ Muckamore Abbey Hospital Notes of Core Group Meeting – 08/12/15 – Page 2

to concerns, in investigation and in decision-making. There were some minor issues about process and a recommendation in a limited number of cases for more explicit recording.²⁵ This would appear to confirm the findings of the serious adverse incident (SAI) Level 3 'A Way to Go' report, which reviewed safeguarding records at MAH between 2012 and 2017. 'A Way to Go' found little consistency across files,²⁶ suggesting that even after the 2013 audit, the service failed to institute effective quality assurance of the record-keeping.

11.14 It appears that the risks identified in the individual safeguarding investigations were not considered thematically anywhere within BHSCT's structures, nor through the professional social work route. This was a significant gap in assurance, as discussed in Chapter 9.

11.15 The 2020 Department of Health (DoH) leadership and governance review examined BHSCT's discharge of delegated statutory functions (DSF) reports from 2012 to 2017. It found them repetitive and lacking detail on how statutory duties under the MHO, particularly Article 121 on ill-treatment, were discharged.²⁷ The Chief Social Work Officer told the Inquiry that safeguarding is not a delegated statutory function, suggesting that DSF reports were not used to monitor safeguarding for patients not subject to the MHO.²⁸ As a result, it remains unclear how BHSCT or indeed NIASP assured themselves of the quality and consistency of safeguarding record-keeping. Reviews of safeguarding files in 2017 and 2020 (following the CCTV revelations) highlighted poor and inconsistent safeguarding documentation, raising concerns that safeguarding reports may not have been properly managed or monitored.

²⁵ MAHI – Additional Materials Referenced – Page 314 (Belfast Local Adult Safeguarding Partnership (LASP) Report - 01/04/12 -31/03/13)

²⁶ Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Page 10 (Exhibit MF/1) – A Way to Go Report – Page 13

²⁷ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital – Page 62.

DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

²⁸ Sean Holland Transcript – 21/10/24 – Page 18 – Line 4

- 11.16 BHSCT translated regional policy into operational guidance for staff. This began with its 'BHSCT Adult Protection Policy and Procedures' in November 2012.²⁹ It was updated in 2013 and 2020 to reflect evolving regional standards.³⁰
- 11.17 A 2012 joint review by the Regulation and Quality Improvement Authority (RQIA) and Criminal Justice Inspection Northern Ireland (CJI) found progress across HSCTs, including good working relationships with LASPs. NIASP's Chair was proactive in oversight and in developing reporting mechanisms. However, safeguarding processes varied significantly between trusts.³¹ A 2013 DHSSPS-commissioned review of safeguarding in mental health and learning disability (MHLD) hospitals confirmed these inconsistencies. Trusts had developed their own policies and procedures, some aligned with 2006 or 2009 guidance, others incorporating elements of the 2010 guidance. Procedures were inconsistently applied, and the DAPO role was poorly understood by those outside the DAPO role.³²
- 11.18 At MAH, this was evident in tensions between the social workers investigating the 2012 Ennis Ward allegations and the clinical and management staff. This should have signalled the need for additional planning and training to support implementation of the regional strategy, particularly around the safeguarding social worker role. In 2013, a memorandum of understanding (MoU) was issued jointly by the PSNI, DHSSPS, Health and Safety Executive for Northern Ireland (HSENI) and Northern Ireland Courts and Tribunals Service (NICTS).³³ It clarified that PSNI investigations should proceed only where there is clear evidence or reasonable suspicion of a criminal offence having been committed.³⁴

²⁹ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 7

³⁰ Belfast Health and Social Care Trust (updated 2020) BHSCT Adult Protection Policy & Procedures – https://belfasttrust.hscni.net/wpfd_file/32042-attachment-bhsct-adult-safeguarding-policy-and-procedure-redacted/

³¹ Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, February 2012

³² The RQIA Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, February 2013 - Page 13

³³ PSNI, DHSSPS, HSENI and NICTS (2013) Memorandum of Understanding: Investigating patient or client safety incidents (unexpected death or serious untoward harm) – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mou-patient-client-safety-incidents.pdf>

³⁴ PSNI, DHSSPS, HSENI and NICTS (2013) Memorandum of Understanding: Investigating patient or client safety incidents

Safeguarding thresholds

- 11.19 Determining what constitutes ‘serious harm’ is inherently complex and requires professional judgement, taking into account the degree, severity, duration and frequency of harm. The Inquiry heard that the publication of ‘Adult Safeguarding: Prevention and Protection in Partnership’ in 2015 effectively lowered safeguarding thresholds.³⁵ Its implementation was hindered by the absence of a funded plan. BHSC noted difficulties in implementing it in their DSF reports and to the NIASP,³⁶ though the Inquiry received no information on NIASP’s response. We go on to discuss the local lowering of thresholds after 2017 below.
- 11.20 The system continued to rely heavily on frontline staff identifying and reporting concerns, whether observed directly or raised by families. This required staff to distinguish ‘safeguarding issues’ from ‘poor practice’, recognising what should be escalated as a safeguarding issue. It also required staff to recognise that behaviours and practices once deemed acceptable may no longer be appropriate. Although vulnerable adult training became mandatory for all nursing and social work staff in 2004, a 2013 RQIA report found that only two-thirds of staff had completed it.³⁷ Some parents felt that MAH staff were insufficiently alert and/or responsive to safeguarding concerns and, in some cases, retaliated against them for raising issues.³⁸
- 11.21 Concurrent to the introduction of safeguarding, the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 imposed a ‘statutory duty of quality’ on HPSS boards and Trusts.³⁹ In 2004, ‘Circular HSS (PPM) 05/05’ provided interim guidance on the reporting and following up of SAls.⁴⁰ Further circulars reinforced and clarified these arrangements.⁴¹

³⁵ DHSSPS (2015) Adult Safeguarding: Prevention and Protection in Partnership

³⁶ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Pages 49-50

³⁷ The RQIA Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, February 2013 – Page 14

³⁸ P1’s Sister Transcript – 28/06/22 – Page 52 – Line 18

³⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 57

⁴⁰ Department of Health, Social Services and Public Safety (2005) Circular HSS (PPM) 05/05. DHSSPS, Belfast www.ihrdni.org/311-042-1.pdf

⁴¹ Health and Social Care Board (2016) Procedure for the Reporting and Follow Up of Serious Adverse Incidents. HSCB, Belfast – [https://online.hscni.net/wp-content/uploads/wpdf/preview_files/Procedure-for-the-reporting-and-follow-up-of-SAls-2016\(f128882bfc796624ce7a9f94cca9e58e\).pdf](https://online.hscni.net/wp-content/uploads/wpdf/preview_files/Procedure-for-the-reporting-and-follow-up-of-SAls-2016(f128882bfc796624ce7a9f94cca9e58e).pdf)

- 11.22 The HSCB designated three levels of SAI investigation based on the severity of the incident. Most SAIs were subject to a Level 1 internal review, which was a significant event audit. Level 1 cases required a summary report to be sent to the HSCB. More complex cases triggered either a Level 2 internal root cause analysis or a Level 3 independent review for the most serious incidents.⁴² HSCB guidance stated that any incident involving suspected abuse, exploitation or neglect should be investigated under child or adult protection procedures. If the incident also met the SAI criteria, it should be reported immediately to HSCB as an SAI. Where feasible, safeguarding and SAI investigations would run in parallel but remain distinct, with safeguarding findings informing the SAI review.⁴³
- 11.23 However, inconsistent interpretations of what qualifies as an SAI versus a safeguarding-only investigation have long been problematic. For example, the BHSC Director of Nursing told the Inquiry that she believed serious safeguarding concerns were not required to be reported as SAIs until 2016.⁴⁴ Ultimately, the BHSC acknowledged breaches of both the 2010 and 2013 SAI procedures in relation to the Ennis Ward allegations.⁴⁵ It accepted these procedural breaches on the basis that the safeguarding investigation did not substantiate the substantive concerns.⁴⁶

Safeguarding records and notes

- 11.24 The first Northern Ireland regional adult safeguarding forum was established in 2002.⁴⁷ Prior to this, families raising concerns about vulnerable adults typically relied on the complaints process. In 2004, the North and West Belfast Health and Social Services Trust (NWBHSST) introduced a vulnerable adult policy and procedure. However, there were still no dedicated adult safeguarding forms. Incidents, particularly those involving patient-on-patient interactions, were

⁴² HSCB (2016) Procedure for the Reporting and Follow Up of SAIs – Pages 15-18

⁴³ HSCB (2016) Procedure for the Reporting and Follow Up of SAIs – Page 19

⁴⁴ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Pages 37-41.

⁴⁵ Department of Health (2020) A Review of Leadership & Governance at MAH – The Muckamore Abbey Hospital Review Team. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

⁴⁶ DoH (2020) A Review of Leadership & Governance at MAH

⁴⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 34

recorded in nursing progress notes and discussed with medical staff, rather than through a formal safeguarding framework.⁴⁸

- 11.25 From 2007 onwards, adult safeguarding investigations were led by social workers rather than by clinical staff.⁴⁹ In 2009, the 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults'⁵⁰ formalised collaboration between trusts and the PSNI, including the use of referral forms. In 2010, the publication of 'Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements'⁵¹ established the NIASP and five LASPs. The latter became responsible for operational safeguarding procedures at the local level.⁵²
- 11.26 These developments led to the creation of the BHSCT's Adult Protection Gateway Service, the central referral point for all safeguarding concerns.⁵³ Referrals were submitted using an APP1 referral form and the gateway service determined the level of safeguarding response required.⁵⁴ This could include appointing a DAPO, who maintained a separate safeguarding file outside the clinical record.
- 11.27 If a referral did not meet the threshold for a formal safeguarding investigation, alternative responses included disciplinary investigation (if the member of staff failed to follow BHSCT policy but the patient was not harmed), or a reflective supervision conversation with the member or members of staff. If the safeguarding referral related to peer-on-peer abuse, measures could include increased supervision or adjustments to daily routines to prevent further interaction between patients.

⁴⁸ H298 Transcript – 12/09/24 – Page 83 – Line 22

⁴⁹ Eilish Steele Transcript – 04/06/24 – Page.70 – Line 13

⁵⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/24 – Page 35

⁵¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/24 – Page 3620

⁵² Mark McGuicken 1st Statement (Evidence Module) – 13/02/23 – Pages 34-35

⁵³ Department of Health, Social Services and Public Safety (2015) Adult Safeguarding: Prevention and Protection in Partnership – Page 19. DHSSPS, Belfast – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>

⁵⁴ Elizabeth Brady 2nd Statement (Evidence Modules) – 15/09/23 – Page 2

Safeguarding in practice

11.28 Following the Bamford Review's 'Equal Lives' report (2005), there was renewed impetus to resettle patients into the community.⁵⁵ As discharges reduced the patient population in MAH, wards were closed and remaining patients transferred to other wards. This led to the mixing of individuals with diverse and often incompatible needs. Some patients required a low-secure environment with locked doors and restrictive practices. Other patients were acutely unwell and needed high levels of observation due to behaviours that challenge. And others, though mentally stable, required a high level of support with activities of daily living. For the latter group, discharge was often delayed because their required level of support was not available in the community.⁵⁶

11.29 The Inquiry heard that merging wards was unsettling:

'It was distressing at the time. The patients had to move to Greenan Ward, and neither ward had much preparation time for that so it was very unsettling. The patients were moving to a new area, mixing with new people they potentially had never met before. You had two staff teams merging together with lots of changes. I remember the initial days, you know, moving everybody's belongings and things were chaotic, and particularly those first few days to weeks were very unsettled. The patients coped remarkably well but it still was distressing to be suddenly moved to a new area'.⁵⁷

11.30 The evidence provided to the Inquiry suggests that mixing patient groups had disproportionate consequences for stable patients awaiting discharge, who became increasingly exposed to peer-on-peer abuse. This was a risk less prevalent when they were on rehabilitation wards. Evidence provided by the BHSC Co-Director of Learning Disability Services demonstrated that by 2015, over half of safeguarding incidents at MAH involved delayed discharge or priority transfer list patients, yet this did not appear to influence decisions about ward configuration.⁵⁸

11.31 Staff on the wards were left to manage this increase in aggression on the wards. The Inquiry heard evidence about how staff created positive behaviour plans and

⁵⁵ Brendan Whittle Statement (Evidence Modules) – 10/02/23 – Page 7474 (Exhibit BW/122) – Equal Lives 2005

⁵⁶ Alan Guthrie Statement (Organisational Modules) – 28/03/24 – Pages 18-19; H230 Transcript – 15/05/24 – Page 146 – Line 14

⁵⁷ H330 Transcript – 05/06/24 – Page 58 – Line 18

⁵⁸ John Veitch Statement (Evidence Modules) – 23/02/24 – Page 62

there were MDT reviews of the number of incidents each patient had been involved in,⁵⁹ but there was no evidence of any consideration by senior management of how the environment or mix of patients might reduce aggression rather than actions to contain the behaviours of individual patients in inadequate conditions to meet their needs.

- 11.32 In 2015, BHSCT established an Adult Safeguarding Committee, chaired by the Executive Director of Social Work.⁶⁰ Its purpose was to strengthen corporate oversight and assurance. However, the BHSCT Board did not appear to consider individual cases nor trend analysis of the themes. It noted a rise in safeguarding incidents across the Trust in 2015 but highlighted increased safeguarding training.⁶¹ This may have been a missed opportunity to delve into trends and patterns that were emerging in particular units, particularly at MAH. When asked if the Trust Board received reports on safeguarding at MAH, Cecil Worthington (former Director of Social Work at BHSCT) told the Inquiry:

'I do not recall the Trust Board receiving reports of this type [safeguarding], whether in relation to MAH or any other service within the Belfast Trust. The Delegated Statutory Functions reports, which I discuss below, provided information on adult safeguarding, but specific reports arising from adult safeguarding investigations were not tabled at Trust Board'.⁶²

This was despite the fact that the MAH service manager reported to the regional directors of nursing January 2013 meeting that MAH was generating approximately 60-65 safeguarding referrals per month (see para 11.50).

- 11.33 Governance of safeguarding at both regional and trust level remained unclear, with no information on how a safeguarding investigation was subject to assurance or controls.⁶³ The NIASP was responsible for ensuring robust governance, while the five LASPs were accountable to their local HSCTs' implementing policy and procedures. Neither body, however, appeared to have a direct role in overseeing individual investigations.⁶⁴

⁵⁹ H330 Transcript – 05/06/24 – Page 92 – Line 9

⁶⁰ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

⁶¹ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 165 (T05.01) – BHSCT Board public minutes 4th June 2015

⁶² Cecil Worthington Statement (Organisational Modules) – 18/07/24 – Page 6

⁶³ DoH (2020) A Review of Leadership & Governance at MAH

⁶⁴ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 34-36

- 11.34 Each Trust's director of social work had ultimate responsibility for safeguarding.⁶⁵ In the case of BHSCT this was Cecil Worthington from 2012 to 2017 and Carol Diffin from 2017 to 2021. This meant they were professionally responsible for the oversight of the safeguarding processes and escalating and addressing any risks identified. However, the Inquiry heard that safeguarding concerns invoking the joint protocol, and therefore the PSNI, were not routinely reported either to the BHSCT Director of Social Work or the Adult Safeguarding Committee.⁶⁶
- 11.35 Adult safeguarding could have been monitored through SAIs, PSNI investigations, internal safeguarding investigations and the BHSCT incident reporting system (Datix). However, adult safeguarding was both 'centralised', via the Adult Protection Gateway Service, and 'structurally separated' from general management and clinical governance to preserve independence. This arrangement was described by the Co-Director for Children and Adult Learning Disability Services during the 2012 Ennis Ward investigation. The Co-Director was himself a senior social worker. However, the structural separation described above meant that an investigating officer reported through their professional line, rather than through him as the managerial line.⁶⁷
- 11.36 While this separation may have protected the integrity of investigations, it also risked disconnecting them from operational context. This may have led to failures to fully understand the context or history of a particular service unit and limit general management's ability to identify patterns and trends. It also meant that safeguarding data was not triangulated with incident and complaint data, reducing opportunities for systemic learning and improvement.
- 11.37 The BHSCT Board holds ultimate responsibility for ensuring effective processes to prevent and identify harm to vulnerable adults. However, it is unclear what training Board members, particularly non-executive directors (NEDs), received, although meeting minutes show that the Board was briefed on adult safeguarding

⁶⁵ Cecil Worthington Transcript – 16/10/24 – Page 11 – Line 22

⁶⁶ Cecil Worthington Transcript – 16/10/24 – Page 15 – Line 22

⁶⁷ Module 6b Ennis Ward Bundle – 20/12/12 – Page 43 – Minutes of Strategy Review Meetings (Page 46)

policies and procedures in June 2012.⁶⁸ The Board also received annual DSF reports.

11.38 The DSF report was presented to the Board annually. While child protection is a statutory function formally included in the DSF, the CSWO told the Inquiry that adult safeguarding is not a delegated function.⁶⁹ Nevertheless, vulnerable adults were included in DSF reporting at the discretion of the Director of Social Work, often focusing on policies and resources. For example, the 2012/13 BHSCT DSF report noted that the resettlement of people with learning disabilities 'generated particular challenges'. However, the DSF did not report on trends and themes within adult safeguarding at MAH. It also highlighted increased reporting of incidents that would previously have been considered minor.⁷⁰ Despite receiving this information, the Board did not appear to discuss risk mitigation.

11.39 There were missed opportunities for the Board to delve more deeply into what was happening at MAH. In 2012, in-reach staff from a community provider alleged that staff had abused patients on Ennis Ward. This triggered a joint protocol review and an internal safeguarding investigation (considered in more detail in Chapter 9). On 11 April 2013, the BHSCT Board noted that PSNI had investigated two Ennis Ward staff members and was awaiting decisions from the Public Prosecution Service (PPS). NEDs were advised that safeguarding policies were in place and appeared to accept this assurance without further enquiry.⁷¹ The incident was not reported as an SAI and underwent a local investigation in line with policy. Consequently, the Board treated it as a routine internal safeguarding matter and did not pursue it further.

11.40 The DoH leadership and governance review later criticised the omission of this investigation from the DSF annual report. However, even if it had been included, it is unclear what action the Board would have taken, given the inconclusive findings and the lack of evidence to support disciplinary action. Nevertheless, as

⁶⁸ MAHI – Additional Materials Referenced – Page 1 (BHSCT Board public minutes 27/06/12)

⁶⁹ Sean Holland Transcript – 21/10/24 – Page 18 – Line 5

⁷⁰ Colm Donaghy Statement (Organisational Modules) – 14/06/24 – Page 90 (Trust Board public minutes 06/06/13); MAHI - DSF Reports (LD Extracts) – Page 166 (Papers Considered for Public meeting 05/06/13)

⁷¹ Colm Donaghy Statement (Organisational Modules) – 14/06/24 – Page 41 (Trust Board confidential minutes 11/04/13)

discussed in Chapter 9, if considered with other warning signs, consideration could have been given to introducing CCTV far earlier than it was.

11.41 A more significant concern is the absence of data on the frequency of adult safeguarding investigations at MAH, rather than across learning disability services more broadly.⁷² Such data would have provided a clearer picture of the culture and risks within MAH. Residential settings inherently carry a high risk for abuse of vulnerable people and therefore require close oversight. The 2018 SAI Level 3 review report 'A Way to Go' revealed there had been 69 safeguarding investigations that had taken place at MAH between 2012 and 2017.⁷³ Yet it appears that neither the BHSC Board nor the HSCB was aware of these figures. While it would be unrealistic for the Board to review each case individually, it should have been receiving regular data on trends, themes and outcomes by clinical service via a safeguarding dashboard. Such data should have prompted greater curiosity, particularly among NEDs, to enquire about underlying causes and what could be done to prevent such incidents.

11.42 The BHSC Board put their faith in the processes that they had established but did not appear to see it as its role to monitor and assess whether these processes were delivering the intended outcomes. This stance persisted even after the 2017 CCTV revelations.

External inspection

11.43 Under Article 86(2) of the MHO, the Mental Health Commission (MHC) was required to investigate any case suggesting ill treatment or deficiencies in care. The RQIA assumed this role from the MHC in April 2009.⁷⁴ Separately, under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003,⁷⁵ the RQIA must inspect health and personal social services bodies regarding their statutory duty of quality. These duties are complementary: the 1986 Order focuses on individual patient cases, while the 2003 Order requires inspection of service-wide quality.

⁷² MAHI - DSF Reports (LD Extracts)

⁷³ Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Page 10 (Exhibit MF/1) – A Way to Go Report

⁷⁴ Margaret Cullen Statement (Organisational Modules) – 19/04/24 – Page 2

⁷⁵ Articles 34 and 35

- 11.44 RQIA service reports prior to 2017 did not raise any major safeguarding concerns at MAH. For instance, a 2007 review noted that 139 staff had received Management of Potential or Actual Aggression (MAPA) training between 2005 and 2007, with 228 receiving training updates in 2006-2007.⁷⁶ A 2008 RQIA report recorded 26 adult safeguarding allegations between 2004 and 2007, of which 23 were unsubstantiated and three substantiated. This was comparable to other learning disability inpatient units, such as Longstone (three substantiated, one not) and Lakeview (three substantiated, six not).⁷⁷ However, the nature of the allegations at MAH and the basis for deeming 23 allegations unsubstantiated (disproven versus insufficient evidence) are not available.
- 11.45 The 2017 Level 3 SAI review 'A Way to Go' found safeguarding files from 2012 and 2017 difficult to follow. It noted that many cases were reduced to the patient's word against staff, with little use of independent advocacy. The review found the files to be disorganised such that it could not determine how closely practice aligned with the safeguarding protocol and procedures.⁷⁸
- 11.46 Some RQIA inspections did identify good practice, and it may be that these reflected greater attention to safeguarding following the Ennis case in 2012. For example, in 2012, Moylena Ward demonstrated detailed and timely recording and reporting of concerns, detailed risk assessments and responsive care plans reviewed in light of identified concerns.⁷⁹ In 2013, Psychiatric Intensive Care Unit (PICU) staff had received safeguarding training and relatives were informed of safeguarding referrals.⁸⁰ In the same year, Cranfield Ward displayed safeguarding information on the ward and ensured all staff on duty had received training. Referrals had been made to the designated adult safeguarding office and protection plans were completed and recorded in patient care documentation.⁸¹ In

⁷⁶ Clinical and Social Care Review Assessment and Management of Risk in Adult Mental Health Services and Safeguards for Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals (RQIA, September 2007)

⁷⁷ RQIA – Review of the Safeguards in place for children and vulnerable adults in mental health and learning disability hospitals in HSC Trusts - Overview Report - June 2008 – Page 25

⁷⁸ Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Page 7 (Exhibit MH/1) – A Way to Go Report

⁷⁹ RQIA- Announced Inspection, Moylena – 18 & 19/0612

⁸⁰ RQIA - Mental Health and Learning Disability, Unannounced Inspection, Cranfield ICU – 01/07/13

⁸¹ RQIA - Mental Health & Learning Disability, Announced Inspection, Cranfield Male Ward - 18 & 19/11/13

2014, Killead Ward achieved overall compliance under the 'Protection' theme of the human rights inspections.⁸²

11.47 Where the RQIA raised concerns, follow-up visits often found improvements.⁸³ A February 2017 inspection of Sixmile Ward reported positive staff–patient relationships and comprehensive, consistently monitored, safeguarding procedures.⁸⁴

11.48 However, following concerns arising from 2017 CCTV footage, the RQIA intensified its inspections of MAH and raised further issues. An Improvement Notice for safeguarding was issued in August 2019. A remote inspection in April 2020 found CCTV live across the site, with learning from the adult safeguarding team's viewing shared at ward manager meetings. Monthly audits of managers' decision-making showed that no safeguarding referrals had been inappropriately screened out.⁸⁵

BHSCT response to safeguarding concerns before 2017

11.49 Concerns about staff behaviour toward patients at MAH date back to at least the 1980s. Between 2009 and 2022, six complaints were received regarding staff assault or verbal abuse, and one involved peer-on-peer assault.⁸⁶ The outcomes of these complaints remain unclear. Several incidents were investigated by the PSNI, including prosecutions in 2014 and 2015, though none of these were successful.⁸⁷

11.50 In January 2013, the MAH service manager reported to the regional directors of nursing meeting that MAH was generating approximately 60-65 safeguarding referrals per month, including peer-on-peer abuse.⁸⁸ We also heard of the dramatic rise in seclusions at around this time (see graph in Chapter 9). However, it remains unclear how many of these adult safeguarding referrals related to peer-

⁸² RQIA -Mental Health & Learning Disability Announced Inspection, Killead Ward - 20 & 21/01/14

⁸³ RQIA - Unannounced Inspection Report, Moylena - 18 November 2015

⁸⁴ RQIA - Mental Health and Learning Disability Inpatient Inspection Report, Six Mile Ward – 31/01/17 to 02/02/17

⁸⁵ RQIA - Announced Enforcement Inspection Report, 02 to 16/04/20

⁸⁶ Analysis of data supplied by BHSCT to Inquiry

⁸⁷ P1's Sister Transcript – 28/06/22 – Pages 19-20; P68's Brother Statement – 25/04/22 – Page 3

⁸⁸ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 711 – Meeting with Directors of Nursing to discuss Learning Disability Nursing issues, Wednesday 30 January 2013

on-peer incidents, despite Datix data showing such assaults doubled between 2011 and 2014.⁸⁹

- 11.51 The Inquiry found minimal evidence of organisational learning from safeguarding investigations. For example, an incident on Greenan Ward (between 2013 and 2014), where two healthcare assistants (HCAs) squirted water on a patient to make it appear that he had wet himself, dismissing it as 'just banter', was reported to the PSNI.⁹⁰ However, we heard little of any attempt to engage reflectively with staff about why this sort of behaviour was unacceptable in order to help them change their practice.⁹¹
- 11.52 A retrospective review of safeguarding files by the 2017 SAI Level 3 'A Way to Go' team identified 128 allegations of staff abuse at MAH between April 2012 and September 2017. Investigations were frequently undermined by inconsistent documentation and the categorisation (in around a third of files) of patients as having a history of making allegations. There was limited evidence of independent advocacy to help investigate claims. Nor was it clear what the outcomes were, as safeguarding files were inconsistent and incomplete.⁹² The review also identified two SAI investigations relating to safeguarding between 2013 and 2017: one in Cranfield Ward in 2014 and one in Killead Ward in 2016. Had there been appropriate safeguarding governance reporting mechanisms, the BHSCT Board would have been aware of both the volume of abuse allegations and the challenges in effectively investigating them.

BHSCT response to 2017 allegations

- 11.53 On 12 August 2017, a staff nurse promptly reported witnessing an assault by another member of staff on a patient in PICU. However, the nurse in charge failed to follow adult safeguarding policies, instead emailing the deputy charge nurse to arrange a meeting to discuss the concern. Once the charge nurse was informed

⁸⁹ Chris Hagan Statement (Evidence Modules) – 20/03/23 - Page 5490 (Exhibit T05.01) – MAH Behavioural Incidents by selected Incident Type Tier Two, Jan 2009 to Dec 2022

⁹⁰ H324 Transcript – 03/06/24 – Pages 41-44; H324 Statement – 22/05/24 – Page 2

⁹¹ H324 Transcript – 03/06/24 – Pages 41-44

⁹² Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Page 4 (Exhibit MH/1) – A Way to Go Report

on 20 August, appropriate action was taken.⁹³ Initially treated as an isolated incident, further concerns emerged following review of CCTV footage, leading to the first strategic multi-agency meeting on 30 October.⁹⁴ The aftermath of the discovery that CCTV had been recording over the previous six months is described in detail in Chapter 10 (CCTV, 2017 Revelations and the Response). Here we consider the BHSCT Board's response to the 2017 revelations.

- 11.54 In December 2017, BHSCT commissioned an independent team 'to independently review the response of the Trust and the Learning Disability service and provide a report to the Trust Directorate Level Governance and Improvement Board'. The draft report (based on the information provided to the independent assurance team between December 2017 and 04 April 2018) was provided to the Director of Nursing and Director of Adult Social and Primary Care, on 04 April 2018. The review stated:

'It is a major concern that aspects of the key "evidence base" used to underpin these policies was out of date when the policy was written'.⁹⁵

The review also discussed confusion about funded ward staff posts and long-term concerns about adequate staffing (both the total number and the skills). It concluded that the review team:

'Believe urgent action is needed to address the observations within this report and the recommendations made in order to address important aspects of the operational culture within Muckamore Abbey Hospital'.⁹⁶

- 11.55 Despite the clear evidence of structural problems (which we discuss in Chapter 13, and which the Inquiry heard persisted in 2019), between late 2017 and early 2018, BHSCT's Executive Team, led by Chief Executive Officer (CEO) Martin Dillon, assured the Board and external bodies (such as the RQIA and Chief Nursing Officer (CNO)) that the concerns identified through viewing CCTV footage had been addressed. For example, on 02 November 2017 the CEO informed the Board that he had provided assurance to the Permanent Secretary that all

⁹³ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital – Pages 202-203. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

⁹⁴ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Page 159 (Exhibit Tab 17) - BHSCT Strategic Multi-Agency Group Meeting in response to Safeguarding Concerns at Muckamore Abbey – 30/10/17

⁹⁵ Owen Barr 2nd Statement – 25/04/24 – Page 37 (Exhibit 2) Final Report of Independent Assurance Team 19/09/18

⁹⁶ Owen Barr 2nd Statement – 25/04/24 – Page 37 (Exhibit 2) Final Report of Independent Assurance Team 19/09/18

necessary safeguarding actions were being taken by the Trust.⁹⁷ In January 2018, the Service Director stated to the Board that executive directors were assured of the safety and quality of care for all patients currently in MAH.⁹⁸

11.56 At the September 2018 confidential Board meeting, Martin Dillon reported more incidents had been uncovered through historical CCTV review.⁹⁹ It was reported that a number of workshops had been held with sister/charge nurses and senior nurse managers to develop a paper on workforce needs. A new lead nurse for PICU had been appointed, with ongoing work to stabilise the ward. The Director Oversight Group continued to meet regularly on the MAH site to provide support and monitor the service. In October 2018, Martin Dillon reported at the public Board meeting that 13 staff had been suspended and the Director of Adult Social and Primary Care reported that 50 patients remained resident in MAH. While 34 staff were reported to have been recruited, the Board did not discuss the current shortfall and the impact on patients. Staffing gaps remained, together with risks associated with using new staff who did not have training in learning disabilities; however, Martin Dillon continued to reassure the Board that the remaining patients at MAH were safe.¹⁰⁰

11.57 This narrative was used beyond the Executive Team. At the December 2018 public meeting, a Member of the Legislative Assembly (MLA) addressed the Board regarding concerns about the incidents at MAH. Martin Dillon provided assurance that the Trust was committed to support families. Miriam Karp (a NED) advised that she was reassured by regular briefings from Martin Dillon that remedial actions had been taken. On 06 December 2018, a NED expressed confidence that appropriate remedial actions had been taken and that families had been informed of unacceptable incidents.¹⁰¹ In January 2019, the Director of Nursing described her visit to MAH the previous day as ‘uplifting’, praising how positive it had been to ‘witness the tremendous skill and care provided by the staff there’.¹⁰² However, following the discussion of the draft SAI Level 3 report, ‘A Way to Go’,

⁹⁷ MAHI – Additional Materials Referenced – Page 90 (BHSCT Board confidential minutes – 02 November 2017)

⁹⁸ MAHI – Additional Materials Referenced – Page 92 (BHSCT Board confidential minutes – 11 January 2018)

⁹⁹ MAHI – Additional Materials Referenced – Page 95 (BHSCT Board Confidential minutes – 06 September 2018)

¹⁰⁰ MAHI – Additional Materials Referenced – Page 60 (BHSCT Board public minutes - 04 October 2018)

¹⁰¹ MAHI – Additional Materials Referenced – Page 98 (BHSCT Board confidential minutes - 06 December 2018)

¹⁰² MAHI – Additional Materials Referenced – Page 101 (BHSCT Board confidential minutes - 10 January 2019)

in late 2018, a decision was made to send a letter to all families of patients at MAH. This appears to have been the first time the Board recognised the systemic issues, that is, considering MAH as a whole system, rather than dealing with individual parts, and that concerns raised in relation to one patient would likely affect all patients, and that all patients were at risk.

11.58 Reassurances that concerns had been resolved persisted, despite a lack of supporting data. The role of the NEDs is not to be operational, but to hold executive directors to account by providing independent scrutiny, constructive challenge and strategic oversight within the Board.¹⁰³ On 07 February 2019, Marie Heaney (then Director of Adult Social and Primary Care) provided reassurance around the steps being taken at MAH, but two NEDs continued to express concerns. However, the CEO reminded the Board that the PSNI-reviewed incidents were historical. This of course was entirely correct; however, it failed to assure current patients were safe. Martin Dillon referred to contemporaneous viewing providing assurance of current safety, but was unsure what the sample size was. In any event, new safeguarding referrals were emerging. The Chair, instead of supporting the NEDs' scrutiny in holding the executive directors to account, requested a statement affirming no current safety concerns about safe working at MAH, rather than a more neutral request for an evaluation of whether MAH was safe.¹⁰⁴ In March 2019, an Assistant Director of Nursing reported that the PSNI had escalated concerns to the DoH Permanent Secretary, Richard Pengelly, citing BHSC's lack of timeliness in engaging with its findings about the incidents recorded on CCTV.¹⁰⁵

11.59 One month after the Chair's request for a safety assurance statement, the Board meeting on 07 March 2019 was informed that executives had attended an RQIA meeting immediately before the Trust Board meeting, regarding Service Improvement Notices that the RQIA intended to serve, and that the DoH had been

¹⁰³ Scottish Government (2015) Induction Approach: What NHS Non-Executive Directors can expect from induction. Scottish Government, Edinburgh – <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2015/11/nhsscotland-induction-approach-non-executive-directors-expect/documents/induction-approach-nhs-non-executive-directors-expect-induction/govscot%3Adocument>

¹⁰⁴ MAHI – Additional Materials Referenced – Page 105 (BHSC Board confidential minutes 07 February 2019)

¹⁰⁵ Moira Mannion Transcript – 23/09/24 – Page 92 – Line 15

informed. The Executive Team questioned the RQIA findings. The Director of Nursing reassured the Board that wards were safely staffed. The Service Director also reassured the Board that current patient care at MAH was safe. A group chaired by the Medical Director was established to provide assurance to the CEO and Chair on the MAH HSC Action Plan's delivery. The Board continued to assert that care remained safe. As accountable officer for the statutory duty of quality, the Chief Executive did not challenge either director for supporting data to refute the RQIA concerns.¹⁰⁶

- 11.60 By letter dated 14 March 2019 to the DoH under Article 4, the RQIA reported serious concerns in relation to insufficient staffing, as well as patients' physical care needs, financial governance, safeguarding practices, seclusion practices and hospital governance.
- 11.61 Following an unannounced inspection of MAH on 15-17 April 2019, the RQIA issued an 'Article 4 letter' to the DoH on 30 April (in line with its responsibilities under the 2003 Order) advising of continuing concerns at MAH and highlighting staffing as the most pressing issues (in particular nursing shortages).¹⁰⁷
- 11.62 On 02 May 2019, the Board was briefed on an incident involving multiple staff injuries and a patient being escorted to PICU's 'secure room'. Notably, the RQIA took the 'unusual' step of contacting the ward directly to ask about staffing. Despite Brenda Creaney (then Director of Nursing) expressing confidence in staffing adequacy at MAH, the RQIA appeared to distrust BHSCT's assurances. The Director of Nursing also noted that while the Chief Medical Officer (as RQIA sponsor) had been broadly supportive of the Trust's work, RQIA's letter had placed the DoH in a difficult position. The Board meeting minutes also recorded how the PSNI was making safeguarding referrals back to the Trust:

'Mr Dillon updated further on the normal process and advised PSNI had now made referrals to the Trust, describing their threshold he advised twenty referrals had been received already and it was not clear as yet if these were new or previously identified. Following a query from Mr McNaney, discussion followed regarding learning disability expertise provided to PSNI and the

¹⁰⁶ MAHI – Additional Materials Referenced – Page 109 (BHSCT Board confidential minutes 07 March 2019)

¹⁰⁷ Richard Pengelly Statement – 28/06/24 – Page 197 (Exhibit 12) Submission to Richard Pengelly re formation of MDAG – 10/05/19

*complexities of the CCTV footage being viewed. Prof Bradley emphasised the importance of understanding fully the context of what happened in the course of a day or night when considering. Mr McNaney referred to a meeting being scheduled with the PSNI and requested clarity be sought on this issue’.*¹⁰⁸

- 11.63 On 06 June 2019, the Board was informed that the RQIA had issued an Article 4 letter to its sponsor in the DoH. That letter had raised serious concerns about service provision.¹⁰⁹
- 11.64 In August 2019, the RQIA issued Improvement Notices to MAH concerning nurse staffing, patient finances and safeguarding.¹¹⁰ These were all areas that the Board had repeatedly deemed satisfactory.
- 11.65 By September 2019, public representatives expressed concern over the Improvement Notices. At the BHSCT Board meeting, Northern Ireland Patient Voices highlighted the disconnect between RQIA’s findings and the internal assurances recorded in the BHSCT Board minutes. Patient Voices noted that the Improvement Notices were issued two years after the initial CCTV incidents and criticised BHSCT’s failure to address core issues. The Board continued to affirm that current patient care was safe and compassionate and it was asserted that there were no concerns about financial mismanagement of patient monies, only that ‘processes’ were not being followed.¹¹¹ This approach demonstrated a troubling disregard for the very processes intended to prevent such mismanagement.
- 11.66 Following the 2019 RQIA Improvement Notice on safeguarding, the distinction between an ‘adult at risk of harm’ and ‘adult at risk of harm and in need of protection’ was removed. Consequently, all safeguarding concerns within MAH were to be referred to Adult Safeguarding. However, this change was not made through BHSCT’s formal policy approvals process, nor was the policy formally amended. This led to confusion among MAH staff as to what should or should not

¹⁰⁸ MAHI – Additional Materials Referenced – Page 113 (BHSCT Board confidential minutes 02 May 2019)

¹⁰⁹ MAHI – Additional Materials Referenced – Page 118 (BHSCT Board confidential minutes 06 June 2019)

¹¹⁰ RQIA Improvement Notices Ref IN000003, IN000004 and IN000005 – 16/08/19

¹¹¹ MAHI – Additional Materials Referenced – Page 71 (BHSCT Board public minutes 05 September 2019)

be referred to as a safeguarding incident.¹¹² The change in practice increased the workload of the adult safeguarding team and created friction between this team and MAH staff and management, who were unaware of the change.

- 11.67 By February 2020, the Adult Protection Gateway team was reported to be ‘experiencing instability in staffing levels’, with vacancies in DAPO and investigating officer roles. These issues were added to the principal risks register.¹¹³
- 11.68 By May 2020, all RQIA Improvement Notices for MAH had been lifted.¹¹⁴ However, in July 2020, following an unannounced visit, the Board was informed that the RQIA had raised serious concerns about safeguarding, culture and incident management at Knockbracken (a BHSCT-managed mental health unit), dating back to 2017.¹¹⁵ This suggested a failure to transfer learning across the Trust.
- 11.69 Safeguarding referrals remained high. Each ward held weekly safeguarding meetings chaired by the DAPO. There was also a monthly safeguarding forum, which was typically chaired by the divisional social worker or DAPO. It invited representatives from all MAH departments. However, attendance at the forum was reportedly poor.¹¹⁶ It remains unclear whether the reasons for this lack of engagement were investigated or actively addressed.
- 11.70 Dr Jack became Chief Executive in September 2020, shortly after the publication of the MAH leadership and governance review. She appeared to acknowledge the Board’s prior false sense of reassurance, stating to the Board that there had been too much reliance on trust in the past and that new ‘forces’ of data-driven transparency were now in place.¹¹⁷ Despite this, the Board deflected criticism by the review, which described the discharge of delegated statutory functions (DSF) reports from BHSCT as ‘largely repetitive and gave little sense of the extent of

¹¹² A3 Transcript – 15/11/23 – Pages 85-86

¹¹³ MAHI – Additional Materials Referenced – Page 121 (BHSCT Board confidential minutes - 06 February 2020)

¹¹⁴ MAHI – Additional Materials Referenced – Page 124 (BHSCT Board confidential minutes - 07 May 2020)

¹¹⁵ MAHI – Additional Materials Referenced – Page 127 (BHSCT Board confidential minutes - 02 July 2020)

¹¹⁶ A3 Transcript – 15/11/23 – Page 94 – Line 27

¹¹⁷ MAHI – Additional Materials Referenced – Page 130 (BHSCT Board confidential minutes - 21 September 2020)

compliance with statutory functions'.¹¹⁸ The review team found that, as currently structured, the DSF reports did not provide sufficient assurance about the DSF as they related to learning disability patients.¹¹⁹ This should, they concluded, have resulted in challenges at BHSCT Board and HSCB levels.¹²⁰ The sense was that these criticisms were aimed at the DoH rather than the Trust. The Board also defended the Chair of the Social Care Committee, despite that committee's responsibility for approving the reports.¹²¹ Given that the DSF template allowed for extensive free-text input, including non-mandatory information, this defence reflected a concerning abrogation of oversight.

- 11.71 While BHSCT claimed to have shifted from trust-based governance to data-driven transparency, it did continue to raise concerns regarding the criteria for declaring an SAI with the HSCB. Between January and December 2020, BHSCT submitted 26 early alert notifications for learning disability services, 13 of them from MAH. The HSCB requested SAI submissions for 11 of these, but BHSCT argued that they did not meet the threshold SAI criteria. In December 2020, the HSCB confirmed that all 11 early alerts required SAI submissions.¹²²
- 11.72 A persistent belief that abuse stemmed from individual 'bad apples' rather than systemic environmental failure seemed to remain. Staff suspensions were seen as sufficient remedies, yet new safeguarding referrals remained high four years after the 2017 index incident. In 2021, the Muckamore Departmental Assurance Group (MDAG) commissioned an independent review of 60 out of 116 safeguarding referrals made between January 2020 and April 2021. The review found inconsistent practices among DAPOs and unclear levels of supervision or audit. Agency ward staff brought in to replace suspended personnel were disproportionately represented in referrals. This led reviewers to have concerns about the knowledge, skills and experience of these staff.¹²³ Despite immediate suspensions and protection plans, patients at MAH remained at high risk of abuse,

¹¹⁸ Leadership and Governance – Page 54 - [A Review of Leadership & Governance at Muckamore Abbey Hospital](#)

¹¹⁹ Leadership and Governance – Page 55 – [A Review of Leadership & Governance at Muckamore Abbey Hospital](#)

¹²⁰ Leadership and Governance – Page 85 – [A Review of Leadership & Governance at Muckamore Abbey Hospital](#)

¹²¹ MAHI – Additional Materials Referenced – Page 130 (BHSCT Board confidential minutes 21 September 2020)

¹²² Additional Materials Referenced – Page 375 (Extract from Serious Adverse Incident Notification Form – 18/02/21)

¹²³ MDAG Minutes – 25/08/21 August 2021 – <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mdag-minutes-250821.pdf>

with no clear evaluation of whether these measures were effectively safeguarding them.

11.73 Despite the attention paid to the hospital and the actions taken since the 2017 CCTV revelations, 116 safeguarding referrals involving staff behaviour towards patients in MAH were made between January 2020 and April 2021.¹²⁴ This suggests the presence of CCTV alone was not – and is not – sufficient to prevent abuse and a more sophisticated understanding of the underlying causes is required in order to prevent it.

11.74 In addition to the SAI Level 3 ‘A Way to Go’ review of safeguarding files from 2012 to 2017, the DoH commissioned a review of the 116 safeguarding referrals between January 2020 and April 2021. Reviewers found a mixed picture on risk and response.¹²⁵ There was some evidence of over-referral, however new incidents were continuing to occur, mostly physical abuse but with no evidence visible on examination.¹²⁶ While the files contained clear referral information, the management of the investigations was not well recorded, and conclusions were hard to ascertain. The subsequent protection plans did not consider the risks associated with the proposed plans (for example, an increase in number of staff supervising a patient meaning there would not be enough staff available to take the patient off the ward for activities).¹²⁷ Safeguarding investigation and protection plans rarely looked at the whole system, including the mix of patients, the environment and the staff available, focusing instead on the isolated facts of a single incident.

11.75 These findings were echoed in a 2022 internal review of operational working and relationships at MAH, which concluded:

‘We found the safeguarding policy context that staff were working to was unclear and at the root of the conflict between teams. MAH operated under the BHSC Adult Safeguarding Policy and Procedure SG 20/19, training was

¹²⁴ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 49 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review

¹²⁵ Owen Barr Second 2nd Statement (Evidence Modules) – 25/04/24 – Page 49 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review

¹²⁶ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 50 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review

¹²⁷ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 52 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review

*provided based on this policy and despite the policy having been reviewed in February 2020, no provision was made for its different application in MAH which removed line managers from the screening process as part of additional assurances post uncovering of historical abuse in MAH March to September 2017’.*¹²⁸

- 11.76 The findings of this review suggest that there was confusion about how to manage incidents. This contributed to the tensions described above between the operational staff in MAH (including managers with social work qualifications and not just the ward nurses and HCAs). These tensions should have been promptly managed by the director team, but appear to have festered and continued to be expressed in evidence given to the Inquiry. These tensions are discussed further in Chapter 10.
- 11.77 The very high levels of alleged abuse uncovered, and the extremely large numbers of staff suspensions that were required, meant that the hospital became increasingly hard to operate and relationships between staff began to break down even further.

Department of Health response

- 11.78 On 30 August 2017, the CNO was informed that Gavin Robinson MP had raised an allegation of staff abuse involving a current inpatient at MAH.¹²⁹ On 01 September 2017, the CNO contacted the BHSCT Director of Nursing and received assurances that patients in MAH had adequate surveillance and supervision in place to ensure that no further potential harm was caused.¹³⁰
- 11.79 In September 2017, BHSCT issued early alert notifications regarding this incident. Subsequent early alerts advised that additional safeguarding concerns had emerged following the review of CCTV footage.¹³¹ On 20 October 2017, the CNO and the CSWO wrote jointly to the Trust seeking assurances that effective arrangements were being put in place to address the issues and requested monthly updates.¹³²

¹²⁸ MAH Intellectual Disability and Psychological Services Directorate Investigation - Executive Summary Page 2

¹²⁹ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 46

¹³⁰ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 47

¹³¹ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 47

¹³² Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 47

- 11.80 The CNO and CSWO acted swiftly, challenging BHSCT to provide data on both the incidents and its response. They followed up on 30 November 2017 to press for further written assurances, updates on the proposed 'turnaround' team and progress on adult safeguarding investigations. Concerned by the BHSCT's plan to review only 25% of the available CCTV footage, they requested a full review. The Trust was formally requested to provide the DoH with a copy of the terms of reference for the Level 3 SAI investigation. On 22 December 2017, the BHSCT confirmed that the SAI Level 3 review would cover all allegations of abuse from the previous five years. The review was commissioned in January 2018.¹³³
- 11.81 The Level 3 SAI review took 11 months to complete, delaying recognition of the scale of the problem. The DoH received the Level 3 SAI report, 'A Way to Go', on 06 December 2018. On 17 December 2018, the Permanent Secretary, the CNO and the CSWO met with families, accepted the report's recommendations and committed to expediting resettlement of patients then resident in MAH.¹³⁴
- 11.82 By February 2019, BHSCT acknowledged challenges in delivering effective safeguarding. It was agreed that the Trust and DoH would meet on a formal monthly basis to provide assurance.¹³⁵ However, the Inquiry has not seen evidence that the BHSCT was systematically analysing the data it did have. At the DoH's request, the HSCB commissioned a review to examine the effectiveness of the Trust's leadership, management and governance arrangements in relation to the MAH for the five years preceding August 2017. The final report (The 'A Review of Leadership & Governance at Muckamore Abbey Hospital') was submitted to the DoH in August 2020.¹³⁶
- 11.83 Following concerns raised during unannounced RQIA inspections of MAH in February and April 2019, the DoH intensified its oversight and established the Muckamore Departmental Assurance Group (MDAG) in April 2019. MDAG was co-chaired by the CNO and the CSWO. MDAG was intended to provide support to the BHSCT team at Muckamore and provide a mechanism for escalating issues.

¹³³ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 48

¹³⁴ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 48

¹³⁵ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 49

¹³⁶ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 51

It also oversaw the MAH HSC Action Plan, which covered actions arising from the SAI review 'A Way to Go' and the leadership and governance review.¹³⁷

- 11.84 The first MDAG meeting was held in August 2019, two years after the index case.¹³⁸ Since the establishment of MDAG, the BHSCT has been required to submit regular safeguarding data from MAH, including trend data on Adult Safeguarding Gateway referrals, such as sources of referrals and categories of abuse.¹³⁹ There is no evidence in the minutes of either the public or confidential BHSCT Board meetings that the Director of Social Work shared this with the Board. At its October 2019 meeting, MDAG noted that safeguarding arrangements had also been identified as an issue in the Dunmurry Manor Nursing Home review and anticipated that the DoH's response would include a commitment to reviewing safeguarding arrangements for vulnerable adults.¹⁴⁰

Conclusions

- 11.85 Safeguarding definitions and practices have evolved significantly. Since 2002, when the first Northern Ireland regional safeguarding forum was created, there has been growing recognition that certain categories of individuals (including those with learning disabilities) are more vulnerable to abuse than the rest of the population, which may extend beyond physical harm. While regional guidance and organisational structures were introduced, their translation into practical direction for frontline staff, especially HCAs, was inconsistent. Some behaviours at MAH, now widely recognised as abusive, may previously have been considered acceptable. This underscores the need for clearer standards and training.
- 11.86 Ward reconfigurations linked to patient resettlement at MAH had unintended consequences that increased the risk of abuse. Staff recruitment freezes and the mixing of patients with differing needs led to a rise in peer-on-peer abuse and patient-on-staff assaults. Because peer-on-peer abuse in learning disability services is not considered intentional, it was managed locally rather than through the Adult Safeguarding Gateway. This meant that managers failed to recognise

¹³⁷ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 20

¹³⁸ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 49

¹³⁹ Sean Holland Statement (Organisational Modules) – 28/06/24 – Page 10

¹⁴⁰ Minutes of MDAG meeting on 01 October 2019

the escalating risks between 2011 and 2014 at MAH, despite data being available via Datix.¹⁴¹ The clinical governance team failed to highlight these trends, and there was limited awareness beyond ward staff of the increasingly violent environment and its impact on both patients and staff. It is well established that when incident reports receive no response, staff often stop submitting them.¹⁴² This is especially the case when reporting is time-consuming and completed outside working hours.

- 11.87 Potentially abusive events were reported and managed through multiple channels. In the five years prior to 2017, concerns were raised through incident reports, safeguarding referrals, SAls, complaints and PSNI investigations. Yet BHSCT lacked the governance systems to synthesise this information. As a result, the Board and its subcommittees received fragmented insights, preventing them from receiving a comprehensive overview. Instead, they relied on the existence of policies and reassurance from executive directors, rather than interrogating the data for themselves.
- 11.88 The 2015 DHSSPS regional guidance made provision for large-scale adult protection investigations where multiple adults at risk had allegedly been abused, or patterns of concern emerged about quality of care.¹⁴³ Yet MAH cases were handled in isolation until 2017. The 2012 Ennis Ward investigation had already revealed that safeguarding protocols were inadequate for cases involving multiple victims and perpetrators. However, this gap was not addressed, and this remained the position when the 2017 allegations arose.
- 11.89 The response to the 2017 CCTV-triggered investigation marked a significant departure from previous safeguarding investigations. The CSWO told the Inquiry that the number of staff placed on suspension following viewing of CCTV

¹⁴¹ Chris Hagan Statement (Evidence Modules) – 20/03/23 – (Exhibit T05.01) – Page 5490 – MAH Behavioural Incidents by selected Incident Type Tier Two, Jan 2009 to Dec 2022

¹⁴² J. Benn, M. Koutantji, L. Wallace, P. Spurgeon, M. Rejman, A. Healey and C. Vincent (2009) Feedback from incident reporting: information and action to improve patient safety, *BMJ Quality & Safety*, 18(1), pp.11-21 – <https://qualitysafety.bmj.com/content/18/1/11>

¹⁴³ Department of Health, Social Services and Public Safety (2015) Adult Safeguarding: Prevention and Protection in Partnership – Pages 39 and 41 – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>

recordings was unprecedented.¹⁴⁴ MDAG noted that these suspensions destabilised the hospital environment and the resulting influx of replacement staff disrupted continuity of care.¹⁴⁵ This resulted in less than optimal care provision for the complex needs of the inpatient population.¹⁴⁶ Staff on suspension would still have been receiving pay and the use of agency staff is generally an expensive alternative. Little consideration seems to have been given to bringing in senior nursing staff from elsewhere in BHSCT as supervisors, or the training of assistant practitioners, as discussed in Chapter 12 (Staff and Ward Management), to augment or replace agency staff if necessary.

- 11.90 A 2021 review of safeguarding referrals revealed that agency staff, many without learning disability qualifications, were disproportionately represented in new adult safeguarding cases.¹⁴⁷ Despite this, there is no evidence that MDAG or BHSCT reassessed their safeguarding approaches. In January 2019, the Service Director suggested that on reflection the SAI process and associated review may not have been the correct vehicle for investigating widespread abuse.¹⁴⁸ However, there is no evidence that this concern was seriously considered, or that alternative mechanisms were considered, by either the Trust or MDAG.
- 11.91 Throughout this period, the BHSCT Board repeatedly reassured itself that care at MAH was safe, despite mounting evidence to the contrary. In doing so, it failed to manage risks or ensure adequate patient protection. The Board appeared to confuse risk appetite with risk assessment. The Panel does not believe it was a safe environment and BHSCT, rather than repeatedly assure itself that care was safe, compassionate and effective, should have acknowledged that it could not provide safe care at all times but recognise that it had to accept and carry this risk as there were no alternative placements. If BHSCT had done this, it would have forced the DoH, and potentially the Northern Ireland Assembly, to seek alternative solutions.

¹⁴⁴ Sean Holland Statement (Organisational Modules) – 28/06/24 – Page 8

¹⁴⁵ Sean Holland Statement (Organisational Modules) – 28/06/24 – Page 9

¹⁴⁶ Sean Holland Statement (Organisational Modules) – 28/06/24 – Page 9

¹⁴⁷ Owen Barr Statement (Evidence Modules) – 25/04/24 – Page 47 – Muckamore Abbey Hospital: Adult Safeguarding File Review 2021

¹⁴⁸ MAHI – Additional Materials Referenced – Page 101 (BHSCT Board confidential minutes 10 January 2019)

- 11.92 In its closing statement, the PSNI reported that 274 staff had been triaged, 97 interviewed and 68 files submitted to the PPS.¹⁴⁹ Nine years after the CCTV footage emerged, the number of staff to be charged remains unknown. The full extent of abuse, distinct from poor practice, is still unclear and may never be fully understood. The primacy of the police investigation may have delayed safeguarding investigations that could have identified systemic enablers of abuse or highlighted poor practice. Investigations into structural and environmental conditions that enabled abuse could have been conducted without compromising the criminal or disciplinary processes and might have created a safer environment sooner.
- 11.93 Abuse may be intentional or unintentional and may originate from peers as well as from carers. The impact of intentional or unintentional abuse can be equally severe. High levels of peer-on-peer abuse signal a poorly controlled environment and may also be a marker for other forms of abuse, including staff-on-patient abuse, which is far less likely to be voluntarily reported. Failure to monitor the incidence of peer-on-peer abuse at MAH was a missed opportunity to monitor the overall culture of care.

¹⁴⁹ PSNI Closing Submission – 04/03/25 – Page 5 – Line 21

Recommendations

R61	Vulnerable children and adults are inherently more susceptible to abuse or neglect than other people. Adult safeguarding should be formally recognised as a statutory function, equivalent to child protection.
R62	Metrics on both child and adult safeguarding processes should be reported monthly via a safeguarding dashboard, with the same visibility and status as monitoring elective surgery or emergency department waiting times. These metrics should be publicly available.
R63	Incidents of peer-on-peer abuse should be included in adult safeguarding metrics and included on a published safeguarding dashboard.
R64	The dashboard should include the number of allegations reported, together with the screening decision (referral to the Adult Safeguarding Gateway, referral to the joint protocol or no further action). Particular scrutiny should be given to allegations of abuse by staff that are screened out due to lack of supporting evidence. DoH Northern Ireland should develop such a dashboard to be used across the health and social care sector within six months.
R65	There should be common standards for the conduct of safeguarding investigations. These should be drafted and approved by the Northern Ireland Adult Safeguarding Partnership (NIASP) and adopted by the DoH as policy.
R66	A quarterly multidisciplinary audit of 10% of safeguarding files per ward or residential unit should be conducted. Findings must be integrated with incident data and reported to the Executive Team, NEDs and the Strategic Planning and Performance Group (SPPG).
R67	Where there is evidence or suspicion of widespread abuse involving multiple staff and residents, focusing solely on individual perpetrators is insufficient. An independent review of enabling conditions should be conducted separately from case-specific or PSNI investigations. This review must be led by investigators with appropriate expertise in safety science to support rapid system-level changes. PHA, in conjunction with the Chief Social Work Officer (CSWO), should issue guidance for such reviews.
R68	Protection plans should include an assessment of risks arising from the plan itself. Where multiple protection plans are in place for vulnerable adults within a single unit, cumulative risks arising from those individual protection plans across all residents must also be evaluated.

Do you see me?

'My brother lived at home with my parents. He loved the Transformers and Airwolf and watched the videos on repeat at home. When he was around thirteen years old he was able to make breakfast, wash and dress himself, make his bed and Hoover. He was amazingly good at jigsaws, much more capable than I was at them, and he liked to colour in.'

'Then, when we went on holiday, she loved the pool. As soon as she knew when we were coming out of the apartment, she was going like this (indicating). She knew she was going down to the pool. We used to bribe her to come out. She was wrinkled. She loved the pool. Then after that, when she came out of Muckamore, it was her expression. And she hasn't been in a pool from it.'

Chapter 12

Staff and Ward Management

- 12.1 This chapter will focus both on the people who managed Muckamore Abbey Hospital (MAH) directly and on those who staffed the wards at MAH. We will look at how management was structured and how that changed as the hospital changed. There was, and still is, a difficult interaction between the policy of resettlement and how staff are funded and deployed to meet the needs that arise in the community, as compared against the continuing need to fund and staff the hospital. We will consider whether there was a proper appreciation of the tension between the policy of resettlement and continuing to care for patients at MAH. We will consider also how the known policy that MAH was going to close affected staffing stability and the question of whether there were sufficient staff with the right skills to look after the patient population effectively and safely. Finally, we will look at the effect of the 2017 CCTV revelations and how the suspension of staff affected the mix of permanent versus agency staff and learning disability trained to non-learning disability trained staff.

Changing workforce requirements

- 12.2 Workforce requirements are dependent on purpose. From 1949, when it opened, MAH ran as a long-stay residential hospital for people with learning disabilities, with some beds later allocated for patients detained under the Mental Health (Northern Ireland) Order (MHO) 1986.¹ It functioned as a self-contained community, which included paid work for those patients who were sufficiently able, arranged by an employment officer.² There was also an entertainments officer.³ The number of staff and their skills reflected a relatively stable population of patients who needed support with day-to-day life.⁴ Forensic beds were designated in 1994, and these patients were often able-bodied and with challenging behaviours requiring a different staff skill set.⁵

¹ Eilish Steele Statement – 21/05/24 – Page 27

² H471 Statement – 12/03/24 – Page 3

³ Eilish Steele Statement – 21/05/24 – Page 7

⁴ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 198 (Exhibit JV2) – Nursing Workforce Paper

⁵ I. Montgomery and J. Armstrong (2009) From Special Care to Specialist Treatment: A History of Muckamore Abbey Hospital – Page 141. Ulster Historical Foundation, Belfast (ISBN:978-1-903688-41-0)

- 12.3 Attitudes to care for people with learning disabilities began to change globally in the 1970s, with the advent of the 'normalisation' movement.⁶ Subsequently, the government's 1987-1992 Northern Ireland regional strategy for health and personal social services (HPSS) gave a commitment that rather than live in hospitals like MAH, people with 'mental handicap' should be enabled to live in the community. The strategy's ambition was to reduce the number of people in long-stay hospitals by at least 20%.⁷ All subsequent Department of Health Social Services and Public Safety (DHSSPS) and Department of Health (DoH) strategies reaffirmed this vision,⁸ though the target of a 20% reduction altered radically over time to become much more ambitious. The nature of the service at MAH began to change toward therapy; for example, the light-industry workshops were reframed as day care and became activities rather than work.⁹

The move towards resettlement

- 12.4 As the move to resettle patients out of the hospital continued, it was assumed that only a small number of assessment and treatment beds would be needed, and that during the transition period the needs of patients awaiting resettlement (and therefore the staff required to support them) would be unchanged. The target to reduce the number of long-stay patients was replaced in 1997 with a commitment to having zero long-stay patients by 2002.¹⁰ With this ambition, planning for a future without long-stay patients began in earnest, although there was a lack of certainty over the exact number of short-term assessment and treatment beds that would be required after all long-stay patients had been resettled, and there was little consideration of the nature of the workforce that would be required in the hospital.
- 12.5 By the 1990s much of the hospital estate was in poor condition, with patients sleeping in dormitories, and external reviews by the Mental Health Commission (MHC) in 1993 and Northern Ireland Hospital Advisory Service in 1994 raised

⁶ N.E. Bank-Mikkelsen (1969) Normalization: Letting the Mentally Retarded Obtain an Existence as Close to Normal as Possible. Washington DC: President's Committee on Mental Retardation

⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 95 (Exhibit MMcG-3) – People First: Community Care in Northern Ireland in the 1990s

⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 46

⁹ H471 Statement – 12/03/24 – Page 3

¹⁰ DHSSPS (1996) Health and Wellbeing: Into the Next Millennium – Regional Strategy for Health and Social Wellbeing 1997-2002, cited in From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 144

concerns about the fabric of the wards.¹¹ Overcrowding was a problem from at least the late 1980s, leading to patients ‘sleeping out’ on different wards from where they spent their days.¹² As late as 2004 it was noted there had been up to 16 patients ‘sleeping out’.¹³ A patient census in 1996 categorised all remaining patients as either requiring hospital care, community treatment or continuing (but not specialist) care. This information was used to reprofile the wards (defining which category of patient was admitted to which ward) into eight treatment wards, seven resettlement wards and the children’s unit.¹⁴ To achieve this, 180 patients were moved to different wards in 1998.¹⁵ At the same time, the Eastern Health and Social Services Board (EHSSB) approved a plan to reduce MAH to 115 beds.¹⁶ Many of the patients on the resettlement wards had serious physical and learning difficulties but not challenging behaviours,¹⁷ and staff focused on personal physical care, including support with eating.¹⁸

- 12.6 Only half the long-stay patients had been resettled by 2002,¹⁹ and the Bamford Review’s 2005 ‘Equal Lives’ report extended the original target of no long-stay patients in hospitals to June 2011.²⁰ This too was not achieved, and ‘Delivering the Bamford Vision: The response of Northern Ireland Executive to the Bamford Review of mental health and learning disability. Action Plan 2009-2011’, published by the DHSSPS in 2009, extended the target to 2013.²¹ Nonetheless, plans for a very different hospital progressed with a 2002 business case for a new unit of 35 non-forensic essential assessment beds and 23 forensics beds.²² The Cranfield and Sixmile wards opened in October 2006 with single rooms for all patients.²³ A further proposal for the future shape of the hospital was submitted in 2015 with an

¹¹ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 127

¹² Eileen McLarnon Transcript – 06/02/24 – Page 11 – Line 7

¹³ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 176

¹⁴ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 146

¹⁵ Eilish Steele Statement – 21/05/24 – Page 38

¹⁶ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 145

¹⁷ H330’s Statement – 22/05/24 – Page 11; A9’s Transcript – 21/02/24 – Page 14 – Line 14 (restricted)

¹⁸ Eileen McLarnon Transcript – 06/02/24 – Pages 6-7

¹⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 48

²⁰ Review of Mental Health and Learning Disability (Northern Ireland (2005) Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland. Department of Health, Social Services and Public Safety, Belfast – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Equal%20Lives%20Report.pdf>

²¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 1958 (Exhibit MMCG-39) – Delivering The Bamford Vision – Action Plan 2009-2011

²² From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 152

²³ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 164

associated workforce plan²⁴ and yet another proposal and workforce plan in January 2017.²⁵

- 12.7 Changes in the mix of patients on wards created tensions that increased the need for close observation of individual patients and the Regulation and Quality Improvement Authority (RQIA) began to note concerns about ward moves unsettling patients, leading to an increase in incidents (particularly peer-on-peer abuse).²⁶ This continued in 2016 and the Society of Friends and Parents of Muckamore Abbey Hospital (SPFM) wrote to the DoH with concerns about the movement of staff and patients between wards.²⁷

Change to a directorate structure

- 12.8 MAH was the responsibility of North and West Belfast Health and Social Services Trust (NWBHSST) from 1994 until 2007, with a hospital director reporting to the trust Chief Executive Officer (CEO). The hospital director was supported by four assistant directors (for social work, nursing, governance and business management).²⁸ When Belfast Health and Social Care Trust (BHSCT) was established in 2007 it became responsible for MAH (which still had 296 patient beds across 16 wards and over 250 adult patients).²⁹ MAH was incorporated into a subdivision of BHSCT – a ‘directorate’.³⁰ The directorate structure is used widely across the National Health Service (NHS) in the UK and internationally. Directorates have delegated day-to-day decision-making to teams assigned to specific groups of patients rather than having a small number of managers for a large set of patients with very different conditions. However, management at MAH remained largely the same except that the hospital director reported to the Director of Mental Health and Learning Disabilities rather than to the CEO.³¹

²⁴ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 189 (Exhibit JV2) – Adult, Social and Primary Care Directorate, Learning Disability Service Group MAH Hospital Modernisation Group Proposal for Muckamore Abbey Hospital November 2015

²⁵ MAHI - Additional Materials Referenced – Page 348 (Strategic Outline Case for Modern Assessment and Treatment Facility at MAH – January 2017)

²⁶ RQIA - Unannounced Inspection Report, Killead - 14-15/02/17

²⁷ MAHI – Additional Materials Referenced – Page 373 (Response from LDU re MAH Concerns – 05/01/17)

²⁸ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 2

²⁹ June Champion Statement (Evidence Modules) – 10/03/23 – Page 53; Bed occupancy data furnished by BHSCT to Inquiry

³⁰ June Champion Statement (Evidence Modules) – 10/03/23 – Page 40

³¹ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 2

- 12.9 Directorates comprise a number of discrete services. The name and composition of directorates changed several times between 2007 and 2021, but MAH always remained within a combined hospital and community learning disabilities services division of the directorate, with a learning disabilities services manager (known as a co-director) responsible for both community and hospital services, reporting to the director of the directorate. There were separate service managers for hospital and community services who reported to the co-director.³² There were regular management meetings at the divisional level (learning disabilities hospital and community services)³³ as well as at the hospital level.
- 12.10 At MAH, the core hospital management team comprised the Co-Director for Learning Disabilities Services, the MAH Service Manager, the Senior Social Worker, the Lead Consultant Psychiatrist and the Governance Lead.³⁴ The core group received weekly (until 2011, then fortnightly)³⁵ reports on incidents (including seclusion) and complaints, compiled by the Information Nurse,³⁶ and a summary of safeguarding investigations, compiled by the Senior Social Worker.³⁷ A policy group reviewed and drafted policy updates, which were considered by the core group then submitted to BHSCT's corporate approval process.³⁸ Once approved, BHSCT policies were cascaded to frontline staff via line managers.³⁹ There were separate monthly meetings of medical staff at MAH and ward managers.⁴⁰
- 12.11 Ward staff comprised registered nurses – learning disabilities (RNLDs) and their assistants, known at various times as either healthcare assistants (HCAs) or nursing assistants. Care was provided by other professions who visited the ward but were not based full time on an individual ward.

³² Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 2; John Veitch Statement (Organisational Modules) – 31/05/24 – Page 2

³³ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 5

³⁴ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 4; Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 12; Eileen McLarnon Transcript – 06/02/24 – Pages 29-30

³⁵ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 7

³⁶ Eileen McLarnon Transcript – 06/02/24 – Pages 29-30; Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 5

³⁷ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 7 and Page 10

³⁸ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 6

³⁹ John Veitch Statement (Organisational Modules) – 31/05/24 – Pages 17-18

⁴⁰ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 5

- 12.12 Quality of care was reviewed through MAH's monthly quality forum.⁴¹ Use of 'pro re nata' (PRN) as-needed prescriptions (including analgesia as well as sedation) was reviewed every 52 days⁴² and, between the 1990s and 2017, care on the wards was audited every six months. The audit team was formed from all hospital disciplines, including estates, support services, administration and nursing staff.⁴³
- 12.13 Day-to-day management of the hospital was led by the hospital director, which became the service manager role and later combined with the Associate Director of Nursing role.⁴⁴ Nursing officers (later called senior nurse managers) were responsible of a number of wards each, or for a hospital-wide function,⁴⁵ and there were two night supervisors.⁴⁶ In 2010 a senior nurse post was created to facilitate resettlement. This included managing the closure of wards and deployment of both patients and staff to other wards.⁴⁷
- 12.14 The service manager held the budget for the MAH-based nursing and ancillary staff. Other professions were line-managed off site by their professional leads but were responsible to the service manager for care delivered at MAH.⁴⁸ Each ward had a ward manager and a deputy ward manager. Nursing officers/senior nurse managers were responsible for managing day-to-day staffing of their wards, within the funded establishment of posts.⁴⁹ Prior to the introduction of electronic records, nursing officers received a paper report from each ward at the end of each day and a night report from the night supervisors⁵⁰ detailing any significant events or issues. The service manager and senior nurses met formally once a week and there was a monthly ward manager meeting, to which a representative of the medical staff was invited. The culture and practices were different in each ward, depending on case mix, and the ward managers had a

⁴¹ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 4

⁴² Eilish Steele Statement – 21/05/24 – Page 86

⁴³ Eilish Steele Statement – 21/05/24 – Page 41; Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 7

⁴⁴ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 3

⁴⁵ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 3; Eilish Steele Statement – 21/05/24 – Page 34

⁴⁶ Eilish Steele Statement – 21/05/24 – Page 63

⁴⁷ Eileen McLarnon Transcript – 06/02/24 – Page 26 – Line 10

⁴⁸ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 2

⁴⁹ A12's Statement – 28/03/24 – Page 17

⁵⁰ Eilish Steele Statement 21/05/24 – Page 5 and Page 22

degree of autonomy.⁵¹ Managers had personal contribution plans set against corporate objectives,⁵² and all ward staff had annual appraisals conducted by the ward manager.

- 12.15 Management at MAH became less stable from 2011, when both the Co-Director for Learning Disabilities Services and the MAH Service Manager retired.⁵³ This coincided with a period of financial austerity but increasing pressure to resettle patients. Five years later, in 2016, both the Director of Primary and Social Care (the directorate in which MAH sat at the time), and the Co-Director for Learning Disabilities Services left and there were temporary cover arrangements for a year, with the Executive Director of Social Work combining his role with that of interim director⁵⁴ until a substantive appointment was made in September 2017. The co-director role was covered by the Co-Director for Mental Health in addition to his own role.⁵⁵ In September 2017, the MAH Service Manager took up the directorate-wide Divisional Nurse role but covered both roles until a new service manager was appointed in March 2018.⁵⁶

Changing requirements after Bamford

- 12.16 The Northern Ireland Executive's Action Plan 2009-2011⁵⁷ did not specify the number or type of staff required to implement the Bamford Review's Equal Lives vision,⁵⁸ and in 2009 the DHSSPS commissioned consultants Deloitte to consider the workforce needs.⁵⁹ Equal Lives had proposed a new 'health facilitator' role and Deloitte recommended that this could be undertaken by the RNLDs or social workers who would be released by the bed closures at MAH.⁶⁰ It was assumed that services in the community could be expanded by moving funding out of MAH through reducing staff posts. However, overheads are fixed and do not decrease

⁵¹ Eileen McLarnon Transcript – 06/02/24 – Pages 36-38

⁵² John Veitch Statement (Organisational Modules) – 31/05/24 – Page 20

⁵³ Miriam Somerville Statement (Evidence Modules) – 27/04/23 – Page 1; Eilish Steele Statement – 21/05/24 – Page 5 and Page 98

⁵⁴ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Page 3

⁵⁵ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 2

⁵⁶ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 3

⁵⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 75

⁵⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 717 (Exhibit MMcG-27) – The Acute Hospital Review part 4 (2001)

⁵⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 75

⁶⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 7160 (Exhibit MMcG-172) – Workforce Planning in Mental Health and LD Implementation of Bamford Review Recommendations (2009)

in a linear fashion with every patient discharged, so the new roles did not materialise as funding could not be released from the hospital even as the beds closed. This should have been predicted when the Western Health and Social Care Trust (WHSCT) moved its inpatient provision out of MAH in 2007 – income fell but expenditure at MAH did not, and MAH needed bridging funding from DHSSPS to continue to function.⁶¹

12.17 These pressures had not been considered in the Deloitte workforce plan so there was a ‘chicken and egg’ situation where staff could not be released until patients had been resettled, but patients could not be resettled because community services were not available. The Deloitte report was published in June 2009 but in October 2009 the Northern Ireland Audit Office reported that delays in resettlement were primarily due to a lack of funding for care and support services in the community.⁶² Failure to resettle patients as a result of the lack of appropriate community services was more costly than ‘pump-priming’ the staffing costs for community services. This was a missed opportunity to accelerate resettlement at marginal cost. This marginal cost pressure would also have prevented the huge emotional cost to patients and their families, who had been promised resettlement in the Bamford Review.

12.18 Brendan Whittle (Director of Hospital and Community Care at Strategic Planning and Performance Group (SPPG) of the DoH) gave evidence about the continuing dialogue between the Health and Social Care Board (HSCB) finance teams and BHSCT in relation to bridging finance when the WHSCT withdrew its patients and its funding, and pointed to the additional funding of £22.9 million provided by the HSCB over and above the August 2011 agreed resettlement retraction and bridging model.⁶³

⁶¹ June Champion Statement (Evidence Modules) – 10/03/23 – Page 14

⁶² Northern Ireland Audit Office (2009) Resettlement of Long-Stay Patients from Learning Disability Hospitals – Pages 3-4. NIAO, Belfast – https://www.niauditoffice.gov.uk/files/niauditoffice/media-files/resettlement_of_long-stay_patients_from_learning_disability_hospitals.pdf

⁶³ Brendan Whittle 1st Statement (Organisational Modules) – 07/06/24 – Page 53

- 12.19 However, the mismatch between workforce funding based on the aspirations of policymakers and actual patient needs was noted by the MAH Hospital Modernisation Group in 2015:

'The skill mix, staffing ratios reflected [a] settled population and patient mix; however, with changing profiles and acuity levels ... a new and emerging patient population has required increased staffing ratios and skill mix for safeguarding issues, risk management and staff safety'.⁶⁴

Initial planning assumptions did not recognise this emerging population, which required more intensive support than the patients who were being discharged. While non-recurrent funding was provided for patients awaiting resettlement,⁶⁵ the new and emerging population was not acknowledged, as highlighted by Dominic Bradley (Member of the Legislative Assembly (MLA) and Chair of the All-Party Group on Autism (APGA)), who wrote to the Health Minister in 2014 about the lack of autism services at MAH.⁶⁶

Responsibility for medical care

- 12.20 All patients within MAH had a named consultant psychiatrist, who oversaw their medical care and decisions about admission and discharge. Two consultants covered both MAH and community services but were not available overnight or on Sundays. One of the consultants focused on forensic patients in Sixmile Ward and community clinics.⁶⁷
- 12.21 Patients living at MAH for over six months were automatically removed from their home general practitioner (GP) list,⁶⁸ and their physical health became the responsibility of the MAH medical staff, but patients did not have access to a full range of primary health services leading, for example, to a lack of the annual health checks available to those with learning disabilities living in the community. This problem does not appear to have been addressed by way of a contract to provide primary care services. Doctors in training posts provided day-to-day cover for the wards for both psychiatric and physical health needs, and BHSCT had a

⁶⁴ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 198 (Exhibit JV2) – Nursing Workforce paper

⁶⁵ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 178 (Exhibit JV2) – Community Integration Project – Paper for Additional Resources

⁶⁶ MAHI – Additional Materials Referenced – Page 347 (Letter to Minister from Dominic Bradley MLA – 22/07/14)

⁶⁷ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 8

⁶⁸ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 175 (Exhibit JV2) – Notes of Hospital Modernisation Group meeting 19/06/15

specific arrangement with a local GP practice to provide an on-call night-time service.⁶⁹ Dr Hughes (former consultant psychiatrist at MAH) told the Inquiry:

[Counsel]: *'Then you go on to say: ... "In the absence of any primary care services day to day clinical issues were addressed by one of the psychiatry team. More recently before I left Muckamore in 2018, a general practitioner was welcomed on to the medical team". So really before 2018, did the hospital have to rely on the services of a GP in the community to attend the hospital if it was felt that a GP was needed to see a patient, or was it managed by the psychiatrists really?*

[Dr Hughes]: *Yeah, exactly the latter ... There was no routine access to general practice for the patients who lived there, to all intents and purposes, or for the patients who were there being treated for illness'.⁷⁰*

12.22 Dr Milliken (former consultant psychiatrist at MAH) was also asked about the provision of primary care services at MAH. He told the Inquiry:

[Counsel]: *'You say that you advocated for the best physical healthcare that could be provided to patients in the hospital. You advocated for the employment of primary care specialists for a long time. You had historical arrangement with a number of local general practitioner services. How long were you advocating for the introduction of such an arrangement?*

[Dr Milliken]: *Well, for a long period of time I think we had an awareness that all of our patients had primary care needs that would best have been addressed by primary care physicians in the same way as all of us would expect. That resource wasn't made available to us. So there was the routine primary care in hours or within the normal working week, and then the primary care input out-of-hours. We were able to make progress with improving the out-of-hours care with changing the arrangement from the local general practitioner services providing that to the Beldoc [Belfast doctors out of hours service] arrangement. So there was a rota that GPs were on-site for a number of hours each evening, and on Saturdays and Sundays as well, and were able to provide more specialist primary care and direct and prompt input for those times. We advocated long and hard for the resource to employ primary care specialists during the ordinary working week as well, and as I've said in my statement, John Veitch and I met with the Eastern Board to advocate for that as well and had e-mail correspondence with commissioners about the need for that, and it certainly didn't happen as quickly as I would have wanted, but it was a very welcome addition when it did arrive [in around 2017]'.⁷¹*

12.23 Multidisciplinary meetings to review individual patients' ward care had been in place since the 1980s,⁷² although largely attended by medical staff and nurses only. Following the 1998 reprofiling of wards, multidisciplinary team (MDT)

⁶⁹ Miriam Somerville Statement (Evidence Modules) – 27/04/23 – Page 77 (Exhibit MS/1) – Mental Health Commission Visit October 2004

⁷⁰ Damien Hughes Transcript – 24/09/24 – Page 43 – Line 2

⁷¹ Colin Milliken Transcript – 23/9/24 – Page 181 – Line 8

⁷² From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 142

meetings were introduced on the resettlement wards.⁷³ These meetings were attended by nursing and medical staff, together with patient advocates and the patient's home health and social care trust (HSCT) care management staff.⁷⁴ Initially monthly, the MDT meetings were increased to weekly in 2012 when dedicated consultant psychiatrist time for resettlement was funded.⁷⁵ When the electronic records system (Paris) was introduced, the meeting notes were recorded on that system.⁷⁶ From 2015 a weekly patient forum was introduced.⁷⁷

- 12.24 Dental services were provided by a visiting dentist in an on-site dental department, there was a full-time clinical psychologist attached to the forensic ward and (at times) a further clinical psychologist was available for the rest of the hospital. Allied health professionals (AHPs) were accessed on a referral basis,⁷⁸ including a speech and language therapist (SALT), who provided advice on swallowing as well as communication skills, and one physiotherapist plus a part-time dietician. Three social workers spent most of their time on Mental Health Review Tribunal and vulnerable adults processes.⁷⁹ Occupational therapists (OTs) were patchy until a dedicated service for resettlement was introduced in 2012 and there had been no clinical pharmacist at MAH for at least 10 years prior to 2018.⁸⁰

Familial recruitment

- 12.25 The majority of direct patient contact in the hospital was undertaken by registered nurses and HCAs. Given the remoteness of the hospital site and the difficulty in recruitment, it had been common for staff to be recruited from the same families, and in the early days this was celebrated as enhancing the community feel of the hospital.⁸¹ The Inquiry heard that senior nurse managers made efforts to ensure this did not cause problems in relation to line management.⁸²

⁷³ Eileen McLarnon Transcript – 06/02/24 – Pages 18-20

⁷⁴ Eilish Steele Statement – 21/05/24 – Page 38

⁷⁵ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 8

⁷⁶ Moira Mannion Statement – 19/09/23 – Page 9

⁷⁷ Adult, Social & Primary Care Directorate, Learning Disability Service Group MAH Hospital Modernisation Group Proposal for Muckamore Abbey Hospital November 2015 – Page 47

⁷⁸ RQIA - Mental Health and Learning Disability Unannounced Inspection Report, Erne 1 & 2 – 21/12/16

⁷⁹ John Veitch Statement (Evidence Modules) – 23/02/24 – Pages 63-64 (Exhibit 7) – BHSCT MAH Note of Hospital Modernisation Meeting 09 January 2015

⁸⁰ Steven Guy and Deirdre Murray Transcript – 27/06/23 – Page 8 and Page 40

⁸¹ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 172

⁸² A12's Statement – 28/03/24 – Page 29

12.26 After the Ennis Ward safeguarding investigation was published in 2013, Esther Rafferty (former service manager and Associate Director of Nursing for MAH) issued guidance (approved by the BHSC Human Resources department) that two members of the same families could not work together with the same patient.⁸³

12.27 Philip Ward was a day-care worker at MAH from 2008 to 2010, later returning to the hospital in 2022. He said that on one occasion he was concerned that a member of staff would cause trouble for him with a more senior member of staff, who was a relative, and so he avoided challenging conversations. He told the Inquiry:

*'Looking back on my time in MAH I feel that I learned a lot and gained a lot of experience working in the field of learning disability. This has helped me progress my career as a care worker. Working with patients with challenging behaviours was very difficult. From my experience, the fact that staff were related to each other did have an impact on the culture within MAH. I had a general feeling of unease at the lack of oversight on the running of MAH. My experience reaffirmed my belief that no-one really knows what goes on in there as there was no transparency and that what happens at MAH stays at MAH'.*⁸⁴

12.28 Shelley Crawford (occupational therapist) worked at MAH from 2012 to 2015. Her recollection was that several members of staff were related to each other. She recounted an incident where a patient was inappropriately handled by a member of staff. She reported this to a senior member of staff who, it then transpired, was the staff member's brother-in-law.⁸⁵

12.29 H885 detailed a number of staff who would have been working together on the same wards as each other permanently, even though family members were not meant to be allowed to work with each other.⁸⁶ P118's mother told the Inquiry:

'There appeared to be a greater number of staff working within the new wards with a good mixture of both gender and age. I felt that incidents were not being reported by staff. One of the reasons why I suspected that incidents were not being reported, particularly by junior staff, was that there were many staff members from the same family. I suspect that if two staff who were working together and were related, incidents of abuse were not being reported. I was also aware that there was a great sense of fear not only displayed by the

⁸³ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 15

⁸⁴ Philip Ward Transcript – 15/11/23 – Page 26 – Line 3

⁸⁵ Shelley Crawford Transcript – 14/11/23 – Pages 85-86

⁸⁶ H885 Transcript – 27/06/24 – Pages 47-48

*patients but also the junior staff members. One junior staff member came close to talking about what was happening but appeared to stop from giving out the information. I think it was because she was afraid. There was a palpable sense of fear and secrecy in around the wards’.*⁸⁷

- 12.30 The 2018 safeguarding review report ‘A Way to Go’ concluded that the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients, and that despite the review team being advised of the presence of related staff at MAH, there was no reference to conflict-of-interest declarations in any file.⁸⁸
- 12.31 The 2020 DoH leadership and governance review noted that ‘A Way to Go’ stated that because of staff relationships the likelihood of peer challenge was constrained, and the review team considered that the problem was not in governance but rather in people’s response to working in a closed environment with its own set of norms and loyalty to the group rather than the patients or the BHSC. ⁸⁹ The Panel does not agree – a good governance system would have identified this as a potential failure in the system.

Staff and staffing levels

- 12.32 A ‘named nurse’ (a concept introduced by the UK-wide Patient’s Charter to be a key worker)⁹⁰ undertook the patient’s admission assessment,⁹¹ using the Roper–Logan–Tierney model of activities of daily living to design a care plan. Initially this was completed in paper records but around 2012 this in part moved to the electronic records system PARIS. This led to a mixture of paper and electronic records rather than a single file,⁹² potentially meaning that the whole record was not available at the same time and some elements were unknown to some staff. RNLDs recorded progress notes at a minimum of every 24 hours, whereas other professions made entries only when required.⁹³

⁸⁷ P118’s Mother Transcript – 09/10/23 – Page 104 – Line 1

⁸⁸ Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Page 16 (Exhibit MF/1) – ‘A Way to Go’ Report

⁸⁹ David Bingham Statement (Evidence Modules) – 24/04/23 – Pages 33-34 and Page 66 (Exhibit DB/1) – Leadership and Governance Review

⁹⁰ Department of Health (1991) The Patient’s Charter. London: HMSO – <https://www.ihrdni.org/306-085-1.pdf>

⁹¹ Eileen McLarnon Transcript – 06/02/24 – Pages 47-48

⁹² Moira Mannion 1st Statement – 19/09/23 – Page 9

⁹³ Moira Mannion 1st Statement – 19/09/23 – Page 9

- 12.33 Named nurses were responsible for up to six patients each⁹⁴ and had overall responsibilities for their patients, including purchasing clothes if required,⁹⁵ as well as writing and reviewing care plans. While the named nurse was responsible for planning care, care was delivered by others when they were not on duty or by HCAs. The nurse in charge of each shift allocated tasks via an allocation book.⁹⁶ The HCAs completed tasks assigned to them and may not have been aware of all the patient's needs.⁹⁷
- 12.34 Positive behaviour support (PBS) was introduced in 2015 partly in response to the 2014 Department of Health England policy 'Positive and Proactive Care: reducing the need for restrictive interventions'.⁹⁸ Training was delivered to all ward and day-care staff by MAH psychology services' behaviour therapy staff, but recommended updates planned for 2018 were cancelled due to staffing shortages. From November 2017, the British Institute of Learning Disabilities (BILD) e-learning 'PBS Awareness' course was made mandatory for all MAH staff.⁹⁹ Nevertheless, by no means all patients had PBS plans.
- 12.35 All registered nurses have been required to have regular clinical supervision since 1993 to reflect on their practice, and the Nursing and Midwifery Council (NMC) published guidelines in 2006.¹⁰⁰ Clinical supervision for all professions was incorporated into the DHSSPS Quality Standards in 2006. However, a Northern Ireland Practice and Education Council for Nursing (NIPEC) review that same year reported that 67% of registered nurses across Northern Ireland said they had not received any.¹⁰¹ By 2012, registered nurses at MAH were supposed to be receiving clinical supervision twice a year, with data being reported corporately.¹⁰² The BHSC annual report on clinical supervision for 2016-2017 reported that 12%

⁹⁴ H324 Transcript – 03/06/24 – Page 40 – Line 1

⁹⁵ A14 – 06/06/24 – Page 11 – Line 7; H324 Transcript – 03/06/2024 – Pages 35-39

⁹⁶ Eileen McLarnon Transcript – 06/02/24 – Pages 40-41

⁹⁷ Paula McCann's 2nd Statement – 26/01/24 – Page 10

⁹⁸ Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions.– https://assets.publishing.service.gov.uk/media/5a7ee560e5274a2e8ab48e2a/JRA_DoH_Guidance_on_RP_web_accessible.pdf

⁹⁹ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 76

¹⁰⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 2768 (Exhibit MMcG/54) – NIPEC Report of the Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS

¹⁰¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 2755 (Exhibit MMcG/54) – NIPEC Report of the Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS

¹⁰² Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 19

of registered nurses in learning disabilities services had received one session and 88% had received two or more (although the data was not provided at unit level and included community staff). The report also reported that only 40% of bank nurses across the whole of BHSCT had received any clinical supervision.¹⁰³ We heard from witnesses that clinical supervision at MAH (as opposed to learning disabilities services as a whole) was variable:

'Regarding clinical supervision, I should have received this although I do not feel that I did receive it sufficiently. The arrangements were in place for it but it would not have happened often, if at all. It consisted of a discussion with a Band 6 or Band 7 nurse around an area of learning or identifying needs that I felt I needed more learning on'.¹⁰⁴

12.36 Given the high use of bank nurses at MAH, the Panel found this concerning. The Panel also felt that two sessions a year is insufficient given the intensity of the work. Other professions had their own supervision arrangements through their professional lead.¹⁰⁵

12.37 Staffing shortages are not new at MAH and BHSCT has acknowledged a long-standing shortage of RNLDs.¹⁰⁶ Shortages appear to have been more acute after 2009. The RQIA repeatedly reported that ward staffing levels were compromising patient care between 2010 and 2017. The RQIA recommended in October 2010 that Ennis Ward be provided with clerical support to relieve nurses so they could spend more time directly with patients and to review the practice of taking staff from the ward to relieve other wards as it impinged on patient care.¹⁰⁷ In March 2011 the RQIA recommended that staff report any cancellation of planned activities due to low staffing or ward disturbances on the BHSCT incident system.¹⁰⁸ In June 2012 the RQIA reported that staffing on Finglass Ward had been compromised by staff sickness, including work-related injuries.¹⁰⁹ The independent assurance team commissioned by BHSCT in 2018 reflected on the difficulties created by resettlement and the consequent retraction of MAH.¹¹⁰ The team also reported

¹⁰³ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 6572

¹⁰⁴ H330 Statement – 22/05/24 – Page 35

¹⁰⁵ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 7

¹⁰⁶ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 81

¹⁰⁷ Ennis Bundle – Page 113a – Quality Improvement Plan Announced Inspection

¹⁰⁸ RQIA – Quality Improvement Plan, Announced Inspection, Cranfield Male – 15/02/11 & 08/03/11

¹⁰⁹ RQIA – Mental Health and Learning Disability, Announced Inspection, Finglass - 25 & 26/06/12

¹¹⁰ Martin Dillon 2nd Statement (Evidence Modules) – 06/04/23 – Page 53

that whistleblowers began to raise staffing issues at MAH from 2012 onwards – 3 in 2012-2015, 10 in 2016-2018 and 13 in 2019-2021.¹¹¹

- 12.38 Families told the Inquiry that as well as a lack of continuity, the temporary staff did not appear to have the necessary specialist skills for caring for people with learning disabilities and autism:

*‘Lots of the issues seemed to be around funding. They were using agency nurses who were not properly qualified or experienced to be dealing with the patients’ disabilities’.*¹¹²

*‘There were always different nurses on the ward, and they always seemed to be very young’.*¹¹³

- 12.39 Most registered nurses were recruited from the pre-registration education programme, having undertaken placements at MAH, but there was a reduction in the number of training places between 2010 and 2015.¹¹⁴ This was compounded by a freeze on recruiting substantive staff from 2012 to 2015 as the hospital was scheduled for closure.¹¹⁵ Experienced staff were leaving as they could not see a long-term career at MAH, but newly qualified staff were employed on temporary, rolling contracts,¹¹⁶ which were sometimes only renewed a week before they ran out.¹¹⁷ This was a lost opportunity to bring in newly qualified RNLDs, who in consequence forged careers in other settings and were not attracted to MAH when the freeze was lifted. At the same time, there was an increase in opportunities for community-based RNLD posts, which made working in a hospital a less attractive option for new graduates.

- 12.40 The new service manager raised concerns about staffing levels on her appointment in January 2012¹¹⁸ and a Workforce Strategy Steering Group was convened during February 2012.¹¹⁹ Staffing was rated ‘red’ on the Learning

¹¹¹ Briege Donaghy 3rd Statement (Evidence Modules) – 08/12/23 – Page 2

¹¹² P1’s Sister Transcript – 26/06/22 – Page 26 – Line 16

¹¹³ P64’s Father Transcript – 23/11/22 – Page 30 – Line 20

¹¹⁴ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 231(Exhibit 5) – Nursing and Midwifery Task Group Report and Recommendations March 2020

¹¹⁵ Eileen McLarnon Transcript – 06/02/24 – Page 27 – Line 2

¹¹⁶ H324 Statement – 22/05/24 – Page 2

¹¹⁷ H324 Transcript – 03/06/24 – Page 9 – Line 26

¹¹⁸ John Veitch Statement (Evidence Modules) – 23/02/24 – Page 14; Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Pages 6-7 and Page 24 (Exhibit 1) – Report to RQIA

¹¹⁹ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 41; John Veitch Statement (Evidence Modules) – 23/02/23 – Page 14

Disabilities service risk register in Summer 2012¹²⁰ and by September 2012 the service manager escalated her concerns to the Co-Director and the RQIA.¹²¹ By 2014 there had been little improvement,¹²² with an unfunded staffing cost pressure of £3 million.¹²³

- 12.41 Ward staffing numbers were mentioned by most families consistently across time. Some parents told the Inquiry that they thought omissions in care were due to staff shortages. P16 was in MAH from 2010; his mother told the Inquiry:

*'Well, Muckamore was short staffed with their day care workers, and in the end the girl that was doing day care had to go off sick and they only had one other person up in Muckamore at the time, so they hadn't got enough staff to come down to P16'.*¹²⁴

- 12.42 Some families recognised that some staff were suffering from burnout, and were coming in to work when they were not fit because they knew no one would be able to cover their shift. Referring to a period in May 2014, P1's sister told the Inquiry:

*'I suppose it was happening in the context of there being a lot of sick leave and stuff at that time in Muckamore. A lot of staff were out on sick leave and things. So, no, she was just like "I have no choice, I have to keep going'.*¹²⁵

- 12.43 From 2012, when BHSCT announced its long-term plans for MAH (including the closure of many of the wards), families noticed that staff felt very insecure about their jobs:

*'We were hearing from carers and from staff at the time is that they were advertising for temporary positions at that time because they were closing down the wards, so they weren't taking on full-time staff. People that were leaving through natural attrition, through, you know, retirements, through leaving, they were only -- they weren't advertising for full-time staff, so they're either taking on agency staff or they were advertising temporary contracts'.*¹²⁶

- 12.44 Family members were aware that staffing shortages meant planned care was not delivered:

¹²⁰ Esther Rafferty Transcript – 17/06/24 – Page 35-36

¹²¹ Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 24 (Exhibit 1) – Report to RQIA

¹²² H324 Transcript – 03/06/24 – Page 15 – Line 24

¹²³ John Veitch Statement (Evidence Modules) – 23/02/24 – Page 63 (Exhibit 7) – BHSCT MAH Note of Hospital Modernisation Meeting 09 January 2015

¹²⁴ P16's Mother Transcript – 20/09/22 – Page 83 – Line 19

¹²⁵ P1's Sister Transcript – 26/06/22 – Page 33 – Line 12

¹²⁶ P1's Sister Transcript – 26/06/22 – Page 86 – Line 25

'During his time at MAH P60 required 2:1 care at all times. I know that there would have been times when he was not cared for by the required number of staff. My family learned that this was due to staffing shortages'.¹²⁷

- 12.45 The Inquiry heard from one ex-patient that in the past patients were directed by staff to undertake some care duties for other patients:

'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'.¹²⁸

- 12.46 Staffing problems got worse after the 2017 CCTV evidence was made public and staff were suspended or left. The wards were covered by large numbers of temporary staff, and the continuity of care was disrupted. P28 was admitted to the hospital in February 2017:

'We started to notice a deterioration on the ward regarding staff levels around this time, which would have been from around October 2018 through to when he left in February 2019. We noticed a lack of staff training and that there were a lot more agency workers and a lot of dinners [of patients] untouched'.¹²⁹

- 12.47 While the Northern Ireland Collaborative's 2017 'Northern Ireland Action Plan for Learning Disability Nursing' focused on career development, with specialist pathways,¹³⁰ it had little to say about inpatient ward-based nursing, presumably because the policy directive was to minimise this. Workforce planning at a regional level therefore did not address the actual needs of the service at MAH.

- 12.48 BHSC maintained that the lack of supply of RNLDs was beyond its control and there was nothing it could do. However, the BHSC did not consider new types of role increasingly used across the UK to mitigate the risk:

[Dr Maxwell]: 'Can I just ask, that was about registered nurses, but you also had significant vacancies for unregistered staff?'

[Ms Creaney]: Yes.

¹²⁷ P60's Sister Transcript – 02/09/23 – Page 15 – Line 7

¹²⁸ P27 Transcript – 11/10/22 – Page 31 – Line 8 (restricted)

¹²⁹ P28's Father Transcript – 25/08/22 – Page 100 – Line 16

¹³⁰ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 297 (Exhibit 8) – Northern Ireland Action Plan for Learning Disability Nursing

[Dr Maxwell]: *And that isn't a supply problem from the supply from Universities, that's making a job attractive to local people and supporting them?*

[Ms Creaney]: *Yes and to support that we did recruitment again in the local area because people for that level at a Band 3 level were not going to travel out of Belfast when there were opportunities closer to home. So we, we have had an issue with recruiting healthcare support workers into Muckamore and in spite of the efforts we made to do that.*

[Dr Maxwell]: *Did you ever give any consideration to creating Band 4 assistant practitioners?*

[Ms Creaney]: *Not at that stage, no.*

[Dr Maxwell]: *Because that's something that has been used very successfully in the rest of the UK?*

[Ms Creaney]: *Yeah, no, we didn't. We focused on Band 3s largely for Muckamore, not Band 2s and we also encouraged our healthcare support workers to consider applying for nursing posts as well or nurse training through the Open University, which has been latterly very successful. But it was a very challenging place to recruit to.*

[Dr Maxwell]: *Can I ask why you didn't consider assistant practitioners, because that's really what they are designed for, scenarios like this.*

[Ms Creaney]: *There wouldn't have been roles that we would have used at that time.*

[Dr Maxwell]: *So you didn't give any consideration to that?*

[Ms Creaney]: *No, it wouldn't have been within our way of working at that time.*

[Dr Maxwell]: *Have you ever, have you subsequently looked at assistant practitioner roles?*

[Ms Creaney]: *No'.¹³¹*

Associate practitioners undertake a Level 5 two-year foundation degree in health or social care as an apprenticeship programme or Higher National Diploma (HND)¹³² and are designed to bridge the gap between healthcare assistants and registered nurses.

- 12.49 Staff shortages meant that enhanced supervision prescribed to many patients could not be carried out and that staff could not take a relief break every two hours as the policy directed,¹³³ both of which put patients and staff at risk. Staff were focused on completing tasks rather than seeing the patient as a whole person¹³⁴ and felt their concerns were not taken seriously, leaving them at risk of assault,¹³⁵ which staff accepted as part of the role.¹³⁶ The failure to address the working

¹³¹ Brenda Creaney Transcript – 14/10/24 – Page 69

¹³² NHS Careers Assistant practitioner – <https://www.healthcareers.nhs.uk/explore-roles/wider-healthcare-team/roles-wider-healthcare-team/clinical-support-staff/assistant-practitioner#:~:text=As%20an%20assistant%20practitioner%2C%20you,Entry%20requirements>

¹³³ H324 Transcript – 03/06/24 – Page 21 – Line 10; A6's Statement – 09/02/24 – Page 6

¹³⁴ James Wilson Statement – 19/12/23 – Page 4 (restricted)

¹³⁵ H324 Transcript – 03/06/24 – Page 21 – Line 26; H324 Transcript – 03/06/24 – Page 22 – Line 8

¹³⁶ H330 Statement – 22/05/24 – Page 27

environment may have contributed to some staff becoming defensive and using restrictive practices as a first choice rather than a last resort. The task-based culture may have led some to dehumanise their patients and become blind to their emotional needs.

- 12.50 Families noticed an increase in the use of temporary staff who did not have specialist learning disabilities skills, and that the swimming pool and day-care facilities were often closed due to staff shortages, meaning that patients were confined to wards with a lack of stimulation that in turn increased the levels of aggression, with both patients and staff being injured.¹³⁷ In September 2017 understaffing was attributed to the high number of staff who were absent having been injured.¹³⁸
- 12.51 Ward staff shortages were traditionally filled by the internal 'Bank' (often MAH staff doing additional shifts)¹³⁹ but by 2016 the hospital was having to go out to commercial agencies as the Bank was unable to fill the shifts.¹⁴⁰ The disadvantages of this are manifold, but include the higher costs and the difficulties of non-permanent staff building knowledge and relationships with patients.
- 12.52 Brenda Creaney (then Executive Director of Nursing for BHSCT) told the Inquiry she did not recall seeing a paper presented by the Task and Finish Group in July 2017, based on a roster analysis at the end of 2016, which demonstrated that most of the wards had a skill mix of less than 50% registered nurses. The number of staff to meet patient needs had been calculated as 41.78 whole-time equivalents (WTE) on Cranfield 1 but the budget only allowed for 26.25 WTE.¹⁴¹ The Panel was surprised that she was unaware of this paper produced by the corporate nursing team, who reported directly to her, given the alarming staff deficit.¹⁴²

¹³⁷ P1's Sister Transcript – 28/06/22 – Page 26 – Line 17; P1's Sister Transcript – 28/06/22 – Page.123 – Line 9

¹³⁸ James Wilson Statement – 19/12/23 – Page 7

¹³⁹ Eilish Steele Statement – 21/05/24 – Page 93

¹⁴⁰ Mairead Mitchell Statement (Organisational Modules) – 25/04/24 – Page 9

¹⁴¹ Brenda Creaney Transcript – 14/10/24 – Page 62 – Line 5

¹⁴² Brenda Creaney Transcript – 14/10/24 – Pages 61-62

Skill mix on the wards

- 12.53 Skill mix is as important a factor in how care is delivered as the total number of staff. This relates to both the skills of the registered nurses and the ratio of registered nurses to HCAs. RNLDs undertake a three-year course focused on the needs of people with learning disabilities and they must be registered with the NMC. In 2014 and 2015 BHSC opened posts to registered nurses in mental health (RNMH).¹⁴³ While RNMHs are registered nurses, they do not have specialist learning disabilities training.¹⁴⁴ The NMC does not require its registrants to undertake education or development related to the group of patients they are currently working with in order to successfully revalidate every three years. Ms Sam Foster (Executive Nurse Director for Professional Practice at NMC) told the Inquiry:

[Counsel]: *'Pausing there. Do you know or can you help us understand whether revalidation requires the Registrant's CPD [continuing professional development] to be in the field in which they are practising?*

[Ms Foster]: *No, a percentage has to be participatory, and that's the only requirement that's laid out.*

[Counsel]: *Okay.*

[Dr Maxwell]: *So potentially an LD [learning disability] nurse could do a leadership course, or a quality improvement course, but not actually do anything specifically related to LD practice?*

[Ms Foster]: *Yeah, I'd hope that they would apply.*

[Dr Maxwell]: *Hopefully they would, but potentially...*

[Ms Foster]: *But potentially.*

[Dr Maxwell]: *... they could submit something that had not been situated within their field of practice?*

[Ms Foster]: *Yes'.¹⁴⁵*

- 12.54 There is no regulation of, or regional standards for, HCAs who largely learn on the job without any specialist training, although they do receive ward-based induction.¹⁴⁶ Patients who are stable can receive high-quality care from HCAs who follow a plan written by regular nurses, but patients with complex and rapidly changing presentations require the expertise of an RNLD to manage their fluctuating needs. In 2005 there was a 50:50 ratio of RNLDs to HCAs (although it was stated that 60:40 was desirable)¹⁴⁷ meaning that knowledge and skills were

¹⁴³ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 82

¹⁴⁴ Owen Barr 2nd Statement (Evidence Modules) - 25/04/24 – Page 23 (Exhibit 1) – Draft Report of Independent Assurance Team Muckamore Abbey Hospital April 2018

¹⁴⁵ Sam Foster Transcript – 29/05/24 – Page 82 – Line 1

¹⁴⁶ Eilish Steele Statement – 21/05/24 – Page 73

¹⁴⁷ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 177

thinly spread. The ratio remained an ongoing source of debate¹⁴⁸ up to and after the 2017 CCTV revelations. A 2019 review of the MAH workforce recommended a skill mix of 70% RNLDs given the profile of the patients being treated.¹⁴⁹ This was presented to the Public Health Agency (PHA)¹⁵⁰ but not funded as the strategic direction was to close all learning disabilities inpatient units.¹⁵¹

12.55 Employers are responsible for ensuring that there are appropriate arrangements in place to support safe and effective delegation of duties to HCAs, but BHSCT does not appear to have provided any advice to its staff until NIPEC issued regional guidance in January 2019.¹⁵² The NMC makes clear that a registered nurse remains accountable for the work they have delegated and therefore should be closely supervising HCAs,¹⁵³ but shortages meant that as far back as 2012 on Ennis Ward in-reach staff complained of a lack of induction and supervision and in 2017 in-reach care assistants were again working unsupervised by MAH staff.¹⁵⁴

12.56 Staffing shortages were a constant feature up to the index incident that triggered the CCTV viewing. They then increased rapidly after September 2017, often resulting in staff being redeployed from other areas to cover the wards. On 21 occasions over a four-month period in 2018, the specialist forensic practitioner had been required to work on Sixmile Ward to maintain safety, meaning he could not undertake therapeutic work and thereby moving the staffing shortage to another area of practice.¹⁵⁵ The RQIA noted the shortage of staff and that BHSCT had been making efforts to recruit new staff. The RQIA stated that it was satisfied that the Trust was doing all it could to address the staffing shortages. The Panel has already described at 12.48 that the Trust was simply relying on existing roles, and was not looking at additional roles to mitigate the risk or at ways of making MAH more attractive to new graduates,

¹⁴⁸ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 199

¹⁴⁹ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 11839 (Exhibit T13.30) – 2019 Nursing Workforce Staffing Model Inpatient Learning Disability Service

¹⁵⁰ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 220

¹⁵¹ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 222

¹⁵² Northern Ireland Practice and Education Council (2019) Deciding to Delegate, A Decision Support Framework for Nursing and Midwifery (the '2019 NIPEC Framework') – Standard 11. NIPEC, Belfast – https://nipec.hscni.net/wpfd_file/nipec-delegation-decision-framework-jan-2019

¹⁵³ Nursing and Midwifery Council The Code. NMC, London – www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

¹⁵⁴ James Wilson Statement – 19/12/23 – Page 3

¹⁵⁵ RQIA - Unannounced Follow Up Inspection Report, Six Mile Ward 1 - 20-21/02/18

such as rotational posts, where new graduates enter a two-year programme and spend six months in four or five different units, together with protected time for postgraduate learning.

12.57 Staffing issues persisted. At Christmas 2018 the Psychiatric Intensive Care Unit (PICU) was closed due to critical lack of staff.¹⁵⁶ Following an unannounced inspection in February 2019, RQIA noted that the nursing staff complement for MAH for the week commencing 26 February 2019 was subject to significant deficits. This was said to be as a result of a combination of long-term sickness absence, precautionary suspensions, maternity leaves and unfilled vacant posts. More generally, staff of all grades throughout the hospital site informed RQIA that there was insufficient staffing at ward level. Due to those shortages, staff were at times unable to appropriately fulfil their responsibilities. This was impacting on the quality and assurance of care delivered and was in itself a source of anxiety for staff.¹⁵⁷ Concerns about the number and skills of staff were raised by families in March 2021.¹⁵⁸ Protection plans were needed while safeguarding concerns were being investigated, but the risks associated with so many suspensions were not considered, meaning insufficient mitigations were in place. The evidence suggests this led to patients being less rather than more safe.

12.58 P90's sister provided her experience of how staffing changed following the CCTV revelations:

'When the abuse was uncovered in 2017, things were dire in MAH. There was an initial scramble by the Belfast Trust to change and improve the situation. New management was recruited, however the staff turnover rate continues to give rise for concern. Things did improve in some ways but, unfortunately, that momentum has not been sustained and currently things are still far from ideal in MAH. Agency staff were introduced temporarily to fill the void left by suspended staff, or those leaving. Unfortunately, most of those agency staff were from mental health and not learning disability backgrounds. Therefore, through no fault of their own, they were charged with providing good quality care to people with severe disabilities and very complex challenging behaviours for which they had not been given the knowledge and skills to do. This has, I feel, led to a less than ideal level of care for the people who remain in MAH. One only has to look at the numbers of agency staff whose services have been dispensed with to see that this has not been a success. Some do

¹⁵⁶ Gillian Traub Statement – 17/04/24 – Page 33 (Exhibit1) – MAH What is different now?

¹⁵⁷ RQIA - Unannounced Inspection Report - Muckamore Abbey Hospital – 26, 27 & 28/02/19 - Page 10

¹⁵⁸ P90's Sister Transcript – 11/10/23 – Page 89 – Line 6

*provide a good service, but this appears to be the exception rather than the rule’.*¹⁵⁹

Governance

- 12.59 Determining the staff required is an imperfect science, but the number and skills available determine what work that can be done.¹⁶⁰ The BHSCT Executive Director of Nursing and User Experience (and her predecessor in NWBHSST) is responsible for ensuring a framework for determining workforce requirements is in place and is being completed, and Brenda Creaney acknowledged that she was the professional lead for the nursing and HCA workforce.¹⁶¹
- 12.60 Directorates are responsible for determining the actual numbers required in their services.¹⁶² Once that number is agreed, the commissioner (either the HSCB or the DoH Strategic Planning and Performance Group (SPPG) through the PHA) has to agree to fund the posts. In the absence of an evidence base or policy, MAH used the ‘Telford’ method.¹⁶³ This uses professional judgment on how many staff are required per shift. This is used to calculate the number of WTE staff to be funded, then allowances for sickness, absence, holidays and off-ward education are added. The method is dependent on assumptions rather than any empirical assessment of patient needs, and judgement can vary between individuals. Brenda Creaney was asked about the report that Esther Rafferty had presented in September 2012 titled ‘Patient Safety Situation’, which referred to staffing in the hospital being dangerously low and a crisis but was not taken to the Board. Ms Creaney told the Inquiry that in retrospect concerns about staffing should have been taken to the Board.¹⁶⁴
- 12.61 In November 2014, the Acting Executive of Nursing, Midwifery and AHPs at the PHA contacted the Chief Nursing Officer (CNO), providing email correspondence from John Veitch (former Co-Director of Learning Disability at BHSCT) and Molly Kane (Regional Lead Nurse Consultant for Learning Disability Nursing at the

¹⁵⁹ P90’s Sister Transcript – 11/10/23 – Page 121-122

¹⁶⁰ Christine Keenan Statement – 03/11/23 – Page 3

¹⁶¹ Brenda Creaney Transcript – 14/10/24 – Page 71 – Line 12

¹⁶² Brona Shaw Statement (Evidence Modules) – 06/04/23 – Pages 35-36

¹⁶³ John Veitch Statement (Evidence Modules) – 23/02/24 – Page 60 (Exhibit 6) – MAH Modernisation Group Proposal for Muckamore Abbey Hospital

¹⁶⁴ Brenda Creaney Transcript – 11/06/24 – Page 62 – Line 23

PHA). This correspondence raised concerns about recruitment of learning disability specialist nursing staff for PICU and acute admissions at MAH and stated a paper was being prepared on staffing at MAH and would be shared with PHA in due course. The CNO requested further analysis and commented:

'It was my expectation that the PHA and BHSCT would provide deeper analysis of the problem. In my recollection any further analysis was not shared with me'.¹⁶⁵

John Veitch noted that concerns continued throughout 2015 and noted that the rapid expansion of community-based alternative employment accompanying the Regional Community Integration Project was drawing on the same pool of people. Staffing was included on the service group and directorate risk registers,¹⁶⁶ but did not make it onto the principal risk register, despite multiple representations to the PHA, HSCB and DoH. This meant that the BHSCT Board did not consider the risks or mitigations.

12.62 The Telford method does not account for the number of staff required to deliver enhanced supervision, and as this increased over the years, MAH's budget was not increased in response.¹⁶⁷ Nor does it consider fluctuations in work across a shift and there was little recognition in the budgets that personal hygiene care increased between 7am and 9am and 6pm and 11pm,¹⁶⁸ or of the 'sleeping out' policy that allowed some wards to have more patients during the day than beds (the metric on which ward staffing was calculated).¹⁶⁹ Nor was the deployment of MAH staff to community placements to support resettlement included in ward budgets.¹⁷⁰

12.63 An electronic ward rostering system was implemented in MAH in 2015 and this provided a dashboard analysis of staffing compared against patient needs. Patient needs were measured using a tool endorsed by the National Institute for Health and Care Excellence (NICE) for acute hospitals and mental health settings but not

¹⁶⁵ Charlotte McArdle Statement – 28/06/24 – Page 11

¹⁶⁶ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 23

¹⁶⁷ Eilish Steele Transcript – 04/06/24 – Page 108 – Line 2

¹⁶⁸ A14 statement – 20/05/24 – Page 11

¹⁶⁹ A6 statement – 09/02/24 – Page 6

¹⁷⁰ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 20 (Exhibit 1) – Draft Report of Independent Assurance Team Muckamore Abbey Hospital April 2018

for learning disabilities¹⁷¹ and may therefore have offered false assurance that staffing was sufficient. In December 2017 a senior nurse manager acknowledged that there were problems with the e-rostering system,¹⁷² and the RQIA upheld whistleblower concerns about staffing in 2016¹⁷³ and 2017.¹⁷⁴

- 12.64 There remains a lack of evidence-based or nationally agreed criteria for staffing inpatient learning disabilities wards and MAH continues to use nurse-led professional judgement. In 2014 the CNO introduced the regional 'Delivering Care' phased programme to produce 'normative staffing ranges' for different fields of nursing. Work began on learning disabilities nursing (largely focused on community settings) in November 2019 but was delayed by the Covid-19 pandemic. The final draft was shared on 21 June 2022¹⁷⁵ but does not cover staffing of inpatient learning disabilities units.
- 12.65 Changes in the management structure for MAH from 2018 onwards did not prevent the deterioration in the staffing position. The MAH Directors Oversight Group was established in November 2017 and met fortnightly to monitor action plans¹⁷⁶ (renamed the Directors Oversight Senior-Co-ordination Group in January 2019) but there were still differences of opinion on what constituted safe staffing, culminating in a difference of opinion between the BHSCT Board and the RQIA before an RQIA Improvement Notice on ward staffing was served in 2019. Following this, the DoH offered a temporary salary uplift of 15% to all nursing staff working in MAH but this did not have the desired effect and was removed (but reinstated in 2022).¹⁷⁷
- 12.66 The Inquiry heard that ward leadership was key to setting the standards but there appeared to be little leadership at this level. The BHSCT was unable to provide evidence of ward managers receiving training or support in dealing with 'difficult

¹⁷¹ National Institute for Health and Care Excellence (2014) SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals – <https://www.nice.org.uk/guidance/sg1>

¹⁷² RQIA - Mental Health and Learning Disability Inpatient Progress Report – 26/01/17

¹⁷³ RQIA - Unannounced Inspection Report, Killead – 28/10/16

¹⁷⁴ RQIA - Unannounced Inspection Report, Killead -14-15/02/17

¹⁷⁵ Aidan Dawson 3rd Statement (Evidence Modules) – 16/06/23 – Page 6

¹⁷⁶ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Page 22

¹⁷⁷ Brona Shaw Statement (Organisational Modules) – 06/04/23 – Page 11869 (Exhibit T13.31) - Draft Nursing Workforce Paper

staff' whose practice may be poor but did not reach the threshold for disciplinary action.

- 12.67 In May 2019, the CEO briefed the Board about an incident over the weekend that resulted in a number of staff injuries and a patient being escorted to the 'secure room' on PICU. The RQIA had taken the 'unusual' step of contacting the ward directly to ask about staffing. Ms Creaney advised she was content with the staffing (during a May 2019 confidential board meeting). Following the RQIA visit that month, the CNO and Chief Social Worker Officer (CSWO) at the DoH sent a letter to the HSCB. This noted that RQIA remained concerned about the pressures facing staff due to the working environment and surrounding context. Such concerns persisted despite the assurances on staffing numbers, and the CNO and CSWO concluded that:

'We must, therefore, give serious consideration to the possibility that, in the medium to long term, it may simply not be possible to sustain safe, effective and human rights compliant services at MAH'.¹⁷⁸

- 12.68 A consequence of this letter was the appointment by the HSCB of Francis Rice (former Executive Director and Interim CEO of Southern HSCT) in 2019 to provide overview and assistance. He completed a report in February 2020 and reported concerns about the safety and effectiveness of care in MAH,¹⁷⁹ including concerns about care planning,¹⁸⁰ and observed that multiple changes in leadership positions had reduced the effectiveness of leadership at both hospital and directorate level.¹⁸¹

'There are a significant number of vacancies in the nursing workforce in Muckamore Abbey Hospital, which presents a daily challenge to the provision of safe staffing on wards with a disproportionate reliance on bank and agency staff. This is of significant concern in terms of the safe and effective care of patients and the future sustainability of the Hospital. The uncertainty of the future of the Hospital is exacerbating recruitment and retention issues'.¹⁸²

¹⁷⁸ Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 668 (Exhibit 45) – Letter to HSCB from CNO and CSWO 17 May 2019

¹⁷⁹ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 11821 (Exhibit T13.29) – Report of Professional Nursing Assurance Muckamore Abbey Hospital Findings, Recommendations and Action Plan

¹⁸⁰ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 11821 (Exhibit T13.29) – Report of Professional Nursing Assurance Muckamore Abbey Hospital Findings, Recommendations and Action Plan

¹⁸¹ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 11821 (Exhibit T13.29) – Report of Professional Nursing Assurance Muckamore Abbey Hospital Findings, Recommendations and Action Plan

¹⁸² Charlotte McArdle Statement (Organisational Modules) – 28/06/24 – Page 785 (Exhibit 54) – Report on Professional Nursing Assurance MAH Findings, Recommendations and Action Plan: Francis Rice February 2020

- 12.69 A flurry of management actions followed the RQIA Improvement Notice on staffing in August 2019. Four separate operational teams were created, each led by a director, with a Directors Oversight Group created in October 2019 to ensure they were coordinated. A director was seconded from another directorate to manage MAH¹⁸³ while the Director of Adult Social and Primary Care focused on community services and resettlement.¹⁸⁴ A Safeguarding Governance Group was established between the BHSCT, Police Service of Northern Ireland (PSNI), RQIA, DoH and HSCB.
- 12.70 By 2020 only 22% of MAH's staff nurses (Band 5s) were substantive¹⁸⁵ and it was noted that agency staff who 'do not hold an RNLD qualification, which is an inherent risk the Trust is currently carrying',¹⁸⁶ was leaving significant gaps in the skills and knowledge. In March 2022 the RQIA noted that staffing shortages remained a challenge. For registered nurses this was in part due to a regional shortage of RNLDs, and in part due to the historical safeguarding investigation and subsequent Public Inquiry. As a result, the hospital was operating continuously with 63% agency staff, 29% substantive staffing and the remainder working on a bank basis or additional hours. This had an impact on the continuity of care and a training course to upskill agency staff was not yet in place.¹⁸⁷

Conclusions

- 12.71 Plans to change the role and purpose of MAH began in the 1980s. By 2010, all eyes were on the prize of full resettlement, and this led to blindness around problems at MAH, either wilful or neglectful of the evidence. The transition from a large hospital-based service to a predominantly community-based service was poorly planned and inadequately funded. One of the consequences of this was a lack of staff in both the hospital and the community, thereby creating delays in the resettlement of patients and increased risks within MAH.

¹⁸³ Bernie Owens Statement (Organisational Modules) – 07/06/24 – Page 2

¹⁸⁴ Bernie Owens Statement (Organisational Modules) – 07/06/24 – Page 8

¹⁸⁵ Gillian Traub Statement – 17/04/24 – Page 33 (Exhibit 1) – What's different now?

¹⁸⁶ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 11871 (Exhibit T13.31) – Nursing Workforce Staffing Model In Patient Learning Disability Service 2022

¹⁸⁷ RQIA – Inspection Report – 02-30/03/22 – Page 6

- 12.72 There was little evidence presented to the Inquiry to indicate that staff at all levels were fully briefed, trained and supported for the challenges that the change in use of the hospital might, and did, bring.
- 12.73 Following the Equal Lives report it was assumed that services in the community could be expanded by moving funding out of MAH through reducing staff posts. However, overheads do not decrease in a linear fashion with every patient discharged, so the new roles did not materialise as funding could not be released from the hospital. This should have been predicted because when WHSCT moved its inpatient provision out of MAH in 2007, income fell but expenditure at MAH did not, and MAH needed bridging funding from DHSSPS to continue to function.
- 12.74 Given the remoteness of the location, recruitment of staff was largely from the local area and consequently large numbers of people from the same families. This contributed to a strong sense of ‘this is how we do things here’, meaning changes in the philosophy of care were hard to embed, although some staff warmly embraced them.
- 12.75 While senior staff were engaged in planning the changes, the staff with the majority of patient contact time were the least likely to be involved in developing new approaches. HCAs, who had no specialist training, were not closely supervised and were often unaware of full patient care plans, and the new staff learnt through ‘sitting with Nellie’,¹⁸⁸ meaning they could be inadvertently socialised into poor practice. Lack of robust supervision meant poor or, at times, abusive practices were not monitored or challenged.
- 12.76 The BHSCT supplied the Inquiry with an undated learning disability services mandatory training matrix.¹⁸⁹ Other than Management of Actual or Potential Aggression (MAPA) training, nothing on the matrix is specific to the needs of people with learning disabilities who are in hospital for assessment and treatment of mental health conditions. Most of the mandatory training relates to corporate

¹⁸⁸ Oxford Reference definition: ‘sitting with Nellie’ – <https://www.oxfordreference.com/display/10.1093/oi/authority.20110803100509169>

¹⁸⁹ Brona Shaw Statement (Organisational Modules) – 06/04/23 – Page 5953 – Learning Disability Services – Mandatory Training Matrix

liability for health and safety (such as fire safety) or employment law (such as equality training).

12.77 As the new vision for learning disability services developed, the 'imminent closure' of MAH meant that working at the hospital became a less attractive option, exacerbated by the freeze of substantive appointments from 2012 to 2015. At the same time, the needs of the patients were changing and the BHSCT was using a workload measure on its e-rostering system that was inappropriate for learning disabilities services, meaning that shortages may have been even more acute than the number of unfilled shifts portrayed. Reported incidents of peer-on-peer assaults and assaults of staff increased, and it is likely that some staff's personal experiences led them to become inured to the distress of patients so that they used inappropriate or abusive restrictive practices. However, it was consistently assumed that resettlement would in large part resolve the safeguarding risks¹⁹⁰ and little action was taken to reduce the environmental risks (such as excessive noise and an unwise mix of patients) on the wards while they remained open.

12.78 There were many red flags that staffing shortages were becoming critical, and this was recognised as early as 2012 when the issue was entered on the hospital risk register and then the corporate risk register in 2014. Brenda Creaney told the Inquiry that the staffing 'crisis' was 'not entirely abated' and remained 'fragile':

[Counsel]: *'And I am just thinking of the use of those words "crisis" and terms like "dangerously low" in the period late 2012. Do you think the situation had ever been properly resolved between 2012 and 2017?*

[Ms Creaney]: *It was resolved somewhat, but it was -we had a real issue with recruiting to Muckamore Abbey. We also had other nearby facilities who were recruiting learning disability staff, so it was a balance, and we did look at bringing in non-learning disability staff, which, again, was a balance because we needed to have the correct level of skill mix and speciality mix of the nurses.*

[Counsel]: *Yes. So the crisis may not have entirely abated, but improvements were made?*

[Ms Creaney]: *No, no, it didn't --there were improvements at a point in time, but certainly it was a very fragile environment, I would describe it as, and remains so to this day'.¹⁹¹*

¹⁹⁰ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 114 (Exhibit JV2) – Belfast LASP AS Report 2013-2014

¹⁹¹ Brenda Creaney Transcript – 11/06/24 – Page 67 – Line 23

Bids for more staff were submitted and there was recognition from the RQIA that staffing shortages were impacting on care delivery, including the ability to provide enhanced supervision to distressed patients. The BHSCT Board was aware of these red flags but was frequently reassured by the Executive Director of Nursing that staffing was safe, including after the RQIA notified the Board of its intention to issue an Improvement Notice for staffing.

- 12.79 The HSCB and DHSPPS/DoH were also aware of the staffing shortfalls and the framework agreement (the accountability arrangement between Permanent Secretary and HSCT) meant they should have performance managed BHSCT on this issue, but there is no evidence it was discussed at accountability meetings. This may be because there is little evidence that anyone considered the link between staffing and safeguarding risks, both before but especially after the CCTV footage became available in 2017.

Recommendations

R69	Staffing should be based on service user needs rather than a fixed budget, using daily acuity measures designed specifically for units caring for people with learning disabilities. These should include enhanced supervision requirements, personal care support and therapeutic activities. Service managers should receive weekly reports of data of the staff hours needed per day per ward or facility. Monthly reports of these figures should be published by ward or facility by the Department of Health (DoH). This should apply to all facilities in which people with learning disabilities are resident, including private and third sector provision.
R70	Clinical supervision (where individuals' practice with individual patients is discussed) should be mandatory for all ward staff, including healthcare assistants, and should occur monthly. Clinical supervisors should be trained in the conduct of sessions and the outcomes for continuing development should be recorded on personal files.
R71	All healthcare assistants working with people with learning disabilities and autistic people should be provided with training, which should include specialist learning disability training as well as basic positive behaviour support (PBS). They should be required to complete successfully an examined course (with particular focus on behaviours that challenge) within six months of appointment, in addition to their induction. Consideration should be given to creating a Northern Ireland-wide course.
R72	SPPG must commission a review of the potential models for supervision of staff in private and third sector services commissioned by HSCTs, including all associated costs.
R73	Consideration should be given to enhancing the post of healthcare assistant by creating Band 4 associate practitioners in both hospital and community settings in order to increase the skills of those providing the majority of direct care, and also to provide a career pathway that will retain these staff. Such posts must be in addition to, and not a substitution for, the correct number of registered nurses.
R74	Consideration of staffing (including skill mix as well as total numbers) should be a mandatory part of safeguarding investigations in all settings.

(This page is intentionally left blank)

Patients are people first

'Bubbly, could talk to anybody, wanted to be everybody's friend, loved her family, very happy, happy childhood, very happy at home, et cetera, and I suppose she had some demons as she got older in life but her personality shone through no matter what and she's gone but so many people still talk about her and can't believe that she's gone and she made such an impression for such a wee person, you know.'

'Our mother had taught us siblings that my brother was a special child and that our family had been honoured to have a special child to look after'

'We lived in a seaside town and he loved the beach... Our mother made a harness for him so that he could enjoy the shallow water and would still be safe'

Chapter 13

Senior Management and Trust Board Governance

- 13.1 It would be pointless to attempt to analyse what went wrong at Muckamore Abbey Hospital (MAH) without undertaking a careful look at how the governance of the trust that ran the hospital for the most significant period of our Terms of Reference (ToR) was structured and managed. Good working governance is fundamental to any large business, and even more significant where the care of vulnerable patients is part of the business of the trust board concerned.
- 13.2 Making sure that different teams work together towards the same goals and undertaking the functions attributed to them requires formal structures and processes, known as governance systems. The pinnacle of the system is an organisation's board, which must provide leadership but is also accountable for the effectiveness of the governance arrangements. The Institute of Directors summarises the areas requiring governance as the 'Four Ps', which are Purpose, People, Process and Performance.¹ This chapter will explore how Belfast Trust was managed in practice. In Appendix 4 we consider what good management could look like.
- 13.3 Health and social care trust boards set the purpose or goals of the organisation. In doing this, they are putting into effect or crystallising their contractual obligations and statutory duties, as well as Department of Health (DoH) policies.
- 13.4 In addition, in Northern Ireland, Trusts have duties delegated to them by the DoH, known as delegated statutory functions (DSFs). These are duties that were imposed on the DoH by legislation at a time when it directly managed services. With the advent of autonomous health and social service trusts (HSSTs) in 1994, the DoH no longer had a direct reporting line from the front line, and Article 3 of the Health and Personal Social Services (HPSS) (Northern Ireland) Order 1994

¹ Institute of Directors (2025) The four P's of governance: Building a stronger future for your business – <https://www.iod.com/locations/east-midlands/leicestershire-south-east-midlands/news/the-four-ps-of-governance-building-a-stronger-future-for-your-business>

allowed functions contained in a number of separate pieces of legislation² to be delegated by the Department of Health and Social Services (DHSS) to the new trusts (thus 'delegated functions').³ At the time there was no legislation relating to vulnerable adults or adult safeguarding and so there were (and still are) no delegated functions in relation to adult safeguarding.

- 13.5 Despite the delegation of responsibilities, there remained (and still remains) a requirement for an unbroken line of professional oversight to the DoH of the discharge of DSFs.⁴ Given that the delegated functions all relate to social care, professional oversight rests with the Office of Social Services (OSS) within the DoH, led by the Chief Social Work Officer (CSWO).⁵ An unintended consequence of this is that governance of DSFs sits outside the main governance structures within trusts, and governance arrangements are unclear.
- 13.6 When the Northern Ireland Executive was created following the Good Friday Agreement, the Department of Health, Social Services and Public Safety (DHSSPS) was established.⁶ The DHSSPS provided funding to HSSBs to commission services. They commissioned services from Health and Social Service Trusts (HSSTs) (via Service and Budget Agreements) which in turn subcontracted some services to independent sector providers.⁷
- 13.7 Article 34 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order) introduced a statutory duty of quality on health and social services boards (HSSBs) and HSSTs to 'put and keep in place arrangements for the purpose of monitoring and improving the

² The Children and Young Persons Act (Northern Ireland) 1968 – <https://www.legislation.gov.uk/apni/1968/34/content>, Health and Personal Social Services (Northern Ireland) Order 1972 – <https://www.legislation.gov.uk/nisi/1972/1265/contents>, Chronically Sick and Disabled Persons (Northern Ireland) Act 1978 – <https://www.legislation.gov.uk/ukpga/1978/53>, Mental Health (Northern Ireland) Order 1986 – <https://www.legislation.gov.uk/nisi/1986/595>, Disabled Persons (Northern Ireland) Act 1989 – <https://www.legislation.gov.uk/ukpga/1989/10/contents> and Children (Northern Ireland) Order 1995 – <https://www.legislation.gov.uk/nisi/1995/755/contents/made>

³ June Champion Statement (Evidence Modules) – 10/03/23 – Page 21; Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 5999 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

⁴ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 69

⁵ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 69-70

⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 4500 (Exhibit MMcG-92) – Speech, Language and Communication Therapy Action Plan: Improving Services for Children and Young People 2011/12-2012/13

⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 1172 (Exhibit MMcG-31) – Department of Health, Social Services and Public Safety-Framework Document Sep 2011

quality of health and personal services which it provided to individuals; and the environment in which it provides them' – in other words, a system of clinical and social care governance.⁸

- 13.8 The Review of Public Administration (RPA), published in November 2005, led to a reduction from 18 HSSTs to 5 new integrated HSCTs plus the Northern Ireland Ambulance Trust from 01 April 2007. This created Belfast Health and Social Care Trust (BHSCT), which incorporated North and West Belfast Health and Social Services Trust (NWBHSST) including MAH.⁹
- 13.9 The four HSSBs and the social service councils were replaced in April 2009 with a single HSCB, a new Public Health Agency (PHA) and a Patient and Client Council (PCC).¹⁰ The aim of these reforms was to integrate what was perceived to be fragmented care (with separate acute hospital and community-based HSSTs).¹¹ The DHSSPS was renamed the Department of Health (DoH) by the Departments Act (Northern Ireland) 2016.¹² In 2022 the Strategic Planning and Performance Group (SPPG) within the DoH replaced the HSCB, bringing commissioning and performance management back into the Government.¹³
- 13.10 The DHSSPS/DoH directed the HSCB, in consultation with the PHA, to publish an annual commissioning plan for health and social care services.¹⁴ Importantly for those living in MAH, funding is given for specific programmes of care and can only be used within that programme of care and not transferred to a different service. This meant that HSCTs could not move money from acute hospitals to learning disability services.¹⁵ The 2009 Act describes the necessary governance and

⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 57-58

⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 2867 (Exhibit MMcG-55) – A Partnership for Care- Northern Ireland Strategy for Nursing and Midwifery 2010-2015

¹⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 2867 (Exhibit MMcG-55) – A Partnership for Care- Northern Ireland Strategy for Nursing and Midwifery 2010-2015

¹¹ Andrew McCormick Transcript – 17/10/24 – Page 107 – Line 15-25

¹² June Champion Statement (Evidence Modules) – 10/03/23 – Page 3 (footnote 1) - From 08/05/16 the health department was renamed the Department of Health pursuant to the Departments Act (Northern Ireland) 2016 – <https://www.legislation.gov.uk/nia/2016/5/contents> and the Departments (2016 Act) (Commencement) Order (Northern Ireland) 2016 – <https://www.legislation.gov.uk/nisr/2016/89/made>

¹³ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 18

¹⁴ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 5989-5990 (Exhibit MMcG-152) – HSC Board member Handbook May 2021; Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 211-212 (Exhibit MMcG-6) – Health and Social Care (Reform) Act (Northern Ireland) 2009 The Commissioning Plan Direction (Northern Ireland) 2009

¹⁵ June Champion Statement (Evidence Modules) – 10/03/23 – Page 10

accountability arrangements to support the effective delivery of health and social care via a 'framework document'. The HSCB was responsible for commissioning services and performance managing each HSCT against agreed levels of service. It also monitored delegated functions through an annual report on how a trust had discharged its statutory functions.¹⁶

Role of HSCT Boards

- 13.11 The purpose of an HSCT Board is to set a vision and strategy and to establish efficient, effective and accountable governance of the organisation focused on outcomes.¹⁷ Each HSCT Board is required to have a Chair, seven non-executive directors (NEDs) and five executive directors.¹⁸
- 13.12 The voting directors in BHSCT are the Chief Executive, the Director of Finance, the Medical Director, the Director of Nursing and the Director of Social Work. The role of each of these executive directors is set out in the BHSCT Board Assurance Framework (BAF) each year, and they are accountable for maintaining professional standards and all regulatory issues pertaining to their area.¹⁹
- 13.13 The NED role is to set strategy, assess performance and assure that the governance structures are satisfactory, but not to become involved in operational issues.²⁰ All Board members share collective responsibility for decisions taken by the Board as a whole as part of a unitary Board²¹ and for effective governance.²² The 2021 Health and Social Care (HSC) Board Member Handbook warns against Board papers containing excessive detail that risk Board members focusing on operational issues rather than their primary responsibility for strategic and governance issues.²³ However, the Chair and NEDs have particular responsibility

¹⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 5992 and Page 5996 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

¹⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6025 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

¹⁸ Article 2 of the Health and Social Services Trusts (Establishment) (Amendment) Order (Northern Ireland) 2007 – <https://www.legislation.gov.uk/nisr/2007/269/made>

¹⁹ June Champion Statement (Evidence Modules) – 10/02/23 – Page 42

²⁰ June Champion Statement (Evidence Modules) – 10/02/23 – Page 42

²¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6030 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

²² Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6025 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

²³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6039 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

for holding the Chief Executive and executive directors to account for operational delivery of collective decisions.

- 13.14 According to BHSCT's BAF, the Medical Director is the lead director for integrated governance and risk management, including clinical governance, and is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management. This includes ensuring that the BHSCT Board receives the relevant information/annual reports required in the Board's information schedule. The Medical Director will ensure that the Chief Executive and the Board are kept apprised of progress and any changes in requirements, drawing their attention to gaps that may impact adversely on the Board's ability to fulfil its governance responsibilities. The Director of Performance Planning & Informatics and the Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.²⁴

Recruitment

- 13.15 The Chair and NEDs of each HSCT are appointed by the Northern Ireland Health Minister for set periods of time.²⁵ A NED may be reappointed for a second term by open competition. Prior to their reappointment, the DoH, together with the trust Chair, should review the Board's balance of skills and knowledge but it is unclear how this was done, and the Inquiry has not seen any policy or guidance on this.
- 13.16 The BHSCT has been subject to a number of independent reviews of its clinical services. It was fined for a breach of the Data Protection Act, there was a Regulation and Quality Improvement Authority (RQIA) investigation into overcrowding in the hospital emergency department linked to the death of two patients, there had been a dental service inquiry, and a review of Pseudomonas infection in the neonatal unit in relation to the deaths of a number of babies, leading

²⁴ June Champion Statement – 09/12/22 – Page 1590 (Exhibit T15.03) – BHSCT Board Assurance Framework 2013/14

²⁵ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 5990 (Exhibit MMcG-152) – HSC Board member Handbook May 2021; June Champion Statement (Evidence Modules) – 10/02/23 – Page 42; Regulation 3 of the Health and social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994 – https://www.legislation.gov.uk/nisr/1994/63/pdfs/nisr_19940063_en.pdf

the unit to be placed in special measures.²⁶ The Inquiry into Hyponatraemia-related Deaths was published in January 2018 and the Independent Neurology Inquiry was published in June 2022 (relating to practice prior to 2021).²⁷ Both were critical of both clinical services and also of the Board, making recommendations about education and duties of Board members. In 2018 BHSCT commissioned an internal review in relation to an audiologist that identified 45 incomplete patient records and missing key information, and in 2019 an audit of all the adults seen by the audiology team at weekend clinics was commissioned and submitted to the PHA. The Inquiry saw nothing in the Board minutes that indicated that a review of NED skills and knowledge had been undertaken after the Inquiry into Hyponatraemia-related Deaths was published, nor after the HSC Board Member Handbook was published in 2021. A review of the Board papers did not demonstrate increased challenge of executive directors by the NEDs after 2018, nor any evidence of a more sophisticated understanding of clinical governance as opposed to performance management.

- 13.17 The Chair and other NEDs are responsible for appointing the Chief Executive, subject to Ministerial approval. The Chair and Chief Executive are responsible for appointing the other executive directors, with the involvement of other NEDs.²⁸ All executive directors may be appointed substantively, without fixed terms.
- 13.18 There are no common standards or qualifications for Board members and no core training requirements (also noted in the Kark Review of the Fit and Proper Person Test in the NHS in England,²⁹ which made a number of recommendations), although the HSC Board Member Handbook (which was issued in 2021 in response to recommendations from the Inquiry into Hyponatraemia-related Deaths) recommends formal inductions and lists topics to be covered.³⁰ NEDs are usually appointed from outside health or social care backgrounds and are often more comfortable with finance than clinical and social governance. Given the

²⁶ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 3

²⁷ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 7

²⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6027 and Page 6047 (Exhibit MMcG-152) – HSC Board Member Handbook May 2021

²⁹ T. Kark and J. Russell (2018) A review of the Fit and Proper Person Test – <https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test>

³⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6220 (Exhibit MMcG-152) – HSC Board Member Handbook May 2021

nature of the data that HSCT Boards receive, a lack of knowledge or experience may mean that NEDs rely on reassurance from executive directors in relation to patient safety and therefore fail to robustly hold them to account.

- 13.19 Board members are required to have annual appraisals. The Minister (or as delegated) conducts the Chair's appraisal (with input from NEDs). The Chair conducts the appraisals of the NEDs and the Chief Executive.³¹ The Chief Executive conducts the appraisals of the executive directors. It is unclear how the performance of the Board as a whole (as opposed to the individual members) is evaluated, meaning individuals may receive positive appraisals despite significant failings in the organisation they lead. See Appendix 6 for summary findings of previous inquiries.

Assurance

- 13.20 Each HSCT Board is collectively accountable for ensuring that appropriate and effective assurance arrangements are in place. The Accounting Officer's appointment letter issued by the DHSSPS/DoH specifies that an annual Statement on Internal Control, covering issues prescribed by the Department, be submitted.³² These were used as the basis for accountability meetings with the DHSSPS/DoH Permanent Secretary, which were attended by the Department's Chief Professional Officers until 2014, after which they did not attend.³³ This change may have led to an absence of discussion of clinical and social care performance at accountability meetings and an overemphasis on finance and activity throughput.
- 13.21 The Good Governance Institute defines assurance as a 'positive declaration that a thing is true'.³⁴ For an individual to 'be assured' they must have confidence in the information they have been provided and not simply rely on the opinion of others. As an integrated trust operating across a number of sites, including six

³¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 5991 (Exhibit MMcG-152) – HSC Board Member Handbook May 2021

³² Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 1186-1187 (Exhibit MMcG-31) – Department of Health, Social Services and Public Safety; Framework Document September 2011

³³ Charlotte McArdle Transcript – 22/10/24 – Page 9 – Line 6

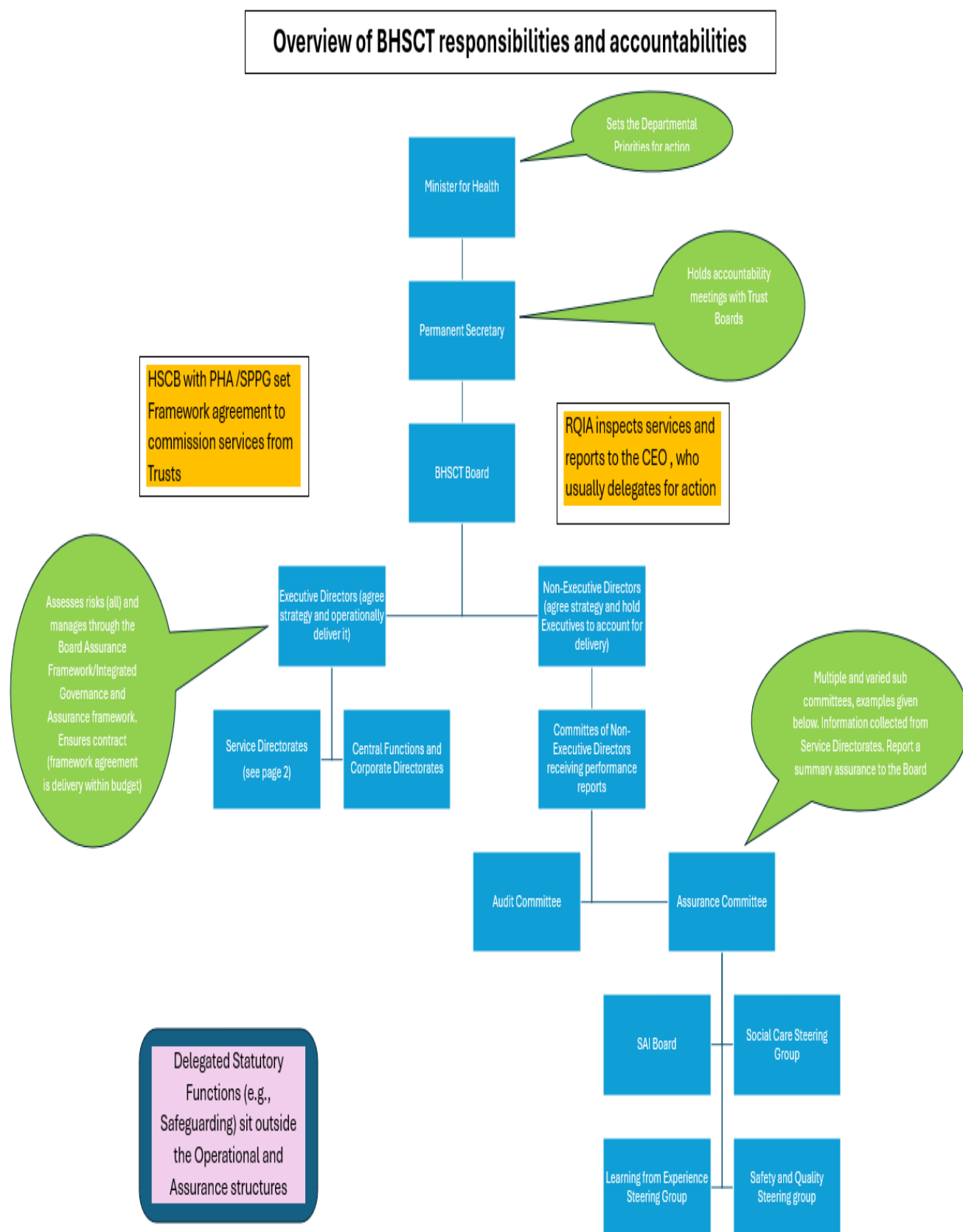
³⁴ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6055 (Exhibit MMcG-152) – HSC Board Member Handbook May 2021

acute hospitals, and four mental health and learning disability hospitals as well as community and social care services (including 11 children's homes),³⁵ BHSC's Board was unable to receive the sheer volume of all of the detailed assurance information from across the whole Trust, so it relied on delegated management through two parallel organisational structures: the directorate structure and the committee structure.³⁶ We need to look briefly at how those were organised and worked in order to understand how their work fed into the Board and the governance system (see also Figure 13.1).

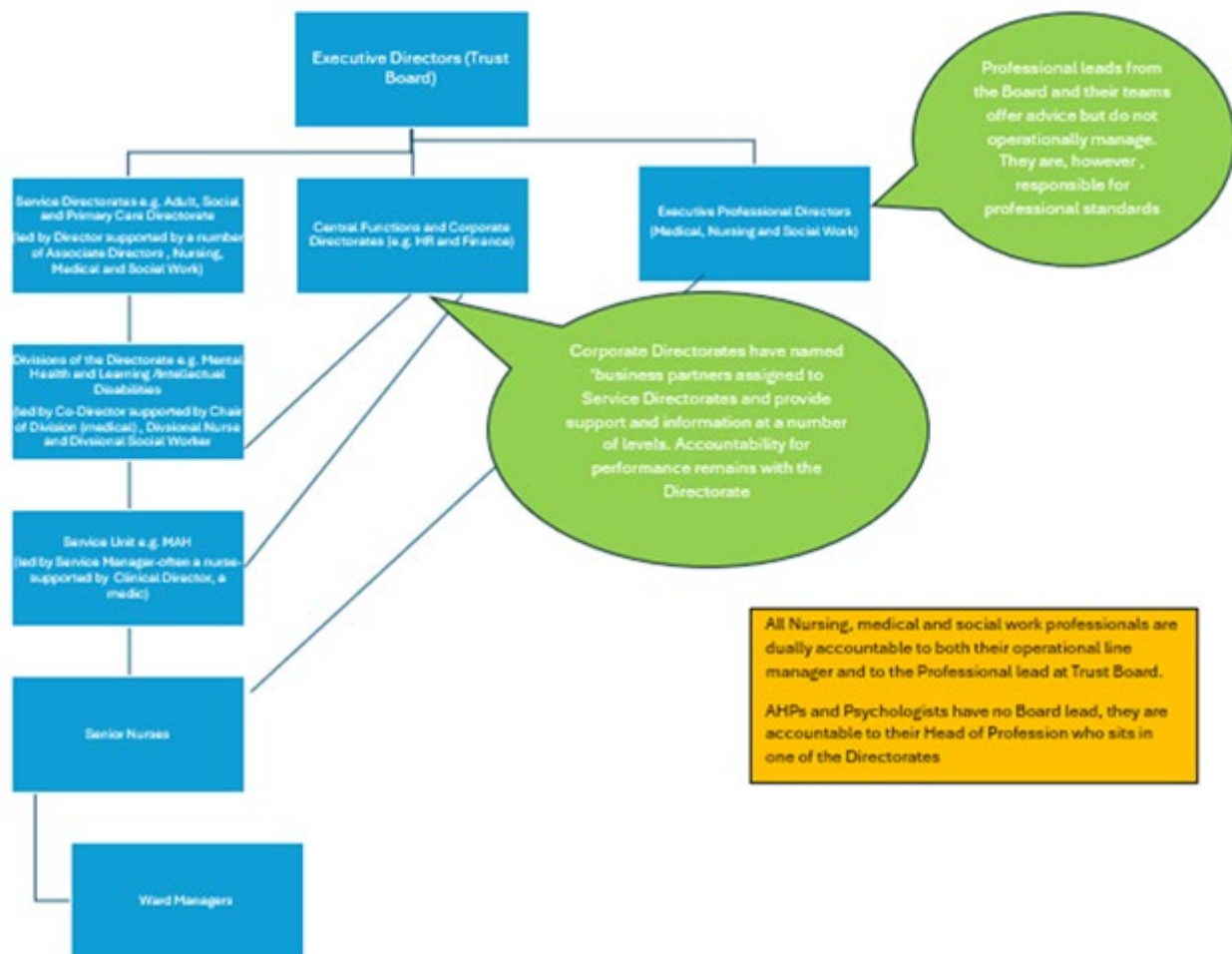
³⁵ June Champion Statement (Evidence Modules) – 10/03/23 – Pages 4-5

³⁶ June Champion Statement (Evidence Modules) – 10/03/23 – Page 40

Figure 13.1 – Overview of BHSCT Responsibilities and Accountabilities



Overview of BHSCCT responsibilities and accountabilities (continued)



Directorates

- 13.22 In 2007 BHSCCT was structured around service delivery groups, supported by central corporate functions including human resources, finance, planning, IT, information and performance management, redevelopment and estates, risk and governance, corporate nursing and medicine. It has evolved into a structure based around directorates, each overseen by a director who sits on the Executive Team. There are two types of directorate: corporate directorates and service directorates. Any directorate that has patient-facing services is a service directorate.³⁷ The directors of the service delivery groups/service directorates report to the Chief

³⁷ June Champion Statement (Evidence Modules) – 10/03/23 – Page 43

Executive and work alongside executive directors in the Executive Team.³⁸ They attend the Board in a non-voting capacity.

13.23 Service delivery groups/directorates have always been broken into smaller service areas, currently referred to as divisions. MAH was originally (from 2007) in the Adult Social and Primary Care Directorate but is currently in the Mental Health, Intellectual Disability and Psychological Services Directorate. Within the directorate MAH sits in the Intellectual Disability Services Division (alongside community learning disability services and children's learning disability services).³⁹ The division is led by a Co-Director (reporting to the Director) and divisional leads. The type and number of divisional leads vary but in the Intellectual Disability Services division they comprise a divisional nurse, a divisional social worker, a divisional psychologist and a divisional medical lead.⁴⁰

13.24 Each division may be broken down further into care delivery units led by service managers or lead nurses who oversee assistant service managers (previously referred to as senior nurse managers). MAH is a care delivery unit of the Intellectual Disability Services Division⁴¹ and one of 120 care delivery units across BHSC. ⁴² Thus, there are two intermediate layers (division and directorate) through which information flows between a care delivery unit such as MAH and the Trust Board although, if the director of the directorate thinks it necessary, they can escalate information directly to the HSCT Board.⁴³ Similarly, any information from the Board is cascaded through the directorate and division.

Committees

13.25 The BHSC Board has standing committees for audit and assurance, both chaired by NEDs. The Assurance Committee is chaired by the Chair of the Board.⁴⁴ Each standing committee has its own subcommittees, referred to as steering groups, which cover cross-directorate topics and provide the standing committee with an overview assurance. ⁴⁵ The standing committees then report aggregated high-

³⁸ June Champion Statement (Evidence Modules) – 10/03/23 – Page 42

³⁹ June Champion Statement (Evidence Modules) – 10/03/23 – Page 44

⁴⁰ June Champion Statement (Evidence Modules) – 10/03/23 – Page 44

⁴¹ June Champion Statement (Evidence Modules) – 10/03/23 – Page 46

⁴² Cathy Jack Statement (Organisational Modules) – 14/06/24 – Page 14

⁴³ June Champion Statement (Evidence Modules) – 10/03/23 – Page 62

⁴⁴ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 6

⁴⁵ Claire Cairns Statement (Organisational Modules) – 24/06/24 - Page 12

level performance to the Trust Board.⁴⁶ Information from service delivery units (such as MAH) is aggregated with other services through a number of committees that are expected to manage any issues as close to the unit as possible. It became apparent during the Inquiry that the system allowed only significant exceptions and concerns to reach the Trust Board but, as we shall see, even issues that most objective observers would have regarded as significant, or exceptional, were still not receiving Board attention.

- 13.26 Between 2007 and July 2023 all NEDs were members of the Assurance Committee, and it was chaired by the Chair of the Trust Board. The executive directors attended but were not members. Prior to 2013, the Assurance Committee met three times a year but following recommendations from an internal audit report, it has since met quarterly.⁴⁷
- 13.27 In 2023, membership of the Assurance Committee was slimmed down. The Chair is now a NED (not the Chair of the Board) and there are three NED members rather than all NEDs. The entire executive team continues to attend along with the Co-Director of Risk and Governance.⁴⁸ It is unclear why the decision to reduce NED oversight was taken.
- 13.28 The Assurance Committee is structured around the Board Assurance Framework (BAF), first developed in 2007.⁴⁹ The BAF is the responsibility of the Medical Director, supported by corporate risk and governance teams who produce reports of the volume and trends in relation to incidents, serious adverse incidents (SAIs), complaints, claims and coroner's cases.⁵⁰ This does not include safeguarding incidents and trends, which are reported by the Executive Director of Social Work via the Social Care Committee (established as an independent standing committee of the Board in 2016).⁵¹ The corporate risk and governance teams do not examine individual cases as this is the responsibility of directorate risk and

⁴⁶ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 18

⁴⁷ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 14

⁴⁸ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 14

⁴⁹ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 6

⁵⁰ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 33-34

⁵¹ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 34-35

governance arrangements.⁵² Since 2022, quarterly whistleblowing reports have also been collated.⁵³ The Social Care Committee (which previously sat outside the BAF) was made a steering group of the Assurance Committee in 2022.⁵⁴

13.29 The Assurance Committee has several steering groups. The External Reports Review Group (ERRG) monitors RQIA thematic reviews and progress against the associated quality improvement plans (but not the unit inspections or mental health and learning disability (MHLD) reviews, although if the RQIA has serious concerns about an individual service, it notifies the Chief Executive directly).⁵⁵ The ERRG receives a summary update on all RQIA regulated provider inspections from the director for MHLD.⁵⁶ The ToR for the ERRG were revised in 2016 to include other external reviews as identified by directors, for example professional college reviews.⁵⁷

13.30 Another steering group is the Governance Steering Group, the purpose of which was described in its 2010 ToR as ‘to provide assurance to the Assurance Group around the health and social care and risk management frameworks’ and to review the principal risks.⁵⁸ Its ToR appeared to focus on whether processes were in place to record and assess risks, but not how effectively risks were managed and mitigated. This reflects a widespread approach in UK healthcare (including regulators such as the RQIA in Northern Ireland and Care Quality Commission (CQC) in England) to measuring process rather than outcomes. The measurement of outcomes is, perhaps obviously, a necessity for good governance.

13.31 BHSCCT introduced safety and quality visits (SQVs) by senior managers in 2014, but NEDs did not join these until around 2018, and NED exposure to the challenges at MAH was limited before 2017.⁵⁹

⁵² Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 15

⁵³ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 16

⁵⁴ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 34-35

⁵⁵ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 39-40

⁵⁶ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 12-13

⁵⁷ Claire Cairns Statement (Organisational Modules) – 24/03/24 – Page 38

⁵⁸ June Champion Statement (Evidence Modules) – 10/03/23 – Page 1718 (Exhibit T19.05) - Governance Steering Group Terms of Reference

⁵⁹ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 33

Risk management

- 13.32 Individual directorates conduct a triannual self-assessment of their processes using the Belfast Risk Audit Assessment Tool (BRAAT).⁶⁰ Risks are recorded on risk registers, commencing with the service delivery unit register. Unmanaged risks are escalated to the divisional register and may be considered for the directorate risk register. The directorate risk register feeds into the corporate risk register. If a risk is considered a threat to meeting the trust's objectives, the Assurance Committee considers including it as a principal risk on the Board Assurance Framework (BAF) document.⁶¹ BHSCT's BAF shows that the Medical Director is the lead director for the strategic design of this system. While the Medical Director is not responsible for the day-to-day operational implementation of the system, they must make sure that it ensures that there are systems in place to monitor and review risks that are delegated.⁶²
- 13.33 As risks progress up the ladder, they are considered against the corporate objectives and so risks rated as 'red' at a care delivery unit may have a lower score if the risk to the wider service is less significant. This means that risks to specific service delivery units may not feature on the highest-level corporate or principal risk registers. The criteria for inclusion as a corporate risk are either that the consequence would be catastrophic and the likelihood of it happening is high, or the risk has ramifications beyond the immediate area and cannot be satisfactorily managed locally, or the risk requires escalation to another health and social care body due to its significance or the need for commissioner involvement.⁶³ One of the dangers of this approach was that data being presented to the Board, such as incidents recorded on Datix and complaints, were aggregated to provide a Trust-wide figure; this meant any variation at local unit level was smoothed out and the Board was unaware of the local picture.

⁶⁰ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 6-7

⁶¹ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 18

⁶² June Champion Statement – 10/03/23 – Page 39

⁶³ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Pages 21-22

- 13.34 Independent assurance of the mitigation of risks contained on the BAF is provided through the internal audit programme. However, there appears to have been no independent assurance of the mitigation of risks on the lower-tier risk registers, such as peer audits or benchmarking clubs.⁶⁴ There is a danger that lower-tier risk registers report processes put in place as mitigating the risks without measuring the outcome and therefore unmitigated risks are not escalated to the Board. It also means that the effectiveness of the mitigation was never measured and so there is every possibility the outcomes remained poor.
- 13.35 Internal audits are commissioned by the Audit Committee. In 2017-2018 an internal audit of complaints management within the Adult Social and Primary Care Directorate (in which MAH sat) provided only limited assurance⁶⁵ (defined as: ‘significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to system objectives not being achieved’) but assurance relating to incidents and patient supervision was reported to be satisfactory (defined as: ‘there may be some residual risk identified, this should not significantly impact on the achievement of system objectives’).
- 13.36 The Audit Committee Chair, who was appointed to the Board of BHSCT in April 2016, told the Inquiry that his understanding was that the committee was established and constituted to provide the Trust Board with an independent and objective review of its financial systems and internal control arrangements.⁶⁶ The committee met four times a year and comprised four NEDs. He told the Inquiry that the committee was reassured that:
- ‘Muckamore Abbey Hospital was subject to on-going service review and that all recommendations made by Internal Audit would be addressed in due course’.*⁶⁷
- 13.37 He went onto explain that the Audit Committee would only follow up limited assurance findings.⁶⁸ The Audit Committee did not receive RQIA reports, trends

⁶⁴ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 7; NHS Benchmarking Network – <https://www.nhsbenchmarking.nhs.uk/>

⁶⁵ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 55 (Tab 6) - BHSCT Adult Social and Primary Care Services Directorate Risk audit – Management of Complaints and Incidents at Muckamore 2017/18

⁶⁶ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 3

⁶⁷ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 5

⁶⁸ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 6

from incident reporting or complaints, and there is no evidence that the Audit Committee considered all the risks at MAH collectively (as opposed to individually) and so did not have a comprehensive view of the hospital as an integrated system.⁶⁹ There was therefore a real risk that significant issues ‘fell between two stools’.

Board awareness of and reaction to risks and incidents at MAH

- 13.38 In the early years of BHSCT, MAH featured a number of times on the principal risk register. In October 2010 ‘risk to the quality of outcomes for patients at MAH due to discharge being delayed and resettlement ceasing. Risk to reputation of Organisation’ was noted on the register, together with inadequate funding for resettlement.⁷⁰
- 13.39 A draft trust incident report tabled at the Governance Steering Group meeting in May 2011 revealed that by far the largest volume of incidents reported across BHSCT between April 2010 and December 2010 was from the Social and Primary Care Services Directorate, with violence, abuse, disruptive behaviour and self-harm by far the biggest category. The largest code was recorded as abuse of staff by patients, followed by patient-on-patient abuse. The minutes of the meeting record no discussion about this data nor any discussion of conditions that might lead to this or action that might be taken to reduce the incidence of abuse.⁷¹ In September 2011, the then Medical Director advised that the principal risk document (which included ‘Management of aggression and Violence - Possible harm to staff, patients/clients should physical intervention be necessary. Ongoing physical and verbal violence against staff and their property’) would be taken to the Executive Team ahead of the Assurance Committee.⁷² It is unclear what, if any, action was taken to address the high rate of violence.
- 13.40 The Governance Steering Group noted that ‘abuse, violence, disruptive and self-harming behaviour’ continued to be the most frequent category in incident

⁶⁹ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 7

⁷⁰ MAHI – Extracts of BHSCT Risk Registers – 17

⁷¹ MAHI – Additional Materials Referenced – Page 161 (Governance Steering Group Meeting Papers – 03/05/11); MAHI – Additional Materials Referenced – Page 157 (Governance Steering Group Meeting Minutes – 03/05/11)

⁷² MAHI – Additional Materials Referenced – Page 175 (Governance Steering Group Meeting Minutes – 09/09/11)

reporting between 2010 and 2011. In January 2013, the Medical Director queried whether incidents such as abuse of a patient by another patient should be reported to the Assurance Committee but was advised that they would not.⁷³ While these figures related to the directorate as a whole, the implications for MAH, with its highly vulnerable patients, should have been clear. The failure to escalate this issue, and importantly, to take action to mitigate the risk, resulted in real risk to patients and particularly those at MAH who were of course highly vulnerable and at very high risk, which should have been recognised.

13.41 On 14 November 2014, 'Risk of abuse and injury to medically fit for discharge inpatients by acutely unwell inpatients' was noted on the risk register, with a proposed action to notify the HSCB about the lack of funding for resettlement and the consequence of delayed discharges leading to the use of special observations to minimise the targeting of vulnerable patients by their peers.⁷⁴ The risk was described as 'moderate', but with mitigations, such as adherence with policies, appropriate training and incident reporting and management, the risk of recurrence was re-graded as 'low'. The risk was reviewed and removed from the corporate risk register on 04 March 2015.⁷⁵ However, on 03 February 2015, a new risk was added, 'Risk of harm to vulnerable adults in MAH, a shared care setting which inherently can complicate the ability to maximise protection plans for all patients'.⁷⁶ This was not mentioned in the Board minutes in 2015. The evidence from incident data shows peer-on-peer abuse was frequent and sometimes serious. The programme of ward closures meant that patients were increasingly likely to be sharing settings with patients who had very different needs, the dangers of which are discussed elsewhere in this report. This should have led to a high-risk score and therefore been included in the BAF.

13.42 At the 10 November 2014 Assurance Committee meeting, the Medical Director reported a 1% year-on-year increase in reported incidents, but the Director of Adult Social and Primary Care Directorate noted the high number of incidents in her

⁷³ MAHI – Additional Materials Referenced – Page 180 (Governance Steering Group Meeting Minutes – 08/01/13)

⁷⁴ MAHI - Extracts of BHSCT Risk registers - Page 221

⁷⁵ MAHI - Extracts of BHSCT Risk registers - Page 221

⁷⁶ MAHI - Extracts of BHSCT Risk registers - Page 228

directorate, which she felt reflected the vulnerable nature of these patients.⁷⁷ However, there is no record of discussion about enhanced measures required for vulnerable patients. At the 05 May 2015 Assurance Committee meeting, members noted that the category with the highest number of incidents reported was abusive or self-harming behaviours in the Adult Social and Primary Care Directorate (which included MAH). Dr Cathy Jack (BHSCT Medical Director from 2014 to 2020) explained that the report indicated an 'increasingly open culture' (even though there had been a reduction in total incidents reported across the Trust compared with the previous year). There was no evidence in the Assurance Committee minutes that members discussed mitigation for the abusive and self-harming behaviours.⁷⁸

- 13.43 The Board was aware of the problems with the reconfiguration of learning disability services and the impact that was having on MAH. In April 2015 the trade union UNISON gave a presentation to the Board regarding its concerns about cuts to MHLD funding.⁷⁹ They did this again in September 2017.⁸⁰ In June 2016 there was an extraordinary Board meeting regarding the consultation on changes to MHLD day services 2,048 responses had been received regarding the learning disability proposal with 87% opposing the plans.⁸¹ The Trust Board discussed MAH performance targets and finance For example, in February 2017 it was noted that learning disability discharge targets were not met and funding for MHLD services did not meet demand, but the impact on residents at MAH is not recorded in the minutes as being mentioned.⁸² There appears to have been a lack of appreciation or connection being made in relation to the impact of these issues on patients.
- 13.44 Failure to recognise peer-on-peer abuse as a red flag, indicating an unmanaged environment and a heightened risk for vulnerable patients, was a constant theme up until, and after, the discovery of the 2017 CCTV footage. Had action been

⁷⁷ MAHI – Additional Materials Referenced – Page 132 (Assurance Committee meeting minutes 01/11/14)

⁷⁸ MAHI – Additional Materials Referenced – Page 144 (Assurance Committee meeting - 05/05/2015)

⁷⁹ MAHI – Additional Materials Referenced – Page 12 (BHSCT Board Public Meeting Minutes – 02/04/15)

⁸⁰ MAHI – Additional Materials Referenced – Page 28 (BHSCT Board Public Meeting Minutes – 07/09/17)

⁸¹ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 411 (Exhibit T16.03) – Extraordinary Trust Board Meeting Minutes 21 June 2016

⁸² MAHI – Additional Materials Referenced – Page 21 (BHSCT Board Public Meeting Minutes – 02/02/17)

taken in 2010 when risks started to be identified, the events on Ennis Ward in 2012 and Cranfield in 2017 may have been avoided.

- 13.45 Board members clearly were aware of the number of alleged incidents of abuse and therefore the heightened risk of abuse or, at the least, poor practice, from November 2017, but did not consider them to meet the definition of a principal risk (that is, the consequence would be catastrophic and the likelihood of it happening was high, or the risk cannot be satisfactorily managed locally) until 13 months later, when in January 2019 a new principal risk of 'Ongoing risk of harm to vulnerable patients in MAH especially in regard to historical incidents' was noted.⁸³ Had it been identified as a principal risk in November 2017, the Board would have had to pay more attention to contemporaneous data reflecting what was happening on the wards. As described in para 13.14, the responsibility for the development of effective integrated governance arrangements, including risk management, lay with the then Medical Director. She had a duty to ensure that the Chief Executive and the Trust Board were kept informed and draw to their attention to the risks highlighted by the rate of Datix reporting and safeguarding referrals made by staff at MAH from 2011 onwards.
- 13.46 Much has been made of the safeguarding investigation into claims of abuse on Ennis Ward in 2012. As a single joint protocol safeguarding investigation, which failed to reach any substantive conclusions, it was managed through the joint protocol strategy meetings and divisional management meetings (see Chapter 11 (Safeguarding)). While in hindsight it was agreed that an SAI should have been declared (although what level of SAI is not noted), the comprehensive safeguarding report and action plan, together with the subsequent disciplinary investigation, mean it is unlikely that an SAI would have added to the findings. As there was insufficient evidence to discipline any staff, or to support the confirmation of institutional abuse, the safeguarding investigation alone would not have warranted an entry on the principal risk register or presentation at the Trust Board. However, there is clear evidence that the Board was aware of the allegations and the investigation. The investigating officer who conducted the investigation was

⁸³ MAHI – Extracts of BHSCT Risk Registers – 169

reporting through her professional line to the Executive Director of Social Work (a voting member of the Board). There is evidence that the Chief Executive, the Director of Nursing, the Medical Director, the Director of Adult Social and Primary Care and the Co-Director of Risk and Governance were aware of the investigation. The Trust Board was informed at its 11 April 2013 meeting that the Police Service of Northern Ireland (PSNI) had investigated two staff at MAH regarding alleged abuse of patients and was awaiting a Public Prosecution Service (PPS) decision. At this meeting the Director of Adult Social and Primary Care advised NEDs that the Trust had safeguarding policies and procedures in place.⁸⁴ None of the executive directors or NEDs asked for further action (including the sight of the safeguarding report once completed or consideration of safeguarding at MAH as a principal risk).

- 13.47 The missed opportunity was not the failure to present this isolated safeguarding investigation to the Board, but a failure to collate the information on all 565 safeguarding referrals at MAH during 2012 (including peer-on-peer abuse),⁸⁵ or to monitor closely and interrogate trends over the subsequent years that might have added substance to the remaining concerns about potential institutional abuse of one (but not all) the social workers who reviewed the claims. See Chapter 9 (Previous Concerns, Previous Investigations and Warning Signs) for more details.
- 13.48 The focus on individual incidents in isolation and failure to aggregate available data to identify patterns (which the Trust has been able to demonstrate retrospectively from its Datix data)⁸⁶ meant that no concerns about MAH were raised with the Assurance Committee prior to 2017, despite staff appropriately reporting them.⁸⁷ This was a significant failure of good governance.

Response to 2017 allegations

- 13.49 The Board delegated management and governance and appears to have believed that its role was simply to put processes in place, but not necessarily to ensure

⁸⁴ Colm Donaghy Statement (Organisational Modules) – 14/06/24 – Page 41 (Exhibit Tab 3) BHSCT Board Confidential Meeting Minutes – 11/04/13

⁸⁵ Brenda Creaney Statement (Evidence Modules) – 22/02/24 – Page 7

⁸⁶ Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 5490 (Exhibit CH1 Tab05.06) – MAH Overview Charts 2009-2022

⁸⁷ Claire Cairns Statement (Organisational Modules) – 24/06/24 – Page 14

that these delivered the required outcomes. Following notification to the Board in November 2017 of the index incident that triggered the review of CCTV,⁸⁸ oversight of MAH by the divisional management team was superseded by the Muckamore Abbey Hospital Directors Oversight Senior Co-Ordination Group (also known variously as MAH Directors Oversight Meeting and the Directors Oversight Senior Coordination Group). This was a director-led group that met on a weekly basis between 27 November 2017 and 01 October 2019 and focused on management of the hospital, while investigating the CCTV footage revelations was overseen by the joint protocol multi-agency meetings (also known as strategy meetings).⁸⁹ Despite this, the extent of the alleged abuse was not really recognised by the Board until September 2019.

13.50 The BHSCT Board commissioned or received six external reports regarding MAH after 2017.⁹⁰ This included one from an independent assurance team that reported in September 2018, an SAI Level 3 review which reported in November 2019, a peer review by the East London NHS Foundation Trust which reported in August 2019,⁹¹ a review of leadership and governance at MAH which reported in July 2020, an independent review of the Learning Disability Resettlement Programme in Northern Ireland in 2022,⁹² and a review of safeguarding files in 2022.⁹³ See Appendix 5 for a summary of the governance findings of each.

13.51 The Executive Director of Nursing established the Independent Assurance Team in December 2017, and it provided a report in September 2018.⁹⁴ This identified a number of problems, including the lack of a consistent approach to managing staff identified in incidents on CCTV, and recommended that decisions about patient protection plans and staff management should be fully documented, with the proactive engagement of the Human Resources department. It also noted that

⁸⁸ MAHI – Additional Materials Referenced – Page 90 (BHSCT Board Confidential Meeting Minutes – 02/11/17)

⁸⁹ June Champion Statement (Evidence Modules) – 10/03/23 – Pages 62-63

⁹⁰ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Pages 43-44

⁹¹ Cathy Jack Statement (Organisational Modules) – 14/06/24 (Exhibit CJ1 Tab 12) – Page 309 – East London NHS Foundation Trust Report, 'Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust', August 2019

⁹² B. Mongan and I. Sutherland (2022) Independent Review of the Learning Disability Resettlement Programme in Northern Ireland – <https://www.northernireland.gov.uk/sites/default/files/publications/health/doh-ind-review-ld-resttlement-july-2022.PDF>

⁹³ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 47 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review September 2021

⁹⁴ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 44

policies were out of date and not based on current best evidence. The team found confusion over the required number of staff on wards and that all wards had vacancies, leading to high use of bank staff shifts without sufficient staff.⁹⁵ It is not clear where within the assurance structure this report was presented, or what actions were taken, The BHSCT Chief Executive, in his statement to the Inquiry, said:

*'It is important that I acknowledge that in preparing to provide this statement and give evidence to the MAH Inquiry it has become evident to me, as it has to other relevant personnel in the Belfast Trust, that for the post August 2017 period it is not always possible, or, where it is possible, not always entirely straightforward, to follow a neat line between a particular recommendation from a review or report, and its subsequent implementation within the Belfast Trust'.*⁹⁶

Failure to track recommendations from different reviews to ensure they were actioned and producing the desired results is a running theme that demonstrates the gap in the Trust's assurance structures. It is simple to create a spreadsheet that lists all the actions required and cross-reference the different reviews that make the same recommendation. Failure to do so risks some recommendations being overlooked as new reports arrive. The commissioning of reports and then not monitoring whether the recommendations were implemented echoes the wider theme of BHSCT's focus on process rather than outcome.

- 13.52 Following three RQIA Improvement Notices issued in relation to MAH in August 2019, BHSCT's MAH Directors Oversight Senior Co-Ordination Group was replaced by the Intellectual Disability Oversight Group between 23 October 2019 and 12 August 2020. Both were responsible for ensuring that the four concurrent management activities (inpatient services, community services, the review of historic CCTV safeguarding concerns and abuse-related disciplinary hearings) were coordinated.⁹⁷

⁹⁵ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 24 (Exhibit 2) – Final Report of Independent Assurance Team Muckamore Abbey Hospital 19 September 2018

⁹⁶ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Pages 55-56

⁹⁷ Marie Heaney Statement (Organisational Modules) – Page 145 (Exhibit Tab 13) – Director Operational Meeting Learning Disability Terms of Reference

- 13.53 The publication of the leadership and governance review in 2020 created another change,⁹⁸ with the MAH Leadership & Governance Review Meeting replacing the Intellectual Disability Oversight Group between 19 August 2020 and 24 January 2022 to focus on key issues raised in the report. The numerous changes in management and leadership at MAH since 2017 suggest that there were concerns that each previous arrangement had failed to get a grip on the situation.
- 13.54 Ongoing reviews of MAH after 2017 suggest that there had been a focus on processes but not outcomes. For example, the Board received an internal report titled ‘What is different now?’ in April 2021, which summarised the changes since 2017, although it did not contain any data on positive patient experience or outcomes.⁹⁹ This focus on process as opposed to patient experience or outcomes data demonstrates a somewhat blinkered faith in processes being effective.
- 13.55 Concerns about care at MAH persisted and on 06 December 2021 Richard Pengelly (then DoH Permanent Secretary) wrote to BHSCT’s Chief Executive expressing his:

*‘... growing concern about the high level of risk associated with the ongoing operation of Muckamore Abbey Hospital. This coupled with the failure to develop a robust and workable regional contingency plan, should Muckamore no longer be considered a safe environment for patient care, means that I am not satisfied that, in my role as Chief Executive of the HSC I can provide the Minister with the necessary assurance he needs over the operation of the hospital’.*¹⁰⁰

A 2022 independent review of safeguarding files at MAH noted that:

*‘... the actual and/or potential harm caused to patients was often difficult to determine as file recording and report writing was problematic, and the impact on the patient was often not well articulated [and] a significant number of incidents were linked to a small number of patients but there was a lack of evidence that these were being considered in the round and seemed to be largely dealt with as entirely separate incidents’.*¹⁰¹

- 13.56 It appears that five years after the initial CCTV footage, BHSCT still had poor assurance of the safety of the patients. While the Board received reassurances

⁹⁸ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

⁹⁹ Cathy Jack Statement (Organisational Modules) – 14/06/24 – Page 57

¹⁰⁰ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 101

¹⁰¹ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 47 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review September 2021

from directors, they rarely provided evidence to support this. Effective governance requires consideration of structural components (budget, environment, staffing and expertise available, and governance structures), process components (policies, action plans and outcomes elements), and outcomes (patient wellbeing, patient harm and safeguarding incidents)¹⁰². When the Board did consider some evidence, it was almost exclusively the process elements, with little attention paid to either the structural elements or the outcomes that their plans achieved. Perfect, or absolute, assurance is not possible, but reasonable assurance requires testing of a range of data. The HSC Board Member Handbook (produced in response to a recommendation from the 2018 Inquiry into Hyponatraemia-related Deaths) states:

*‘Effective scrutiny does not mistake reassurance for assurance (particularly in relation to service quality and patient safety) but is demonstrated through robust and constructive challenge from all Board Members (Executive and Non-Executive)’.*¹⁰³

- 13.57 Despite early knowledge of the allegation and the CCTV footage in September and October 2017, the Board did not acknowledge the scale of the issues until after the Level 3 SAI reported. The independent assurance report in 2018¹⁰⁴ and the SAI Level 3 report in 2019 raised concerns about governance, notably poor and variable record-keeping, and the RQIA (also in 2019) issued three Improvement Notices for MAH (including for safeguarding), and yet in 2021 the Permanent Secretary for Health was advising that he could not assure the Minister that the hospital was safe. Even following the 2017 revelations the Trust governance system lacked effectiveness as did BHSCT’s response to the unfolding disaster.

Reassurance without data

- 13.58 The Board discussed the CCTV footage at MAH, starting on 02 November 2017, and a significant number of the Executive Team were immediately involved operationally. However, the BHSCT Board was receiving frequent reassurance

¹⁰² H. Ibn El Haj, M. Lamrini and N. Rais (2013) Quality of care between Donabedian model and ISO9001V2008, International Journal for Quality Research, 7(1), pp. 17-30 – <https://www.ijqr.net/journal/v7-n1/2.pdf>

¹⁰³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6051 (Exhibit MMcG-152) – HSC Board member Handbook May 2021

¹⁰⁴ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 24 (Exhibit 2) – Final Report of the Independent Assurance Team (September 2018)

rather than data to the point of wilful blindness. Information was available to the Board from 2011 that the resettlement programme was faltering and yet the reconfiguration of the hospital continued, based on a substantially reduced population. This created a situation where there were not enough staff, and not enough specialist skills, and patients with very different needs were housed together inappropriately. The incident reporting trends (Datix) from 2012 onward show a sharp increase in violence, both peer-on-peer and patient-on-staff and there were a number of arrests of staff reported to the Board in this period. The new service manager was raising concerns with the Director of Nursing and the RQIA was raising concerns with the Trust. However, the Board appears to have accepted this data as 'normal for learning disabilities' rather than challenging whether the service could and should have been provided in a different way and whether indeed this was 'normal for learning disabilities'.

- 13.59 As previously noted in Chapter 11, on 02 November 2017 the Chief Executive told the Board he had provided assurance to the Permanent Secretary that the Trust was taking all the actions necessary to safeguard patients.¹⁰⁵ While it is true that the scale of the historic CCTV evidence was not yet fully clear, his focus should have been on the current patients, whether or not they were subject to protection plans based on historic incidents. The Board did not consider the structural problems that were in play, even though the Director of Nursing told the Inquiry that the Royal College of Nursing (RCN) was raising concerns with her about staffing and about how the investigation was being managed.¹⁰⁶ She said that she had worked closely with the RCN as well as the unions around the management of the staffing issue.
- 13.60 On 11 January 2018, the Director of Adult Social and Primary Care assured the Board that arrangements were being made to ensure viewing of all the CCTV footage and that the executive directors were assured of the safety and quality of care for all patients currently in MAH, although no data was provided to justify this.¹⁰⁷ The Chair stated that in order for the Board to be fully assured, two NEDs

¹⁰⁵ MAHI – Additional Materials Referenced – Page 90 (BHSCT Board confidential meeting minutes – 02/11/17)

¹⁰⁶ Brenda Creaney Transcript – 14/10/24 – Page 24 – Line 5

¹⁰⁷ MAHI – Additional Materials Referenced – Page 92 (BHSCT Board confidential meeting minutes – 11/01/18)

would visit MAH, although this meeting minute does not describe the information they would receive prior to the visit or what they would be examining in order to provide the 'appropriate triangulation' stated in the minutes. The Panel notes that the minutes record a further update would be provided at the next meeting and the Medical Director suggested further detail in relation to the action be provided.

- 13.61 On 03 May 2018, while noting the Inquiry into Hyponatraemia-related Deaths report (which particularly highlighted deficiencies in the systems for reporting, analysing and learning from incidents) the Board concluded that it was assured appropriate processes were in place for patient safety at Royal Belfast Hospital for Sick Children.¹⁰⁸ However, there is no evidence that the Board discussed whether the same governance deficiencies existed in other services, in particular in high-risk areas such as MAH.
- 13.62 On 05 July 2018 one NED reported that she was assured appropriate action was being taken at MAH and another NED praised the strong leadership dealing with the issues.¹⁰⁹
- 13.63 Even after a draft version of the SAI Level 3 'A Way to Go' report (later published in November 2018) had been received, the Director of the Mental Health, Intellectual Disability and Psychological Services Directorate emphasised that there were currently no concerns about any patient at MAH and the Chair thanked the Directors Oversight Group for their leadership in ensuring effective action had been taken.¹¹⁰
- 13.64 On 04 October 2018 the Director of the Mental Health, Intellectual Disability and Psychological Services Directorate reported that CCTV viewing continued and no further safeguarding incidents had been identified. The CEO assured the Board that there were no concerns about patient safety at MAH, although this appears to have been based on the absence of data about harm rather than data that demonstrated safe staffing levels and safe practice. Members were advised that

¹⁰⁸ MAHI – Additional Materials Referenced – Page 37 (BHSCT Board public meeting minutes – 03/05/18)

¹⁰⁹ MAHI – Additional Materials Referenced – Page 46 (BHSCT Board public meeting minutes – 05/07/18)

¹¹⁰ MAHI – Additional Materials Referenced – Page 95 (BHSCT Board confidential meeting minutes – 06/09/18)

34 newly recruited staff were being phased into the wards, but they were not told how many vacancies remained unfilled, or whether this led to a reduction in agency use, so it is difficult to determine how much increase in direct patient care this provided. The Board again commended the strong leadership in addressing safeguarding and patient safety.¹¹¹ Despite the reassurances given, incidents and new safeguarding referrals outside PSNI's Operation Turnstone (relating to the 2017 CCTV revelations) continued throughout 2018. The staffing position became less stable and there was an increase in the use of agency staff without specialist learning disability training, but the Board did not discuss any of the conditions that might have given rise to the alleged abuse. The detriment to patients of using agency staff with no learning disability training does not appear to have been prominent in the Board's considerations.

13.65 In December 2018 a local politician addressed the public Board meeting, raising concerns about safeguarding incidents at MAH and the need to provide support not only to families of the patients involved but also to families of other patients in MAH who required assurances.¹¹² We discussed this further in Chapter 11.

13.66 The RQIA undertook an unannounced inspection on 26-28 February 2019, assessing the care and treatment provided to patients currently in MAH.

13.67 The RQIA reported:

'There was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. We evidenced insufficient staffing at ward level on each day of the three day inspection visit. Staff of all grades throughout the hospital site informed us there was insufficient staffing at ward level. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff'.¹¹³

The RQIA further reported:

'We determined that staff morale was low and has been particularly impacted by events at MAH over the last 18 months. We highlighted that the impact of

¹¹¹ MAHI – Additional Materials Referenced – Page 60 (BHSCT Board public meeting minutes – 04/10/18)

¹¹² MAHI – Additional Materials Referenced – 98 Page (BHSCT Board confidential meeting minutes – 06/12/18)

¹¹³ RQIA - Unannounced Inspection Report – 26, 27 & 28/02/19

psychological trauma experienced by staff was significant. We highlighted that the insufficient staffing at ward level had the potential to impact on patient safety and the safety of staff that are at risk from the challenging behaviour of patients who present as unwell. We noted from the minutes of a recent MAH live governance meeting that high levels of adverse incidents involving staff injuries in Ardmore and Cranfield One had been discussed. We noted that almost all wards were in a cycle of continuous crisis management which was impacting on the quality, safety and effectiveness of care delivered. We highlighted our concerns regarding the large number of vacancies that exist and which greatly exceed the number of additional staff recently recruited or in the process of being recruited. BHSC Senior Management informed us of an on-going recruitment campaign for nurse staffing. A day care coordinator had recently been appointed to support all wards and day care staff are now in-reaching to wards. Ward managers confirmed that this has been introduced as a measure to reduce the risk associated with staff having to leave a ward to support a patient attending MAH's day care facility. We highlighted that staff currently in the hospital (both front-line and managerial) have displayed enormous resilience, they are to be commended for their dedicated service to the patients in MAH, however they now require additional support and resources in order to continue to provide safe care. An area for improvement in relation to staffing has been made'.

13.68 Following this inspection the Board was informed at its meeting on 07 March 2019 that the RQIA had written asking for a meeting to discuss its intention to serve Improvement Notices in relation to MAH. The Board was also told that the RQIA had submitted an 'Article 4 letter' that is, under the Article 4(2) requirement of the 2003 Order for RQIA to raise particular concerns with the DoH. That letter had raised serious issues, expressing concerns about staffing, patients' physical health, safeguarding, financial governance, seclusion, hospital governance and discharge planning. Despite the serious implications of this letter, the Director of Nursing queried the RQIA's data and reassured the Board that wards were safely staffed. The director responsible for operations at MAH reassured the Board that current patient care at MAH was safe.¹¹⁴ As Accountable Officer for the statutory duty of quality, the CEO did not challenge either director for supporting data to refute the RQIA concerns.

13.69 This was followed by an RQIA unannounced inspection of MAH on 15 and 16 April 2019, which found limited progress in relation to safeguarding arrangements, and the RQIA remained concerned about the implementation of learning arising from

¹¹⁴ MAHI – Additional Materials Referenced – Page 109 (BHSC Board confidential meeting minutes – 07/03/19)

safeguarding investigations and about the evidence that outcomes from safeguarding investigations were positively impacting patient wellbeing.¹¹⁵

13.70 In May 2019, the Board was briefed about an incident that resulted in a number of staff injuries after a patient was escorted to the 'secure room' on the Psychiatric Intensive Care Unit (PICU). The RQIA had taken the 'unusual' step of contacting the ward directly to ask about staffing. The Director of Nursing maintained that she was content with the staffing and said it appeared there was a lack of trust in the information provided by BHSCT. At the same Board meeting, the Chief Executive reported that the PSNI had made 20 safeguarding referrals to the Trust from its own viewing of CCTV footage, in response to which some NEDs enquired whether the PSNI had sufficient learning disability expertise to make such a judgement.¹¹⁶

13.71 On 10 May 2019 the CSWO at the DoH wrote a briefing for the Permanent Secretary. It notes:

'The Chief Nursing Officer, in light of the RQIA concerns about nurse staffing levels has sought and has been given verbal assurances by BHSCT Director of Nursing that staffing is currently safe. This is being followed up in writing. The Trust is being asked detail patient nurse staff ratio on each shift, how these have improved and will include details of senior nurse governance assurance arrangements to ensure staffing levels are safe'.¹¹⁷

13.72 When asked how she justified telling the Chief Nursing Officer (CNO) that staffing is currently safe, Brenda Creaney (former Executive Director of Nursing) told the Inquiry:

'I don't recall having this conversation, but at this time I've said, "currently safe". But back to my earlier point, it was we were doing a lot of work in this area but it was tenuous, but it was safe, I'm assuming what I meant, but I would have to go back to my notes, is safe on a given day but it's something we kept a very close eye on'.¹¹⁸

There is no universal definition of safe staffing as it cannot be reduced to the number of staff per patient or per funded bed. Patient needs can vary significantly,

¹¹⁵ RQIA – Unannounced Inspection Report - 15 & 16/04/19 – Muckamore Abbey Hospital – Page 13

¹¹⁶ MAHI – Additional Materials Referenced – Page 113 (BHSCT Board confidential meeting minutes – 02/05/19)

¹¹⁷ Brenda Creaney Transcript – 14/10/2024 – Page 75 – Line 24

¹¹⁸ Brenda Creaney Transcript – 14/10/2024 – Page 76 – Line 15

and some patients may require up three or more staff per shift while others require less than the dedicated attention of one member of staff. Safe staffing therefore means sufficient staff to deliver the essential care needs and to prevent the patient coming to harm. Brenda Creaney at no time demonstrated that all essential care needs were met and BHSCT continued to record incidents and safeguarding referrals for patients in MAH.

- 13.73 At the 06 June 2019 meeting, the Board was given assurance by Martin Dillon (BHSCT Chief Executive from 2017 to 2020) that patients at MAH ‘continued to receive safe compassionate care’. The Board was informed that following the Article 4 letter the DoH had convened a meeting at the request of the Permanent Secretary to discuss the issues in the correspondence. The Trust’s comments following a feedback meeting had been returned with queries regarding gaps and inaccuracies and an indication the RQIA would be writing to the DoH to further advise the Permanent Secretary. Marie Heaney (then Director of Adult Social and Primary Care) noted that if the RQIA was to undertake another unannounced visit, it was hoped that a more appropriate evidence-based methodology would be adopted.¹¹⁹
- 13.74 The July 2019 Board meeting minimised the RQIA concerns about patient finances by saying that there was a clear picture about the good management of patients’ money but that the RQIA wanted a robust report from the internal audit. In August 2019, the RQIA issued Improvement Notices to MAH for nurse staffing, patient finances and safeguarding,¹²⁰ all issues that the Board had been reassuring itself were satisfactory.
- 13.75 The RQIA had looked at structures and processes around nurse staffing that might put patients at risk but did not directly measure safety. However, the director responsible for MAH recognised that the staffing situation was ever-changing and becoming more and more risky, with no obvious solution:

¹¹⁹ MAHI – Additional Materials Referenced – Page 118 (BHSCT Board confidential meeting minutes – 06/06/19)

¹²⁰ Gillian Traub Transcript – 10/06/24 – Page 86 – Line 1; Gillian Traub Transcript – 10/06/24 – Page 120 – Line 6; Gillian Traub Statement – 17/04/24 – Page 13

[Dr Maxwell]: *'A couple of things there: Firstly, are you saying that RQIA was concerned about the processes but not that patients weren't safe? Did they have any evidence that patients were unsafe?*

[Ms Heaney]. *No they didn't. There was one incident, one case they raised with me, but I was able to clarify. No, it was process.*

[Dr Maxwell]: *Process. The second thing then is: You had processes in place to keep patients safe and the evidence seemed to be that they were safe, but you have also alluded to the loss of staff and the very high use of agency staff, so whatever training you put in place was bound to have challenges if you were increasing the number of agency staff who didn't have an LD background so wouldn't necessarily understand how safeguarding occurred in LD; and back to your point earlier about the number of suspensions, is that directly linked to this finding that the staff didn't understand the processes?*

[Ms Heaney]. *Well, I haven't thought of it that way, but that's absolutely right. I think one of the challenges and criticisms we faced was the same staff were in place and so on, that we should have replaced everybody in Muckamore almost; (a) that would have been impossible and (b) not necessarily in the patient's best interests who valued familiarity and consistency. I mean, highly autistic patients, they had relationships.*

[Dr Maxwell]: *And understand the processes.*

[Ms Heaney]. *Yes. So I think that was part of the problem and it really was insoluble, it was always going to be a problem. But having said that, the intensity of training and attention to detail and follow-up occurred over the next few months and then that was lifted. But it would have inevitably taken quite a bit of time to get around to all of those wards and then go back and check people's understanding. That's, I think, what's put in place'.¹²¹*

13.76 Despite this acknowledgement of increasing risk and no obvious mitigation, the Board continued to accept reassurances that care was safe, compassionate and effective without outcome measures to justify the claim. The Board appeared to confuse risk appetite/risk tolerance with the actual assessment of the risk, erroneously downgrading the risk rather than acknowledging the unmitigated risks (and indeed that the risk had already been realised).

13.77 On 19 July 2019 and 09 August 2019, the RQIA was notified of two incidents of an adult safeguarding nature in MAH and was concerned about the quality and timeliness of the information provided.¹²²

¹²¹ Marie Heaney Transcript – 26/09/24 – Page 108 – Line11

¹²² RQIA - Improvement Notice 5 - 16/08/2019

13.78 Even after the Improvement Notices, the Board was still denying the problems. At the September 2019 BHSCT Board meeting, NI Patient Voices spoke about the Improvement Notices at MAH and the mismatch between the RQIA report and the assurances in the Trust Board minutes. NI Patient Voices said it was concerning that Improvement Notices were issued two years after the index CCTV incidents and that the Trust was not addressing the issues. The Medical Director gave assurance to the Board that the patients at MAH were receiving safe and compassionate care.¹²³

13.79 The SAI Level 3 'A Way to Go' review team concluded (in the report dated November 2018) that they could not determine from the safeguarding files how closely practice at MAH aligned with the safeguarding protocol and procedures, with confusion about when adult safeguarding should be used. The review found a culture of tolerating harmful and disproportionately restrictive interventions and intensive use of seclusion with a small number of patients.¹²⁴ The report led the DoH to develop its own assurance (because it did not have confidence in BHSCT's assurance processes) with the establishment of the Muckamore Departmental Assurance Group (MDAG) in August 2019. Sean Holland (CSWO from 2010 to 2022) and Charlotte McArdle (CNO for Northern Ireland from 2013 to 2021) wrote to the CEO:

'To be clear: the lack of comprehensive, accurate and timely information to date, as outlined above, has made it difficult for the Department to be assured that the relevant adult safeguarding policy and procedures have been appropriately implemented in relation to these incidents. This is a situation which we find both unacceptable and unsustainable'.¹²⁵

MDAG was still operating in 2023.¹²⁶

13.80 In January 2020 the BHSCT Chief Executive stated there was excellent feedback from the RQIA unannounced visit to MAH on 10-12 December 2019 and the RQIA wanted a few more months to see safeguarding systems were embedded.

¹²³ MAHI – Additional Materials Referenced – Page 71 (BHSCT Board Public Meeting Minutes 05/09/19)

¹²⁴ Margaret Flynn Statement (Evidence Modules) – 24/04/23 – Pages 7-8 (Exhibit MF/1) – A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, published in November 2018

¹²⁵ Martin Dillon Statement (Organisational Modules) – 30/05/24 – Page 335 (Exhibit T04.01) – Letter dated 20 October 2017

¹²⁶ June Champion Statement (Evidence Modules) – 10/03/23 – Page 64

However, as noted in Chapter 11, in January 2020 there was still a high level of safeguarding referrals and the DoH commissioned a review of the 116 safeguarding referrals made between January 2020 and April 2021. Reviewers found a mixed picture on risk and response,¹²⁷ suggesting that in September 2019, at least some patients were not getting safe care. The assurances given by the Medical Director, as lead director responsible for integrated governance and risk management, including clinical governance,¹²⁸ would have been a significant factor in persuading the Board, including the NEDs, that there were no continuing safety concerns at MAH.

- 13.81 In his evidence to the Inquiry Martin Dillon accepted that in his role he was responsible for the statutory duty of quality, which encompasses the duty to ensure patient safety. He was asked about his accountability by Dr Maxwell:

[Dr Maxwell]: 'Sorry, just before you go on to that. As the accountable officer, you were accountable for services. The fact that you delegated it because of the size of the Trust doesn't diminish the fact that accountability still lay with you. You just delegated the collection of data and management of any recommendations but you remained accountable for it?'

[Mr Dillon]: Yes, correct.

[Dr Maxwell]: So it remained your responsibility, therefore you had responsibility to make sure the system of delegation you put in place was effective?

[Mr Dillon]: Correct'.¹²⁹

- 13.82 As Mr Dillon's oral evidence made clear, he had the statutory duty for quality and a responsibility to ensure that the delegated governance systems were effective. He did not appear to challenge the Director of Adult Social and Primary Care and other executive directors or the NEDs to provide supporting evidence. Given the seriousness of the claims being made, it is surprising that he did not request the Director of Adult Social and Primary Care to provide current safety metrics but nevertheless gave frequent reassurances apparently unsupported by data.

¹²⁷ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Pages 48-50 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding File Review September 2021

¹²⁸ June Champion Statement (Evidence Modules) – 10/03/23 – Page 1590 (Exhibit T15.03) – BHSCT Board Assurance Framework (2013-2014)

¹²⁹ Martin Dillon Transcript – 09/10/24 – Page 72 – Line 10

- 13.83 The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team is responsible for ensuring that the Board, as a whole, is kept apprised of progress, changes and any other issues affecting the performance and assurance framework.
- 13.84 When the RQIA reviewed compliance with the Improvement Notices, it lifted all elements relating to safeguarding in MAH except for the action to implement effective mechanisms to evidence and assure compliance and good practice with respect to adult safeguarding, implying that assurance processes were still not adequate.¹³⁰
- 13.85 At the September 2019 BHSCT Board meeting, in response to concerns raised by Patient Voices, the Director of Finance stated that there were no concerns in the RQIA Improvement Notice on patient finances about mismanagement, only that processes were not being followed¹³¹. The Chair of the Audit Committee said he was assured that the issues were being addressed.
- 13.86 The 2019-2020 HSC Business Services Organisation (BSO) internal audit programme included a proposed audit of patients' private property at Muckamore. This appears to have been informed by the results of the RQIA's February 2019 visit and the subsequent Article 4 letter of concerns to DoH. Indeed, the BSO internal audit report introduction commences with discussion of the RQIA Improvement Notice and reports under the heading 'Internal Audit Observations against the RQIA Enforcement notice'.¹³²
- 13.87 The BSO team visited six wards at MAH and examined 120 financial transactions relating to 24 of the 55 patients during 2019-2020. BHSCT was acting as the appointee for 14 patients and collected benefits on their behalf. The Trust had 66 patient property accounts (including for discharged patients), with a total value of

¹³⁰ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 1210 (Exhibit PMcN1 Tab21.01) – 21
September 2020 Muckamore Abbey Hospital – Update to Trust Board

¹³¹ MAHI – Additional Materials Referenced – Page 71 (BHSCT Board public meeting minutes 05/09/19)

¹³² Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 70

£438,000. Although the audit received an overall 'satisfactory' rating, several governance failures were identified:

- One patient lacked a completed assessment of capacity to manage their own finances.
- In only 46% of cases was the required BF57 form (confirming appointeeship) on file.
- One patient had not received their benefits for three months.
- Another patient had a balance exceeding £20,000, but there was no evidence that the RQIA had been informed or that consent had been obtained to hold such a sum.
- In four of the six wards visited staff were not using the Patients/Clients Private Property form as required, with purchased items such as games consoles and rings not recorded as property.
- Staff were not routinely recording items of property.
- One staff member used their personal debit card to make six purchases against one withdrawal of £420.
- Seven patients did not have a financial plan/agreement in place.

13.88 BSO issued an overall level of assurance of satisfactory, which it described as meaning 'Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives' and made 11 Priority 2 recommendations to address the residual risk. Priority 2 recommendations are described by BSO as meaning 'failure to implement the recommendation could result in the failure of an important organisational objective or have some impact on a key organisational objective'.¹³³ The Board did not address the Priority 2 recommendations, even though failure to implement them could result in the failure of an important organisational objective or have some impact on a key organisational objective. Nor did the Board appear to recognise that deviation from processes increases the risk of malpractice.

¹³³ Gordon Smyth Statement (Organisational Modules) – 07/06/24 – Page 73 and Page 83 (Exhibit Tab7) – BHSC
Patient's Private Property Muckamore 2019/20

13.89 While the BSO internal audit report and its recommendations were put before the BHSCT Audit Committee, the Inquiry saw no record of any discussion regarding the Priority 2 recommendations. The only noted outcome was the lifting of the RQIA Improvement Notice in April 2020. The Chair of the Audit Committee, told the Inquiry that the committee only followed up on issues where internal audit had provided a 'limited' assurance rating and that the committee would not follow up the remaining 'satisfactory' issues:

*'Yes, the RQIA stuff, as part of what they'd said was wrong -- or not wrong, what they had said was concerning for them in 2019, they had given a list of issues that we needed to address, and we had gone through those to the point that internal audit felt it was satisfactory. But the rest of those issues had to be completed, and work was ongoing to make sure that was satisfactory going forward ... In that particular one where it was satisfactory, we didn't really need to [follow up] that because it was deemed at that stage to be satisfactory. It was really where there was a limited issue that we had to then make sure we brought things back to being satisfactory'.*¹³⁴

This was incorrect as there were remaining risks identified by the BSO internal audit (as outlined in para 13.87) suggesting poor controls assurance. Had BHSCT been conducting regular internal audits or other mechanisms to monitor compliance with its own policies, these governance failures should have been identified and addressed well before the Improvement Notice or BSO audit.

13.90 The NEDs did not appear to believe it was their role to hold the Executive Team to account for the effectiveness of assurance processes and we discussed this further in Chapter 11. The Panel was concerned to see that the Chair of the Board in February 2019 suggested that NEDs discuss their concerns with executive directors outside the Board meeting.¹³⁵

13.91 In England publicly funded bodies such as NHS trusts are mandated to hold meetings in public to ensure transparency, accountability and public trust in governance under the Public Bodies (Admission to Meetings) Act 1960. These meetings (and their minutes) allow citizens to observe decision-making processes, ensuring officials act ethically and that public funds are managed properly. This means the challenge from NEDs should be heard in public. Although there is no

¹³⁴ Gordon Smyth Transcript – 14/10/24 – Page 148 – Line 10

¹³⁵ MAHI – Additional Materials Referenced – Page 105 (BHSCT Board confidential meeting minutes – 07/02/2019)

similar direct provision in Northern Ireland, HSCTs appear to apply the requirements applying to council meetings under the Local Government Act (Northern Ireland) 1972 as amended by the Local Government (Northern Ireland) Act 2014. It is an important issue of public accountability that they do.

- 13.92 The Inquiry also heard from the NED who chaired the Audit Committee that when there were concerns about a service, the Audit Committee received actions plans, but it was 'down to the Directorate to make sure what they were saying they were going to do, they were going to make the improvements that were needed'. The Audit Committee did not request outcome data to complete the audit cycle.¹³⁶
- 13.93 However, the RQIA lifted the Improvement Notice on 16 April 2020, observing that 'BSO Internal Audit had confirmed that all patients for whom the Trust manages patients' monies and valuables, in excess of £20k, had received consent from us to hold these monies and valuables for each patient in line with the legislation. In general, we were satisfied that the processes for managing patients' finances and property had significantly improved from previous inspections in 2019. The practices and documentation developed and implemented by the Trust could be used as a benchmark for good practice by other Trusts managing patients' finances and property'.
- 13.94 The BHSCT has proposed that its governance systems were satisfactory, but it could not be responsible for staff not using them. This was a view also expressed by the leadership and governance review. However, MAH staff were completing incident forms and safeguarding referrals, the RQIA was reporting concerns and external bodies (including unions and patient representative bodies) were raising concerns. A system that expects concerns to be explicitly spelt out by ward staff rather than deduced by analysis of data from multiple sources cannot be called effective governance and is far from satisfactory. The failure to measure outcomes related to governance systems said to be 'satisfactory' is a wholly unsatisfactory system.

¹³⁶ Gordon Smyth Transcript – 14/01/24 – Page 124 – Line 3

Conclusions

- 13.95 The Board was frequently assured that care was safe, despite the mounting evidence of risks and actual harm to patients. While the Board Assurance Framework requires the Board to consider its risk appetite, or risk tolerance,¹³⁷ this should be done after acknowledging the risks, rather than downgrading the risk. It may be that some risks cannot be mitigated and the organisation has to carry serious risks.
- 13.96 The Inquiry heard that staffing was at times in 2012 ‘dangerously low’ and this was included in the ‘Patient Safety Situation report 21st September 2012, Muckamore Abbey Hospital’, written by Esther Rafferty (former service manager and Associate Director of Nursing for MAH):
- ‘On Friday, 21st September, B. Mills, E. McLarnon and H377 informed me that staffing in the hospital was dangerously low. The duty nursing officer was trying to fill an excessive number of shifts and that this was proving increasingly difficult. Terms such a “it has never been this bad” and “this is now every week” were being used by the senior nurse managers in their language. We, I immediately asked them to try the Nurse Bank Office to see if other grades of staff i.e. RGN, RMN, agency -was available’.*¹³⁸
- 13.97 Both the CNO and CSWO and the DoH Permanent Secretary were giving consideration to the fact that MAH may not be a safe environment, but the BHSCT Board did not appear to consider this. Its failure to do so may have given false assurance to the Department of Health that it was safe to operate when in fact it probably was not.
- 13.98 To avoid a single point of failure, patient safety engineers use a system of ‘redundancy’, where data from two or more separate sources is collected so that failure in one system is picked up by at least one other (which is redundant if the first is working well). The BHSCT had designed that with its directorate structure and its Trust-wide assurance structure. Safeguarding had a third route via the local adult safeguarding partnership (LASP) and the Social Care Committee;

¹³⁷ June Champion Statement (Evidence Modules) – 10/03/2023 – Page 1639 (Exhibit T16.01) – BHSCT Integrated Governance and Assurance Framework (2022-2023)

¹³⁸ Esther Rafferty Statement (Evidence Modules) – 13/04/14 Page 24 (Exhibit 1) – Report to RQIA

however, each system was working independently and there was a failure to cross-check and pick up failures in any of those assurance structures.

13.99 In fact, the staff at MAH were using these systems to report issues and concerns, but a culture of only reporting threats to strategic goals to the Board meant that information demonstrating increasing concerns (even though the Executive Team was aware of them) was only presented to the Board once a failure had occurred.¹³⁹ This reactive approach to only taking notice of failures is known in safety research circles as ‘Safety 1’. A preventative approach, known as ‘Safety 2’, actively measures the conditions that provide safety and acts before patients experience harm.¹⁴⁰ There is extensive research on how this is done well in healthcare. There should be a reluctance to aggregate data, the danger being that patterns that may indicate emerging concerns are smoothed out. Safety 2 is used in healthcare across the world, including in NHS England’s Patient Safety Incident Response Framework.¹⁴¹ However this was not a system being used by BHSCT with disastrous consequences.

13.100 It is clear from the Governance Steering Group minutes that concerns about harm to MAH patients were known by executive directors from 2010, with concerns about abuse and violence known from 2011. Ward staff reported increased peer-on-peer and patient-on-staff incidents via the Datix system, as well as a dramatic increase in seclusions, but these were managed individually and never properly examined by the Board for trends. While the rate of incidents reported may vary for a number of reasons, the fact that it did rise should have aroused curiosity and further investigation. Drilling down into the data would have identified potential causes that applied to all patients and not just each individual. Examining incidents that are graded as minor or insignificant as well as the more serious incidents would have revealed patterns that became apparent after 2017. Nor was any consideration given to the possibility that such a violent environment might be

¹³⁹ Cathy Jack Transcript – 16/10/24 – Page 92 – Line 14; Cathy Jack Transcript – 16/10/24 – Page 101 – Line 1, Page 102 – Line 12 and Page 119 – Line 24

¹⁴⁰ E. Hollnagel (2014) Safety-I and Safety-II: The Past and Future of Safety Management. CRC Press

¹⁴¹ NHS England Patient Safety Incident Response Framework – <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework>; B. Howells (2024) Understanding how work as done of incident investigators supports a safety-II approach, Contemporary Ergonomics and Human Factors – <https://publications.ergonomics.org.uk/uploads/Understanding-how-work-as-done-of-incident-investigators-supports-a-safety-II-approach.pdf>

high risk for unreported staff-on-patient abuse. The Medical Director told the Inquiry that the Board was only aware of the quadrupling of incidents of patients assaulting staff from 2011 to 2017 after analysis conducted for the Inquiry.¹⁴² The Panel notes that this was a failure of clinical governance, even if not a failure in local practice of reporting incidents.

- 13.101 Part of this time period coincided with a freeze of recruitment of ward staff and of moving patients between wards, increasing the risk of tensions within the wards.
- 13.102 It is well recognised in healthcare that when staff do not get feedback after reporting incidents, their motivation to do so reduces, particularly when there are shortages of staff and increased pressure on their time. This was reflected in the testimony the Inquiry received from staff. The failure by management to act upon reports by staff and a consequent failure to change poor practices can easily lead to an acceptance of a culture of ‘this is the way things are done around here’.
- 13.103 Staff also reported safeguarding concerns, including allegations of staff abusing patients. Between 2004 and 2017, PSNI referred 33 non-Operation Turnstone files to the PPS in which staff were alleged to have assaulted patients at MAH. Of these, there was no prosecution in 23 cases, perhaps indicating that those reporting the allegations were using a low threshold. It should however be borne in mind that the test used for a decision as to criminal prosecution is the reasonable prospect of a conviction on the criminal standard of proof (being sure of guilt of a criminal offence) and does not indicate that practice was acceptable. There were two convictions, four not guilty decisions, three cautions and one discretionary disposal.¹⁴³ The Inquiry did not hear any evidence that these concerns were considered collectively or triggered a review of practice, and they appear to have been considered on a case-by-case basis with no further action if no prosecution ensued. This is another example of the governance structure’s failure to consider trends, which can provide better insight than individual cases.

¹⁴² Chris Hagan 1st Statement (Evidence Modules) – 20/03/23 – Page 5490 (Exhibit CH1 Tab05.06) – MAH Overview Charts 2009-2022

¹⁴³ Overview of Non-Turnstone Cases Referred to PPS

- 13.104 External concerns were not given sufficient attention. The RQIA frequently reported concerns but the Trust Board and its senior managers failed to connect the dots between the risk factors for abuse: shortage of staff; lack of therapeutic activities; increase in peer-on-peer and patient-on-staff incidents; increase in seclusions; and increase in use of agency staff (to name but a few).
- 13.105 The Trust only acted after staff had allegedly abused patients. While it may well be that a small number of staff were observing abuse and did not report it, many were reporting the incidents and there was ample evidence of a deteriorating situation in which vulnerable people were at risk. If the Board (which holds the ultimate responsibility and accountability) had had both the curiosity and the knowledge and skills to use the data that had been collected, it could have (and should have) intervened before August 2017. Even after August 2017, the Board failed to provide a safe and therapeutic environment at MAH, reassuring itself that the concerns were 'historic'.
- 13.106 While it is important to ensure that individual Trust Board members have the requisite knowledge and qualifications in clinical and social care governance, this does not guarantee that a Board will execute its responsibilities effectively. HSCTs have unitary boards, in which all members share collective and legal responsibility for all aspects of the business. As well as assessing the performance of individuals, the performance of the collective Board as a unitary team is necessary. This involves examination of how the Board makes decisions, what data it uses to support that decision, and the degree to which NEDs constructively challenge and test executive directors. It also involves evaluating the impact the Board has on meeting its key objectives, sense-making and predicting challenges, and its ability to be agile in responding to the unexpected.

Recommendations

R75	There must be understanding of both individual untoward events but also (and more importantly) systems and trends. Creating and maintaining effective governance for complex systems requires specialist skills. While this is largely recognised within finance governance, only superficial consideration is given to clinical and social care governance. Boards should appoint an Executive Director of Clinical and Social Care Governance because of their specialist training and expertise in this area (rather than assigning it to the existing clinical or social care leads and then provide top-up training). The DoH must produce guidance in relation to the necessary competency and skills for this role.
R76	NEDs should be selected for their expertise across a range of skills and at least one should have extensive experience of clinical or social care governance and be appointed as a senior independent director with that responsibility. The DoH should make training in Board-level clinical and social governance available to all NEDs.
R77	The DoH Permanent Secretary should commission triennial reviews of each Board's collective performance in clinical and social care governance.
R78	HSCT Board audit committees should consider all internal audit recommendations and require directorates to provide updates on implementation three months, six months and one year after the internal audit report is received, and three monthly thereafter if still not fully implemented.
R79	The DoH should commission the HSC Leadership Centre to develop a learning framework for all Board members. All Trust Board directors should be required to undertake an examined course in governance (including both financial and clinical/social care governance, including patient safety). Annual assessments as to the effectiveness of Board performance should be undertaken by PHA.
R80	Consideration should be given to the creation of a role for a NED in each HSCT with the specific remit to receive confidential reports from members of staff. The individual should receive training via a programme focused on safeguarding and patient safety. It should be the duty of that NED to actively seek out information and to ensure there are various routes by which staff at every level can report, anonymously if necessary, concerning behaviour or issues that could put patient safety at risk.
R81	The DoH should establish an expert clinical/social governance advisory function to support providers.

(This page is intentionally left blank)

Do you see me?

'As a small child, my son loved cycling. He was very clever and used to stop the bike using his toes as brakes. He loved playing with toys and had a favourite spinning top.'

'My daughter loved food and going to restaurants. She loved McDonalds in particular. She got very excited and clapped her hands when we were going there'

'My daughter had a waterbed at home which she loved. We also had a small 'Scottie' dog when she was young. She liked to rub him all the time and she thought he was a toy. She loved the Teletubbies and her 'Lala' toy. She loved interactive toys that made a noise'

'She was really, really - she just loved to have fun and to laugh. She was obsessed with the TV programme "Who Wants to be a Millionaire?", and as soon as it would come on she'd like clap her hands.... Yeah. She loved music. One of her favourite songs was - well, she loved the album from Pink Floyd, probably because I used to play it all the time, but she really loved it. She just loved music.'

Chapter 14

External Agencies Inspection and Oversight

Introduction

- 14.1 In the preceding chapters, we have examined work and practice in the hospital and the management of it by the Belfast Health and Social Care Trust (BHSCT). In this chapter, we turn to the role of other agencies in the inspection and oversight of BHSCT (and its predecessors) in relation to the hospital.
- 14.2 The primary agencies we will consider are the Regulation and Quality Improvement Authority (RQIA), Health and Safety Executive for Northern Ireland (HSENI) and the Patient and Client Council (PCC). We will also consider the interaction of the Police Service of Northern Ireland (PSNI) with the hospital. These various agencies evidently have quite different roles and responsibilities with regard to regulation and oversight. They also differ significantly in terms of how they relate to the healthcare system. The PCC and RQIA are arm's length public bodies of the Department of Health (DoH). HSENI is an arm's length body sponsored by the Department for the Economy. PSNI is sponsored by the Department of Justice.
- 14.3 All of these bodies had a role to play in relation to MAH within the time frame of the Inquiry's Terms of Reference (ToR), although the extent of that role differed markedly. In the case of the HSENI and PCC, MAH hardly featured in their work for significant periods, while the RQIA and PSNI had regular and recurring engagement with the hospital throughout the period with which we are concerned.

Health and Safety Executive for Northern Ireland (HSENI)

- 14.4 The Inquiry heard from Louis Burns, Deputy Chief Executive of the HSENI.¹ In Northern Ireland, the inspection and regulation of health and safety at work began with the Factories Act (Northern Ireland) 1965. Initially, hospitals were not within the scope of the legislation. Later, however, the Health and Safety at Work

¹ Louis Burns Statement (Evidence Modules) – 26/01/23 – Page 1

(Northern Ireland) Order 1978 extended the protections of health and safety at work to hospitals and allowed for the appointment of inspectors to enforce the provisions of the Order.

- 14.5 In 1999, HSENI was established as an executive non-departmental public body of the then Department of Enterprise, Trade and Investment (Northern Ireland). The HSENI is an information and advice service. It also provides enforcement and compliance actions, submits proposals for regulations to government, prepares and issues codes of practice and submits annual plans to the department.²
- 14.6 As at 26 January 2023, there were 10 principal inspectors (one of which covers the public sector, including education and health), 24 inspectors and 16 trainee inspectors. They cover over 80,000 businesses and necessarily concentrate their efforts on industries and activities that tend to give rise to greater risk to health and safety. They do not routinely schedule inspections or visits to hospitals. Employers have a duty to record and report certain types of injuries and diseases suffered at work, under what are called the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) (RIDDOR NI) arrangements. There is also a duty to report injuries to people not at work, but where the injury (or disease) has arisen in connection with work.³
- 14.7 Prior to 2006, HSENI records were paper-based and therefore not so easily retrieved. Between 2006 and 2016, however, HSENI received 306 RIDDOR reports relating to MAH, including 234 reports of assault/violence to employees. Only four of the 306 related to patients (two falls, one slip/trip and one injury to a finger). HSENI did not carry out any investigations into these reports on the basis that it relied on the health and safety systems at the hospital, which it knew included staff training, risk assessments and de-escalation procedures.⁴ During this period HSENI did not issue any improvement notices or prosecutions against MAH.⁵

² Louis Burns Statement (Evidence Modules) – 26/01/23 – Page 2

³ Louis Burns Statement (Evidence Modules) – 26/01/23 – Page 3

⁴ Louis Burns Transcript – 04/05/23 – Pages 34-35

⁵ Louis Burns Transcript – 04/05/23 – Page 23 – Line 4

14.8 In the period from 2006 to 2022, HSENI also received two complaints relating to MAH.⁶ The first, in 2019, was a complaint by a member of the public that his relative was left standing in the car park at the hospital. This complaint was investigated and upheld, with the BHSCT then reviewing its Datix record system, revising its risk assessment for patients leaving Cranfield Ward and providing HSENI with its procedure for patients going absent without leave (AWOL). The second, in 2020, related to a building layout issue, and was partially upheld and resolved by the Trust.

14.9 HSENI was not involved in reports of abuse that arose in 2017 and has made clear that it is not responsible for investigating deliberate acts of abuse or injury, this being the job of the PSNI.

Patient and Client Council (PCC)

14.10 The PCC was established in 2009 as an arm's length body of the DoH, with a budget of £1.8 million (this reduced to below £1.2 million by 2019 but had gone back up to £1.9 million by 2022).⁷ It was created as part of the reforms introduced by the Health and Social Care (Reform) Act (Northern Ireland) 2009.

14.11 PCC's functions are prescribed in the 2009 Act as follows: to represent the interests of the public (consulting the public about health and social care (HSC) and informing the DoH of their views); promote public involvement in HSC; provide assistance to those making complaints; and provide advice and information to the public on the design, commissioning and delivery of HSC services.⁸

14.12 The membership was required to comprise 16 people appointed by the DoH, to include five members of district councils, five representatives of voluntary organisations with an interest in HSC and one representative of a trade union.⁹

⁶ Louis Burns Transcript – 04/05/23 – Page 45 – Line 20

⁷ Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/23 – Page 12 – Line 16; Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/23 – Page 38 – Line 2

⁸ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Pages 4-5; Section 17 Health and Social Care (HSC) (Reform) Act (NI) 2009

⁹ The Patient and Client Council (Membership and Procedure) Regulations (Northern Ireland) 2009 – <https://www.legislation.gov.uk/nisr/2009/98/contents>

- 14.13 The functions of the PCC have been unaltered since 2009, but its approaches and structure have changed over time. In 2009, the management structure was based on five district offices, each with local managers, but this was changed to management posts reflecting its various functions: complaints, involvement, research and the Bamford Project. Most of PCC's work pre-2019 involved helping patients and families through the complaints process. This covered the whole of Northern Ireland and all care groups, not just mental health and learning disabilities (MHLD).
- 14.14 Since 2020, the PCC has adopted a new updated model of providing support, which is structured as follows: advocacy (ranging from giving advice and information by phone and email to seeking early resolution and individual casework); engagement (through a membership scheme, PCC citizen hubs and PCC engagement platforms); policy impact and influence; and engagement and advocacy (beyond Bamford).¹⁰
- 14.15 We heard from Vivian McConvey (Chief Executive of PCC from 2019 to 2023) and Meadhbha Monaghan (current Chief Executive of PCC since 2023). Vivian McConvey told the Inquiry that the PCC had not specifically focused on MAH as an institution prior to 2019, although she noted records from 2009-2010 showing that the PCC:
- 'Met with TILII [Tell It Like It Is advocacy group] visited Muckamore ... met with the Friends and Society of Muckamore and all of that would have been around looking at resettlement. And the issues that would have presented there around resettlement would have been access to advocacy, family engagement, placements being available. Also, there was some in relation to some families wishing for their loved ones to stay within Muckamore'.¹¹*
- 14.16 As regards individual casework, only four of the pre-2009 case files reviewed by the PCC (from its predecessor councils) involved complaints relating to MAH.¹² From 2009 to 2022, only 33 of the 236 cases identified in PCC's search of its record management system for the purpose of the Inquiry were specifically related to MAH.

¹⁰ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Pages 3-8

¹¹ Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/23 – Pages 15-16

¹² Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/23 – Page 74 – Line 3

Vivian McConvey told the Inquiry:

'In all of these 33 cases there was evidence of PCC follow up on the referral and where appropriate through to other agencies. In many of the case files there was evidence that families had sought the support of the PCC in relation to a previous complaint made to a Trust and surrounding their loved one's care and treatment in Muckamore Abbey Hospital. The records in these case files provide evidence of requests for support by the PCC from families who had fears and anxieties about the provision of care by Muckamore Abbey Hospital often alongside their engagement in complaints processes with respective Trusts'.¹³

14.17 There seemed to be no MAH individual casework in 2017-2018, and MAH did not appear to be mentioned in PCC annual reports.¹⁴

14.18 When asked about the evidence given to the Inquiry about the raising of safeguarding concerns by patients and their families over a long period, Vivian McConvey said:

'I think in particular, for me, it is that the entire system failed all these families, that they had reached out on a number of levels in a number of ways to quite a wide range of people and somehow, some why they weren't being specifically heard'.¹⁵

14.19 In 2019, when Vivian McConvey came into post as the new PCC Chief Executive, she set out to engage with families and patients in MAH. She was invited to join a Muckamore Departmental Assurance Group (MDAG) group meeting (and later became a regular MDAG member). She attended a meeting of the Society of Parents and Friends of Muckamore (SPFM) in November 2019, along with Sean Holland (former Chief Social Work Officer (CSWO) 2010-2022) and Professor Charlotte McArdle (former Chief Nursing Officer (CNO) 2013-2021).¹⁶

14.20 At that meeting, more than two years after the CCTV revelations, families discussed what they felt was a lack of information from BHSCT on all aspects of the service, including the names of lead managers, information on the future of the hospital and individual plans for patients. Families were concerned that community placements were unavailable or unsustainable and had a lack of

¹³ Vivian McConvey Statement (Evidence Modules) – 27/01/23 – Pages 38-39

¹⁴ Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/23 – Page 17

¹⁵ Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/24 – Page 18

¹⁶ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Page 10

confidence in the reviews and investigations that were ongoing.¹⁷ They did have access to advocacy from Bryson House (for Belfast, South Eastern and Western trust areas), and from Mencap (Northern trust area) and Disability Action (Southern trust area).¹⁸ However, each of these third sector organisations was only able to devote relatively small amounts of time to MAH families, and PCC submitted a business case to the DoH for a dedicated independent advocate for the families and patients of MAH.¹⁹ The person appointed to this post in 2020 was asked both to support individual families and patients and to engage in policy-level work.²⁰

- 14.21 The PCC identified two pieces of research through which concerns were raised in relation to MAH. In a project called 'Life after Living in Hospital' (2013), 15 people with a learning disability and two families were interviewed about their experience of resettlement. The other project 'What Matters to Me' (2015) elicited service user and carer views of learning disability services.²¹ Both included some worrying issues about MAH and yet did not seem to result in any safeguarding actions.²² Reports from these two projects were sent to Members of the Legislative Assembly (MLAs), trusts, the Public Health Agency (PHA) and voluntary sector organisations.
- 14.22 Later, in August 2020, the PCC facilitated a briefing session for families following the DoH review of leadership and governance at MAH. Then in September 2020, after the Minister for Health, Robin Swann, announced that there would be a public inquiry, PCC was asked to consult patients and families on the inquiry's ToR.²³ Nevertheless, many families of MAH residents appeared not to have heard of PCC or to be aware of its functions.²⁴

¹⁷ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Page 11

¹⁸ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Page 11

¹⁹ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Page 12

²⁰ Vivian McConvey Transcript – 24/05/23 – Page 29 – Line 11

²¹ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Page 42

²² Vivian McConvey and Meadhbha Monaghan Transcript – 24/05/23 – Page 79 – Line 9

²³ Vivian McConvey Statement (Evidence Modules) – 30/01/23 – Pages 15-18

²⁴ AFM and SPFMAH Closing Statement Transcript – 03/03/25 – Page 61 – Line 3

The lack of direct assistance historically to patients and relatives in making complaints or raising concerns was recognised by Ms McConvey in her evidence:

[Chair]: *'... I think what Mr. McEvoy is getting at is there was a shift in the way that you approached your, it sounds as if there was a shift in the way that you approached the service. Previously there was the administrative assistance to somebody wanting to make a complaint and perhaps explanation to them of how to do it and some level of support, whereas now you are saying you are much more involved in the complaints process, is that a fair ...*

[Ms McConvey]. *I feel that's a fair comment, yes'.²⁵*

Mental Health Commission (MHC)

14.23 The MHC had been established under the Mental Health (Northern Ireland) Order (MHO) 1986. It was an arm's length body, funded by the DoH, and it had a budget of approximately £600,000.²⁶ Its main duties were to review the care and treatment of detained patients and those under guardianship (detention being the formal and compulsory admission to hospital under a detention order, guardianship being a measure to provide supervision and support to a person living in the community).²⁷ Each year, on average, about 1,500 people were compulsorily admitted to hospital in Northern Ireland (mainly with mental health needs) and about half were detained for treatment.²⁸ Far fewer, approximately 20-30 per year, were subject to guardianship orders (granting parental responsibility to the guardian for a person aged 16 or over).²⁹

14.24 The Inquiry received a copy of the MHC's 2006 inspection report for MAH Greenan Ward. This noted that annual physical examinations were being carried out and rehabilitation was actively considered within care plans. Commissioners also visited Patient P1, whose complex needs were documented and, according to the medical commissioner, were being managed in line with a multidisciplinary care plan. Records were up to date, physical examinations had been completed, and the prescription chart was appropriately and clearly written. However, other MHC inspections were much more negative (see below).

²⁵ Vivian McConvey Transcript – 24/05/23 – Page 61 – Line 24

²⁶ Paul McBrearty Transcript – 09/10/24 – Page 26 – Line 20

²⁷ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 63 (Exhibit 7) Annual Report & Accounts 2007-2008

²⁸ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Pages 16-24 (Exhibit 2) Hansard report dated 03 July 2008

²⁹ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 64 (Exhibit 7) Annual Report & Accounts 2007-2008

- 14.25 We heard from Paul McBrearty (interim Chief Executive of MHC from 2007 to 2009) and received a statement from Noel McKenna (lay member of MHC 2004-2007, then Chairman 2007-2009).
- 14.26 Paul McBrearty explained that MHC visiting teams usually consisted of two to six people. The team always included a psychiatrist and typically one or more nurses, plus an allied health professional (AHP) and/or a social worker and/or a lay member.³⁰ Visits to hospitals could be announced or unannounced. Visits involved an examination of legal documentation related to detention, interviews with detained patients and examination of medical notes, as well as interviews with relatives. Reports of visits went to the Visiting Panel in MHC and to the Untoward Events and Complaints Committee (UTEC), to which serious incidents were also referred. MHC also reviewed medication plans for all those detained for more than three months.
- 14.27 For announced visits, the relevant pro forma indicated the range of issues that MHC members intended to examine,³¹ whereas unannounced visits were more focused. For example, the unannounced visit in December 2008 focused on the Sixmile, Fintona, Cranfield and Psychiatric Intensive Care Unit (PICU) wards, and Mallow Ward (for children) at MAH. The lack of occupational therapy (OT) in the hospital and delayed discharges were noted.³² The announced visit on 05 February 2008 examined admissions, transfers and discharges at MAH, and met with 37 patients and relatives. In MAH at that time there were 296 patients, of whom 241 were 'delayed discharge' patients awaiting community placements and 15 of these were children.³³ The report noted two vacancies for consultant psychiatrists, 30 nursing vacancies, no OTs and limited psychology and speech therapy services.³⁴

³⁰ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 5

³¹ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 12 (Exhibit 1) – Proforma for announced visits of 05 February 2008

³² Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Pages 41-45 (Exhibit 6) – Report of unannounced visit to MAH on 17 December 2008

³³ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Page 32 (Exhibit 4) – Report of announced visit to MAH on 05 February 2008

³⁴ Paul McBrearty Statement (Organisational Modules) – 12/09/24 – Pages 30-37 (Exhibit 4) – Report of announced visit to MAH on 05 February 2008

14.28 These facts alone suggest that MAH was already a failing hospital in 2008 and the other MHC member who provided a statement to the Inquiry reinforced this view.³⁵ Nevertheless, when the Inquiry asked whether MHC brought issues arising from the findings at MAH to the attention of the DoH, BHSCT or any other body, the response was:

*‘Not that I am aware of. A report would have been completed by one of the professional members of staff following the visit and filed away. I do not recall any onward provision of the report to any other body’.*³⁶

14.29 Under Article 86(2) of the MHO 1986, the MHC had a duty to make inquiries into any case where ill treatment or deficiency in care or treatment were suspected. Reporting guidance was updated in April 2000 and again in August 2007.

14.30 Despite this obligation, the Inquiry received no evidence of any action by the MHC following concerns about ill treatment or deficient care prior to the transfer of responsibilities.

14.31 MHC ceased to exist from 01 April 2009, when its functions and responsibilities were transferred to the RQIA.³⁷

Regulation and Quality Improvement Authority (RQIA)

14.32 The Inquiry heard from Briege Donaghy (current Chief Executive of the RQIA since 2021). The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It came into existence in April 2005.³⁸ It is Northern Ireland’s independent HSC regulator, established as a non-departmental public body of the DoH in Northern Ireland.³⁹ Its powers and duties in relation to MHLD are set out in a number of legislative provisions.⁴⁰ Prior to the establishment of RQIA in 2005, the four health and social care boards (HSCBs) in Northern Ireland each had a team

³⁵ Noel McKenna Statement (Organisational Modules) – 23/09/24 – Page 3

³⁶ Noel McKenna Statement (Organisational Modules) – 23/09/24 – Page 7

³⁷ Health and Social Care (Reform) Act (Northern Ireland) 2009, section 25(1); Health and Social Care Reform (2009 Act) (Commencement) Order (Northern Ireland) 2009

³⁸ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 2

³⁹ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Pages 2-3

⁴⁰ Note, in particular, Mental Health (Northern Ireland) Order 1986; Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003; and Health and Social Care (Reform) Act (Northern Ireland) 2009

of inspectors, known as registration and inspection units, whose primary responsibility was to inspect independent (private) and third sector providers of care and nursing homes as well as domiciliary care providers. These teams were combined to form the nucleus of the RQIA in 2005.⁴¹

- 14.33 The 2003 Order required the RQIA to regulate services registered with it under Part III of the legislation, including care homes and independent hospitals and clinics. RQIA had the power to restrict the activities of these facilities. National Health Service (NHS) hospitals like MAH were not registered with the RQIA. Under Part IV of the Order, however, such institutions had a statutory duty of quality and RQIA had a duty to review and inspect them. This included all HSCBs and health and social care trusts (HSCTs).⁴²
- 14.34 Where HSCTs were not providing the requisite quality of services, the RQIA could require an improvement plan to be put in place. If that was not sufficient, RQIA could serve an Improvement Notice or in extreme cases recommend special measures to the DoH.
- 14.35 The HSC Quality Standards were published by DoH in 2006 and MAH inspections began in 2010, after the MHC functions had been transferred to the RQIA. Alongside its statutory functions, RQIA was also designated as a statutory body within the National Preventive Mechanism (NPM) under the United Nations (UN) 'Optional Protocol to the Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment' (OPCAT). The protocol was designed to strengthen protections for people deprived of their liberty.⁴³
- 14.36 Briege Donaghy told us that in 2023 the annual budget for RQIA was approximately £9 million and that it employed about 140 staff.⁴⁴ There are three directorates within RQIA, one of which covers MHL, children's services and prison healthcare. This directorate has a director, assistant director and, for the

⁴¹ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 4

⁴² Briege Donaghy Transcript – 03/05/23 – Page 26 – Line 2

⁴³ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Pages 8-9

⁴⁴ Briege Donaghy Transcript – 03/05/23 – Page 9 – Line 8

MHLD and prisons team, seven inspectors and a senior inspector, with a budget of about £800,000.

- 14.37 In addition, RQIA maintains a list of 'Part II doctors' and 'Part IV doctors' who can provide the specialist input for detaining patients and for advising on a course of electroconvulsive therapy (ECT) respectively.⁴⁵
- 14.38 RQIA is accountable to the DoH, so while it acts independently on a day-to-day basis, the Chief Executive Officer (CEO) and Chair have an accountability meeting twice a year with the Permanent Secretary and the Chief Medical Officer.⁴⁶

Training and briefing of RQIA inspectors

- 14.39 The MHLD inspectors in RQIA are drawn mainly from Northern Ireland, usually from HSCTs (although occasionally from independent healthcare or social care). They typically come from a nursing, social work or AHP background, and are all required to have professional qualifications and maintain professional registration with their relevant regulator. In addition, inspectors have their own personal continuing professional development requirements. On joining RQIA they have to attend a six-week induction programme. This includes mandatory training, human rights training and training on the legislative framework that they are operating within, as well as the tools used for inspection. Those tools include observational tools for people who may not have verbal skills.
- 14.40 Inspectors in training are also sent on inspections to shadow more experienced colleagues and learn on the job. In addition, they are all required to undertake the four modules of Guidelines and Audit Implementation Network (GAIN) training which they have to repeat biannually:⁴⁷
- Module 1 – Introduction to the 1986 Order
 - Module 2 – Admission to Hospital
 - Module 3 – Assessment and Treatment
 - Module 4 – Safeguards and Rights

⁴⁵ Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Pages 5-6

⁴⁶ Brieghe Donaghy Transcript – 03/05/23 – Pages 11-12

⁴⁷ Brieghe Donaghy Transcript – 03/05/23 – Pages 125-126

- 14.41 Finally, they receive training relevant to inspectors from the Northern Ireland Health and Social Care (HSC) Clinical Education Centre on topics such as human rights and serious adverse incidents (SAIs), and from the RQIA 'Learning Week'.⁴⁸

Form and frequency of RQIA inspections

- 14.42 Initially, the RQIA was not required to inspect services at a particular frequency. Rather, it focused its inspections according to perceived risks. These risks were largely estimated from complaints from members of the public and whistleblowers, early alerts and SAIs.⁴⁹ The RQIA could, however, also be instructed to conduct an inspection by the DoH. Notably, the RQIA Chief Executive told the Inquiry that, after the 2013 Francis Inquiry report on failings at Mid Staffordshire NHS Foundation Trust,⁵⁰ the DoH had asked RQIA to do at least an annual inspection of hospitals.⁵¹
- 14.43 When the RQIA was set up, its inspection methodology was not inherited from previous organisations but was developed by RQIA itself. This was initially based on the 2006 Quality Standards, with their five themes of: leadership and accountability; safe and effective care; accessible, flexible and responsive services; promoting, protecting and improving health and social wellbeing; and effective communication and information. RQIA also sought advice from, and consulted with, similar organisations in England, Scotland and the Republic of Ireland.
- 14.44 The form of RQIA inspections of MAH in relation to its compliance with these quality standards changed gradually over time. Initially, inspections of MAH were announced in advance and interviews with patients, referred to as 'Patient Experience Interviews' (a legacy of the MHC), were conducted separately.⁵² This occurred until 2014, when the interviews were merged with the main inspections.

⁴⁸ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 21

⁴⁹ Briege Donaghy Transcript – 03/05/23 – Pages 55-56

⁵⁰ Francis Inquiry (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

⁵¹ Briege Donaghy Transcript – 03/05/23 – Page 34 – Line 3

⁵² Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 2

Inspectors were allocated a number of wards to inspect, including low-risk and high-risk wards, and allocations were reviewed once a year.⁵³

- 14.45 During inspections RQIA inspectors looked at various sources of documentation, including: questionnaires returned from patients, staff and professionals; ward manager self-assessments; staff rotas; case notes; care plans; incident records; referral forms; Kardex (for example, to examine 'pro re nata' (PRN) medication records); Datix systems; detention forms; and complaint records. They would speak to a range of members of ward staff, relatives and advocates. They would also observe what was going on in the ward and speak to the patients. The Inquiry found that RQIA did not ever view CCTV in MAH, even after this was introduced on wards in 2017, though it did advise on CCTV processes and policies. RQIA told the Inquiry that it did have the power to review CCTV footage where it considered it necessary or expedient to do so for the purposes of its functions (see Articles 40 and 41 of the 2003 Order). Nevertheless, it had never done so in relation to MAH, despite the 2017 CCTV revelations.
- 14.46 After inspections, the inspectors would write the report and fact-check it with the organisation inspected. The report would then be peer-reviewed within RQIA.⁵⁴ No overall rating was given but initially the Quality Standards inspected were rated as 'met', 'partially met' or 'not met'.
- 14.47 Between 2009 and 2011, inspections focused on one of six themes: autonomy, dignity, equality, fairness, protection and respect. Performance was assessed as 'compliant', 'substantially compliant', 'moving towards compliance', 'not compliant' and 'unlikely to become compliant'.
- 14.48 Between 2014 and 2015, the RQIA further developed its methodology, dropping self-assessments as these tended to overrate wards. Wendy McGregor (current RQIA Assistant Director of MHL and Prison Healthcare since 2020) gave evidence to the Inquiry. When asked whether she found any particular issues lacking in accuracy across these self-assessment reports, she told us:

⁵³ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 3

⁵⁴ Brieghe Donaghy Transcript – 03/05/23 – Page 62 – Line 20

*‘Yes. There would have been a number of areas, such as the use of restrictive practices ... Care and treatment in terms of the support of individuals who require support with managing their dysregulated behaviours, a lack of understanding on the use of positive behaviour support. Environmentally-wise as well, the Trust may have assessed themselves as higher in terms of the environment that individuals would have been supported and cared for in, and ward governance would have been another area that would have been assessed, I suppose, substantially lower than what the Trust would have assessed themselves as’.*⁵⁵

- 14.49 In 2014-2015, RQIA added lay assessors and multi-disciplinary team (MDT) representatives, as well as including a direct observation tool known as Quality of Interaction Audit Schedule (QuIS).⁵⁶ RQIA also began to use unannounced visits, focusing on the theme of patient-centred care and asking whether care was safe, effective and compassionate. Specialist inspectors (for finance or pharmacy) could be called upon where necessary⁵⁷ and resettlement and discharge plans would also be inspected.
- 14.50 It was estimated that: about 40% of inspection time was spent speaking to staff; 40% checking records and paperwork; only 5% interviewing patients; and 15% observing patients on wards.⁵⁸ Compliance with standards therefore took precedence over gathering the lived experience. One of the difficulties was obtaining patients’ views when they had limited verbal skills. Accessing relatives of patients, especially in unannounced visits, was also difficult. Early on, the RQIA gave leaflets for family members to ward staff but very few relatives contacted RQIA. The RQIA did not begin contacting families directly to get their views until 2023,⁵⁹ and also struggled to get in contact with advocates.⁶⁰
- 14.51 When there were major worries about services, RQIA would set up a ‘Serious Concerns’ meeting with the trust. Ordinarily, however, quality improvement plans (QIPs) were drawn up following inspections, by the ward in question, after the RQIA had submitted its draft report. Thereafter, RQIA analysed these QIPs and monitored progress using a priority rating system. Priority one required

⁵⁵ Wendy McGregor Transcript – 20/06/24 – Page 19 – Line 18

⁵⁶ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 12

⁵⁷ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 4

⁵⁸ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 24

⁵⁹ Wendy McGregor Transcript – 20/06/24 – Page 30 – Line 14

⁶⁰ Wendy McGregor Transcript – 20/06/24 – Page 58 – Line 10

improvement in 24 hours; priority two required improvement between four weeks and three months; and priority three required improvement between three and six months after the inspection.⁶¹

14.52 In 2016, Professor Roy McConkey (Emeritus Professor of Developmental Disabilities at Ulster University) was asked to review this new methodology. He endorsed the changes already made and had some further recommendations for improvement.⁶² Following these, the RQIA included 'Is care well-led?' as an extra domain to inspections, and compliance was rated as 'excellent', 'good', 'requires improvement' or 'unsatisfactory'.⁶³ The new methods of inspection were described in the RQIA's MHLI Inspection Handbook 2016/2017.⁶⁴

14.53 The events of 2017 that prompted the SAI Level 3 review led by Dr Margaret Flynn, culminating in the report 'A Way To Go' in 2018,⁶⁵ prompted further changes to RQIA inspections. From 2019, inspections of MAH were conducted by a more multidisciplinary team and were systemic in nature. Inspections focused on the entirety of the hospital rather than on individual wards.⁶⁶ Inspectors were aligned to a particular HSCT rather than to particular wards.⁶⁷ The intention was to be able to better track governance at all levels.⁶⁸

14.54 We asked Wendy McGregor about this development:

'[Chair]: 'So it's enabled you to have a real focus on governance and leadership across the organisation ... When you look, for instance, at a unit like Muckamore Abbey Hospital, do you look beyond the Hospital to see -- to look, for instance, at the Trust and the leadership of the Trust, and the governance of the Trust?'

[Ms McGregor]: Yes, we do now from the development of the 2019 methodology. So we absolutely look wider into the Belfast Trust, in terms of very senior leadership roles. So not just the leadership within Muckamore Abbey, but also the Directors, the Co-Directors, and sometimes even when,

⁶¹ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 19

⁶² Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 75 (Exhibit BD2) – Evaluation of the Pilot for a Revised Inspection Methodology for Mental Health and Learning Disability Hospitals (February 2016) Roy McConkey

⁶³ Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Pages 14-15

⁶⁴ Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 96 (Exhibit BD3) – RQIA MHLI Inspection Handbook 2016-17

⁶⁵ Margaret Flynn 1st Statement (Evidence Modules) – 24/04/23 – Page 4 (Exhibit MF/1) – A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go (2018)

⁶⁶ Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 16

⁶⁷ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 4

⁶⁸ Lynn Long 2nd Statement (Organisational Modules) – 26/04/24 – Page 4

you know, we're escalating or we need to inform, right up to the Chief Executive'.⁶⁹

14.55 Wendy McGregor clarified the methodology as follows:

'We track information right from ward level. So if I give you an example of perhaps an incident that's occurred at ward level, we'll look at that. Well, actually, we look at a sample of incidents whenever the inspectors are out on inspection, and we're looking at those for several reasons; to see if they've been reported appropriately and have been actioned, where we're seeing incidents, I suppose, risks increasing, we'll see what the system is for that in terms of escalation, where it goes to next, what's the system around perhaps middle management in terms of how it's managed there, how are they assuring themselves that it's being managed appropriately, and then on up to senior management, and right up to senior governance level. So we literally track right up to that level. We look at how they collect the data, how they analyse the data, what they do with the data, what learning has been identified from the data, any action plans that have been developed in respect to the learning, and then we'll track it back down again. So we have to see what assurance mechanisms are in place to make sure any learning that has been identified is shared at the appropriate level, right to ward level again, and then we'll check on the wards to make sure that the learning is there and that it also has been actioned'.⁷⁰

14.56 In addition, from 2019 the development of the RQIA IT system 'iConnect' allowed more sophisticated management of information such as early alerts, SAls and concerns from patients, families and other stakeholders.⁷¹ However, none of the RQIA inspectors to whom we spoke were able to give the Inquiry any reassurance that they were capturing the 'culture' of wards in any way. They were also aware that it was difficult to explain what was seen by inspectors on MAH wards alongside what appeared on CCTV in 2017, but they felt it was inappropriate for them to view CCTV footage as part of their inspections. Wendy McGregor told the Inquiry:

'Because it was, or it is our view that there are processes in place to view CCTV as part of the Trust's policies and procedures, and it's not something that up until now we have considered as part of our inspection. I'm not saying it's something that we may never consider in the future in terms of the use of CCTV in these settings, but it hasn't formed part of our inspection methodology at this time'.⁷²

⁶⁹ Wendy McGregor Transcript – 20/06/24 – Pages 14-15

⁷⁰ Wendy McGregor Transcript – 20/06/24 – Pages 15-16

⁷¹ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 5

⁷² Lynn Long Transcript – 19/06/24 – Page 151 – Line 8

- 14.57 Given that a review of sample sections of CCTV may be the most obvious route by which an inspector could determine what was happening on the ward when concerns were raised (for example by a family member), and when a team of inspectors was not there, the failure to give this appropriate consideration seems a surprising omission and, in the circumstances of MAH with its population of highly vulnerable patients, even without the benefit of hindsight, an important one.
- 14.58 Typically, following inspections, inspectors would meet with ward staff and senior management to conduct a deliberation meeting.⁷³ A draft report would then be provided to the ward for a factual accuracy check. A copy of the final report was also provided to the ward manager (until 2018) and trust chief executive.⁷⁴ QIPs would be drawn up by ward staff. These QIPs were often considered sufficient by RQIA to prompt improvements in services.
- 14.59 Where, however, QIPs were deemed insufficient or there were serious concerns about the safety of service users (as certainly occurred at times in relation to MAH),⁷⁵ the RQIA had the power to serve an Improvement Notice.⁷⁶ This decision was taken by RQIA's Enforcement Decision-Making Group⁷⁷ and communicated to the DoH.⁷⁸ It was also possible to contact the Health and Social Care Board (HSCB)⁷⁹ and DoH by way of an 'Article 4 letter' (that is, under Article 4(2) of the 2003 Order).⁸⁰ Following this, RQIA would continue to inspect and report but might recommend that the DoH take special measures against the service in question, as RQIA did in relation to MAH in 2019.⁸¹

⁷³ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 20

⁷⁴ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 21

⁷⁵ Lynn Long 2nd Statement (Organisational Modules) – 26/04/24 – Pages 11-12

⁷⁶ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 18

⁷⁷ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 127 (Exhibit BD4) – RQIA Enforcement Policy; Briege Donaghy Transcript – 03/05/23 – Page 113 – Line 9

⁷⁸ Wendy McGregor Statement (Organisational Modules) – 28/03/24 – Page 21

⁷⁹ Lynn Long 2nd Statement (Organisational Modules) – 26/04/24 – Pages 14-15

⁸⁰ Wendy McGregor Transcript – 20/06/24 – Page 52 – Line 24

⁸¹ Briege Donaghy Transcript – 03/05/23 – Page 118 – Line 21

Complaints to RQIA

- 14.60 The RQIA has never had a formal role in handling complaints. Nevertheless, RQIA receives calls, letters and emails from patients, staff and service providers. It also conducts public engagement sessions and provides Easy Read material to encourage the public to engage in this way.
- 14.61 When the public raise concerns, the RQIA guidance team records the concerns, assesses risk, provides advice and decides on next steps. These may include: raising the issue with the service provider; logging the concern (for example, as part of pre-inspection information); conducting an unannounced inspection to investigate the concern; and/or taking enforcement action.⁸² Safeguarding concerns are also passed to the relevant trust.
- 14.62 Since 2010, whenever a trust contacts the DoH with an early alert, this may also be passed to RQIA. When this occurs, the early alert is logged on the iConnect system and followed up in the same way as other alerts coming from families, staff and members of the public. In addition, RQIA is a named 'prescribed person' for the purpose of the Public Interest Disclosure (Northern Ireland) Order 1998 and can receive protected disclosures.⁸³
- 14.63 RQIA recognised the need to do better to connect with relatives,⁸⁴ but we also heard that some inspections had been carried out following relatives' complaints. For example, Alan Guthrie (former MHL D and acting Senior Inspector with RQIA 2013-2020) inspected Killead Ward (28 October 2016), Cranfield Male Ward (13 July 2017) and Cranfield Male Ward again (22 November 2018) following anonymous complaints.⁸⁵ Lynn Long (former Senior Inspector in RQIA's Independent Health Care Team 2013-2018) noted that the inspections at Cranfield Female Ward (17 May 2013 and 28 October 2016), Erne Ward (21 December 2016 and 26 January 2017), Killead Ward (14-15 February 2017), Cranfield 1 Ward (13

⁸² Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 29

⁸³ Public Interest Disclosure (Northern Ireland) Order 1998 – <https://www.legislation.gov.uk/nisi/1998/1763/contents/made>; The Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014 – <https://www.legislation.gov.uk/nisr/2014/48/contents/made>

⁸⁴ Lynn Long 2nd Statement (Organisational Modules) – 26/04/24 – Page 25

⁸⁵ Alan Guthrie Statement (Organisational Modules) – 28/03/24 – Page 3

July 2017) and Cranfield 1,2 and ICU (10 July 2017) all followed complaints from relatives.⁸⁶

RQIA's role in SAIs and safeguarding

- 14.64 Under the HSCB's 'Procedure for the Reporting and Follow up of Serious Adverse Incidents' (2016),⁸⁷ all SAIs must be notified to RQIA if they affect a person involved in MHLD services. Such notification is required whether or not the person is detained and regardless of where the service is provided, whether that be in the community or in a hospital.
- 14.65 SAIs are investigated by HSCTs according to the seriousness of the event: significant event audit (Level 1 SAI), root cause analysis (Level 2 SAI) or independent review (Level 3 SAI). RQIA receives initial notification of the SAI and then keeps it under review, taking action where necessary, for example to seek assurance from the trust that patient safety risks have been addressed. RQIA also enters SAIs on iConnect (since 2019). The DoH Strategic Planning and Performance Group (SPPG) (formerly the HSCB) has responsibility for ensuring regional learning from SAIs.
- 14.66 Adult protection and adult safeguarding have been the subject of a series of policies in Northern Ireland as seen in Chapter 11 (Safeguarding). Recent examples include: the Department of Health, Social Services and Public Safety (DHSSPS) 'Adult Safeguarding: Prevention to Protection in Partnership' policy (2015); Northern Ireland Adult Safeguarding Partnership (NIASP) 'Protocol for Joint Investigation of Adult Safeguarding Cases' (2016); and HSCB 'Adult Safeguarding Operational Procedures' (2016).⁸⁸ The procedures for safeguarding are the responsibility of the HSCT and (if a crime is suspected) of PSNI.
- 14.67 The Adult Safeguarding Policy sets out the process in detail, including the need for appointment of a designated adult protection officer (DAPO), who will be

⁸⁶ Lynn Long 2nd Statement (Organisational Modules) – 26/04/24 – Page 28

⁸⁷ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 898 (Exhibit BD8) – HSCB Procedure for the Reporting and Follow up of SAIs, November 2016

⁸⁸ Briege Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 672 (Exhibit BD6) – HSCB NIASP Adult Safeguarding Operational Procedures. Adults at Risk of Harm and Adults in Need of Protection, September 2016

responsible for managing any investigation arising from a referral, although not all referrals justify an investigation. Many investigations proceed as single-agency investigations within a trust. Where, however, there has been a potential crime, they may proceed as joint investigations under the joint protocol, in which the trust and PSNI and RQIA work in partnership.⁸⁹

- 14.68 MAH is not a regulated service, and safeguarding incidents do not have to be referred to the RQIA. However, the Inquiry heard that since 2019, RQIA has required BHSCT to notify it of safeguarding concerns at MAH where there has been an allegation of staff misconduct toward a patient, a serious patient-on-patient incident or an incident resulting in PSNI involvement.⁹⁰ The RQIA does not investigate safeguarding incidents, but it does monitor them and enters them on iConnect (since 2019). RQIA may also be invited to strategy meetings, for example those held by BHSCT in the case of MAH incidents. It also monitors the investigation process and outcome, including protection plans.
- 14.69 The RQIA sits on the MDAG, established in 2019 by DoH, the MAH Safeguarding Governance Group (along with PSNI, BHSCT and DoH) and the MAH Operational Working Group, also established in 2019.

Reports on MAH inspections

- 14.70 From 2009 until 2019, the RQIA made over 100 inspections of the various wards in MAH (from 2019, it inspected the whole hospital). A summary of the inspections of individual wards is shown in Figure 14.1 below. The RQIA inspection reports detail the type of ward inspected and these have been indicated briefly in the table as: male/female; CB for wards designated for patients with challenging behaviour; MH for wards designated for patients with mental health needs; high dependency for wards for the more severely disabled patients; continuing care/rehab for long-stay wards, resettlement etc. Inspections were sometimes announced, meaning the ward was warned in advance; others were unannounced, although of course the inspectors would have to introduce themselves on arrival. The focus of the

⁸⁹ Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Page 790 (Exhibit BD7) – HSCB NIASP Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016

⁹⁰ Brieghe Donaghy 1st Statement (Evidence Modules) – 23/03/23 – Pages 23-24

inspections varied. Some focused on ‘fairness’ (including access to advocacy, patients being informed of their rights, Mental Health Order detentions being explained, being informed of comments and complaints process, etc). Some inspections focused on safeguarding procedures and restrictive practices, some on finances, some on person-centred care and some on patient experience interviews (indicated below as PEI inspections). Over the years the exact methods of inspection varied somewhat as described above in paragraphs 14.42 to 14.63. However, it can be seen from Figure 14.1 that most wards were inspected at least once every two years, and sometimes once a year or more.

Figure 14.1: RQIA single ward inspections 2009-2019

Ward	Type of inspection and date
Donegore (female, CB)	3 PEIs (2010, 2014, 2015) 4 announced (2011, 2013 x 2, 2016) 2 unannounced (2012, 2014, 2017) (Amalgamated with Killead in December 2018 to become Ardmore)
Moylena (male, CB), delayed discharge	2 PEIs (2013, 2014) 2 announced (2011, 2012) 4 unannounced (2014, 2015 x 2, 2016) (Ward closed in December 2016 following a fire)
Greenan (female, high dependency)	3 PEIs (2010, 2013, 2014) 2 announced (2010, 2012) 2 unannounced (2012, 2014)
Finglass (male, CB and MH)	2 announced (2011, 2012) 1 unannounced (2012) (Ward closed October 2012)
Rathmullan (male, high dependency)	1 announced (2011) (Ward closed 2014)
Foybeg (male, CB)	1 PEI (2010) (Ward closed in April 2011)

Mallow (rehab/ continuing care)	1 unannounced (2012) (Ward closed and amalgamated with Erne in December 2013)
Oldstone (male and female, in six step-down houses)	2 PEI s (2010, 2014) 3 announced (2011, 2013 x 2) (Ward closed 2014)
Killead (female admission ward)	2 announced (2011, 2014) 5 unannounced (2014, 2015, 2016, 2017 a & b) 3 PEIs (2010, 2011, 2014) (Amalgamated with Donegore in December 2018 to become Ardmore)
Ennis (female, CB)	1 announced (November 2010) 5 unannounced (November 2012, December 2012, January 2013, May 2013, December 2013) (Ward closed and amalgamated with Erne in December 2013)
Erne (mixed male and female, continuing care/resettlement)	1 PEI (2014) 1 announced (2010) 7 unannounced (2012, 2014, 2015, 2016 x 2, 2017 x 2). Split into male and female wards by 2017 (Ward absorbed Ennis and Mallow in December 2013)
Sixmile (male, forensic; split into assessment and treatment sections)	3 PEIs (2010, 2011, 2014) 4 announced (2010, 2011, 2012, 2013) 4 unannounced (two in 2015, 2017, 2018)
Cranfield (divided into a male and female)	Female 2 PEIs (2010, 2014) 2 announced (2010, 2013) 3 unannounced (2015 x 3, 2018)

ward, and PICU; CB and MH)	Male 3 PEI (2010, 2011, 2014) 2 announced (2011, 2013) 5 unannounced (2015 x 2, 2016, 2017, 2018 x 3) PICU (closed 2018) 1 PEI (2016) 2 announced (2011, 2012) 5 unannounced (2013, 2014, 2015, 2016, 2018)

- 14.71 Typically, a number of recommendations resulted from inspections, but the volume and type of recommendations did not seem to be a guide to whether the ward would later have major safeguarding issues. For example, only minor recommendations were made for Ennis Ward as a result of an inspection in November 2010, before the Ennis Ward complaints from Bohill in-reach staff in 2012 (see Chapter 9 (Previous Concerns, Previous Investigations and Warning Signs)). The next inspection in November 2012 produced 16 recommendations, but this latter inspection came immediately following the complaints from Bohill staff (see Chapter 9).
- 14.72 Similarly, there were nine recommendations for Sixmile Ward in 2011 and 12 recommendations in 2012, this latter inspection following a complaint by a family member. Yet only two recommendations were made in February 2017 (one was that medical staff should complete case summaries for each patient to ensure staff could access information succinctly and quickly; the other was that the ward's ligature risk assessment should include a time frame within which alterations to ligature points would be completed). Given the major concerns that emerged a short time later in 2017, by way of the CCTV footage, it seems extraordinary that so few faults were found with Sixmile Ward, although this may be the consequence of the methods of inspection adopted.
- 14.73 Meanwhile, in Cranfield PICU, there were many recommendations in some inspections (for example, 34 in 2014) but few in others (for example, four in 2015 and seven in 2016). In Cranfield Male Ward, there were only two

recommendations in May 2017 (one that the BHSCT should ensure that patients and staff could access pharmacy services based within the hospital site; the other that the Trust should ensure that patients in Cranfield Male Ward can access a ward based occupational therapist at least two and a half days per week). Given the major issues revealed in the CCTV in late 2017 in both Cranfield and PICU wards, again this seems extraordinary and a reflection upon the methodology of inspection.

14.74 There were some wards where considerable and consistent good practice was described and recognised (notably on Donegore Ward and on Oldstone), but there were usually still some recommendations. For example, a Donegore Ward inspection in 2016 produced four recommendations, all related to medical staff; the PEI of Oldstone in 2014 resulted in one recommendation. Very occasionally wards were rated highly and there were no recommendations made at all, but this was very rare. Examples are the Oldstone PEI in 2010 and Donegore Ward in 2014.

14.75 The failure to detect major problems – later revealed on CCTV – in inspections of individual wards was raised with Wendy McGregor in the Inquiry hearings:

[Counsel]: *‘There were 36 inspections across the various wards, and you were variously an inspector, Senior Inspector, and now in a leadership role. Do you have a concern, would you express surprise when I put it back to you like that, that separately, or cumulatively, those inspections -- none of those inspections led to the triggering of a serious alarm about what was going on in the hospital?’*

[Ms McGregor]: *Inspections are limited in what they can do. You're there for a period of time. You get a snapshot of a service during that time. So I suppose there's -- there was several elements to the safeguarding in terms of the actual incidents that happened. I actually don't know how to answer that question, but what I would say is, the inspection is limited, and there's an element, I suppose, of hindsight from myself, because I'm very aware of the incidents because I'm part of the Operation Turnstone piece, so I'm aware of the nature of them.*

[Counsel]: *But let's deal with it in this way: Assume, assuming for present purposes, and it is an assumption, that there was abuse of some patients on some of the wards that I mentioned, and it wasn't identified by RQIA, what could RQIA, do you think, change about its processes and methods to better identify abuse of patients when it occurs?*

[Ms McGregor]: *I'm not sure. I think our system at the time was as effective as it could be. We're talking about the single ward. I don't know if I can actually answer that. I don't know*'.⁹¹

- 14.76 We also asked whether there were improvements that could be made to RQIA's inspection system and methods:

[Chair]: *'But there are, of course, now, algorithms and the use of AI that can do that for you, and you were just asked if you could change anything, what would you change? Do you think one of those systems would help you?*

[Ms McGregor]: *Yes, absolutely. I mean, we are looking at our system to improve what it does. If you wanted to ask me what my wish-list, I would want a system that would throw out -- that would produce information for me, rather than me having to go look for it. So a system that will automatically identify, we have increasing number of intelligence concerns, or whatever it is, coming in, relating to adult safeguarding, so that would flag that straight away to me, like an alert. Whereas at the minute, you have to actually know what you're looking for in the current system*'.⁹²

- 14.77 The issue of effectiveness was also raised with other RQIA inspectors. We asked Alan Guthrie:

[Prof Murphy]: *'Isn't the real problem that when you arrive on a particular day, even if it's unannounced, you knock on the door and you have to say who you are, and that staff may behave very differently when they know you've arrived than what they would have, perhaps, done had you not arrived? That's a big issue for RQIA in terms of its effectiveness, isn't it? And how would you ever solve that?*

[Mr Guthrie]: *Yes. To answer your question, it is a big issue, because obviously if I'm on the ward as an inspector, it's going to change the dynamic of the ward because I'm on and I'm there to observe, to make judgments, and to measure how effective the ward is or isn't. How RQIA -- to answer the second part of your question, how [can] RQIA challenge that or rectify that? I suppose in my time as inspector some of the methodology introduced tried to address that in terms of, I recall going into a ward at 3:00 o'clock in the morning in 2019, and whilst the staff knew we were on site, because we were there for the week, they didn't realise we were going to come in at 3:00 o'clock in the morning. But, yes, I think that's going to be an area that the regulators will continually address, or try to address. I'm never sure they'll get it absolutely perfect, but it is an area absolutely that needs to be looked at on a continuous basis*'.⁹³

- 14.78 In 2019, the RQIA altered its plan of inspections of MAH by adopting a 'whole hospital' approach, partly as a result of recommendations from the 'A Way To Go' report. These inspections involved larger teams of inspectors (for example, 17

⁹¹ Wendy McGregor Transcript – 20/06/24 – Pages 62-63

⁹² Wendy McGregor Transcript – 20/06/24 – Pages 66-67

⁹³ Alan Guthrie Transcript – 20/06/24 – Pages 92-93

inspectors in February 2019), including multidisciplinary team representatives from learning disability services. Figure 14.2 shows a summary of their findings. They resulted in far more critical reports than had previous RQIA inspections of MAH single wards. In some cases, RQIA served Improvement Notices.

Figure 14.2: RQIA whole hospital inspections

Date	Type of inspection and wards	Main findings
February 2019	Unannounced (67 patients – Cranfield 1 and 2, Ardmore, Sixmile and Erne wards)	6 areas of concern: 1. Staffing levels 2. Patients' physical healthcare needs 3. Financial governance 4. Safeguarding vulnerable adult practices 5. Restrictive practices (seclusion) 6. Hospital governance 11 areas for improvement noted, each with multiple actions needed. Intention to serve 6 Improvement Notices, not served in the end (but see July 2019 below).
April 2019	Unannounced (63 patients – same wards as above)	Same 6 areas of concern as above. Limited progress since last inspection (only 1 of 11 areas for improvement partially met, remaining areas not met). Recommended 10 areas of improvement: 1. Staffing 2. Safeguarding 3. CCTV 4. Restrictive practices (seclusion) 5. Patient observations 6. Patients' physical healthcare needs 7. Discharge planning 8. Strategic planning and communication

		9. Hospital governance 10. Financial governance
July 2019	Announced visit focused on finance (same wards as above)	No documentation on appointeeship arrangements for 5 patients. Still no referrals to the Office of Care and Protection for patients with excess of £20,000. No system for reviewing patients' benefits entitlement or to identify a patient's changing financial circumstances. Inconsistencies in financial records and gaps in the weekly and monthly ledger checks completed at ward level by senior managers. No evidence of discussion or best interest decision-making in respect of decisions to spend patients' monies. 8 areas of improvement. 3 Improvement Notices served on BHSC: staffing, financial governance and safeguarding.
December 2019	Enforcement (53 patients – wards as above)	Staffing improvement met. Financial governance and safeguarding improvements partially met (carried forward). Also, 6 out of 8 of the other previous areas for improvement now met.
April 2020	Enforcement (remote inspection)	Remote inspection specifically of financial governance and oversight and management of safeguarding (the 2 Improvement Notices carried forward last time). Both now considered met. Remaining areas of improvement from last time not reviewed (carried forward).
October 2020	Unannounced (45 patients – wards as above)	Improvements noted in using the least amount of restrictive practices to manage patient behaviours that challenge; the management and monitoring of patients' physical healthcare

		needs; the oversight of medicines management within the hospital; and updated operational policy reflecting the varied use of CCTV within the hospital. 4 further areas of improvement needed: better communication to families by the adult safeguarding team and by ward staff; what to do if ward's medicine refrigerator is outside of safe temperature range; and ensure all patients have audit of their finances by a senior manager.
August 2021	Unannounced (41 patients – Cranfield 1 and 2, Donegore, Killead, Sixmile wards)	Above 4 areas of improvement all met. Also examined the 8 areas of improvement for Erne Ward (January 2021 inspection): 5 now met; 1 partially met; 2 not met (staffing levels and poor environment). Erne Ward later closed.

- 14.79 MAH was not the only learning disability service to receive Improvement Notices and enforcement actions. In February 2025 (outside the time frame of our ToR) RQIA inspected The Mews, a supported living service for 12 service users in Belfast, following concerns raised by families. RQIA reported:

'Enforcement action resulted from the findings of this inspection. Serious concerns were identified regarding the care and treatment of service users which had fallen below an acceptable and expected standard. For instance, there was evidence of some restrictive practices which lacked clear rationale and/or were disproportionate to the risks presented; some service users' living environments required improvement and service users' daily routines lacked structure, predictability and purposeful activity. Concerns were also identified regarding the training, competence and skill levels of staff and in relation to staff knowledge and understanding of care plans'.⁹⁴

RQIA special investigations

- 14.80 From time to time the DoH would request that RQIA conduct a specific investigation, or RQIA would itself decide to do so. For example, in 2008 and in

⁹⁴ RQIA – Inspection Report, The Mews Support Living Spaces, The Cedar Foundation – 24/02/25, 13/03/24 and 21/03/25

2012, the DoH asked RQIA to review safeguarding (see Chapter 11 for details). In 2013, there was an RQIA review of adult learning disability community services. This review highlighted the role and composition of community learning disability teams and examined the level of investment in services for adults with a learning disability.⁹⁵

- 14.81 This was followed by a further investigation into adult community learning disability services in October 2016. The expert team that conducted the investigation assessed the quality of learning disability services against 30 standards for adults in the DHSSPS Learning Disability Service Framework.⁹⁶ These standards are discussed in Chapter 15 (Resettlement). Then in 2019 RQIA reviewed the way that patients' money was handled in MAH (see Figure 14.2 and Chapter 6 (Patients' Property and Finance) for details).⁹⁷
- 14.82 As a result of inspectors raising concerns in relation to a residential care home, the RQIA became concerned about the adequacy of HSCT commissioning arrangements. DoH commissioned RQIA to review the commissioning arrangements for the resettlement of patients into the community since August 2022, who were under the care of the South Eastern Health and Social Care Trust and the BHSC. This review provided a draft report to those trusts in 2025, providing its final report to the DoH in March 2026. This is discussed in Chapter 15.
- 14.83 The RQIA is the agency that members of the public rely on to discover and root out bad practice in healthcare settings. It has powers of inspection no other regulator has. The RQIA inspected wards at MAH on multiple occasions and revised its methods many times over the period investigated by the Inquiry. However, there was a tenor to the RQIA evidence that suggested – this is what we do, but we cannot improve our systems to a point that would ever have rooted out the issues at MAH. Whether or not this is correct will be considered in our conclusions.

⁹⁵ RQIA – A Baseline Assessment and Review of Community Services for Adults with a Learning Disability - August 2013

⁹⁶ RQIA – Review of Adult Learning Disability Community Services Phase II - October 2016

⁹⁷ RQIA – Announced Finance Inspection Report, 01/07/19

Experiences of patients' relatives

14.84 The Inquiry heard some evidence from relatives about their experience of trying to raise issues through the RQIA.

14.85 P60, was in MAH between 2008 and 2022. His sister told the Inquiry of her experience with the RQIA following an allegation that a staff member had kicked open P60's door at 3am and assaulted him:

'At this point I wanted to speak to the senior management of RQIA. They said they would investigate it and would arrange a visit to the ward but they only arrange announced visits. I called RQIA numerous times and requested copies of minutes but I got nowhere. I reported that P60 was being assaulted, that he was not getting therapy, that there were issues with resettlement. I was always told that it was being investigated but I never saw the product of any investigation. The RQIA eventually stopped taking my calls. They said they wanted to arrange a visit and made recommendations but they advised they were always happy with the ward. They advised that there was never anything to say something needed changed'.⁹⁸

14.86 P109's mother raised issues about the failure, in her view, to inspect the seclusion room:

'I do not think RQIA ever went and inspected the seclusion room at this stage. The note also records that the Director of Improvement/Medical Director asked me how I would have liked the RQIA to have responded to my conversation with the inspector, to which I replied that the room was clearly not fit for purpose which is why I had raised it in 2016, and that I would have expected the room to have been dealt with at that time. So far as I was concerned, it was a highly unsatisfactory meeting. Laura pointed out that MAH was transforming the seclusion room having recognised that changes were needed. It was clearly not fit for purpose in at least 2016 when the RQIA inspected it, so the issue is why RQIA had not seen that and reported on it. I regarded that as a failed opportunity to identify the inaccuracy of the seclusion room much earlier which could have prevented other [patients] from having to experience it'.⁹⁹

'Not only was there no real incentive for families to help the RQIA as a regulator, even when they did complain, as I did on several occasions, little came of it. In my view they failed as an effective regulator. I believe that due to the complexity and unsatisfactory nature of the process, the RQIA failed to properly protect the interests and rights of vulnerable people when it could have done so, and that in my view led to avoidable harm being done'.¹⁰⁰

⁹⁸ P60's Sister Transcript – 20/09/23 – Page 39 – Line 3

⁹⁹ P109's Mother Transcript – 21/09/23 – Page 46 – Line 12

¹⁰⁰ P109's Mother Transcript – 21/09/23 – Page 49 – Line 1

14.87 P109's mother also said there was a need for a 'truly independent' regulator:

*'I believe there needs to be an independent regulator that's not affiliated to the Department of Health, because nothing will ever convince me that when I reached out to the RQIA and it was supposed to be an unannounced inspection and it wasn't, they knew they were coming. Then when they went up, they spoke to management, they spoke to consultants, they spoke to senior nurses, they spoke to apparently some patients; they failed to speak to my daughter; they failed to come back and speak to me. I personally feel they from cosyng up to each other. They all work for the Department of Health so from my perspective there's a conflict of interest. They're not independent.'*¹⁰¹

14.88 RQIA would certainly deny that it lacked independence. However, it did fail to detect the alleged abuse seen on CCTV, and it failed to develop a robust risk assessment measure based on factors it was aware of and/or could easily have discovered (such as rises in staff shortages, increased agency staff use, increased incidents of aggression), as discussed in our conclusions below.

Police Service of Northern Ireland (PSNI)

14.89 PSNI was officially formed on 04 November 2001 as part of the reforms recommended by the Patten Commission, which had been established after the Good Friday Agreement in 1998. The Agreement highlighted the need for the police to foster community trust and support across all sections of Northern Irish society. PSNI replaced the Royal Ulster Constabulary (RUC). The statutory role of the PSNI is 'to protect life and property, preserve order, prevent crime, and, where a criminal offence has been committed, bring offenders to justice'.¹⁰²

The joint protocol

14.90 The UK Home Office and DoH recognised that vulnerable adults generally needed better protection and in 2000 the UK 'No Secrets' guidance was published. The aim was to guide the development and implementation of multi-agency policies and procedures to protect vulnerable adults from abuse.

14.91 Subsequently, in Northern Ireland, the so-called 'joint protocol' was published in December 2003: 'Protocol for Joint Investigation of Alleged and Suspected Cases

¹⁰¹ P109's Mother Transcript – 21/09/23 – Page 93 – Line 18

¹⁰² Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 6

of Abuse of Vulnerable Adults'.¹⁰³ This covered peer-on-peer abuse as well as that of staff on patients, and patients on staff. Safeguarding referrals are initially assessed by the 'adult safeguarding gateway'. Where the assessment concludes that a criminal act may have been committed, the joint protocol is invoked. Among other procedures, this introduced adult joint protocol (AJP) forms to improve coordination and record management.

- 14.92 In 2009, following the Criminal Justice (Northern Ireland) Order 2008, an updated version of the joint protocol was introduced.¹⁰⁴ AJP forms became mandatory for all referrals to the police in relation to possible crimes against vulnerable adults (or adults in need of protection or at risk of harm).
- 14.93 A third revision to the joint protocol appeared in 2016.¹⁰⁵ Within all the iterations, PSNI has been required to work in partnership with other agencies, and to engage in consultations with them to determine whether each case needs either no further action, or a trust investigation, or a criminal investigation by PSNI, or a joint investigation involving the trust and PSNI. The outcome of this consultation is recorded on AJP1 forms. Where a crime or potential crime has been committed, PSNI is required to conduct a criminal investigation and prepare a file for submission to the Public Prosecution Service (PPS). The detailed process to be followed in a joint agency investigation is set out in a flow chart within the protocol.¹⁰⁶
- 14.94 Other changes occurred alongside the updated joint protocols. In 2008, the Northern Ireland Department of Justice issued 'Guidance to agencies on public protection arrangements' (known as the PPANI manual). It led to the formation of

¹⁰³ Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 3; Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 23 (Exhibit 1) – Protocol for Joint Investigation of Alleged and Suspected Case of Abuse of Vulnerable Adults

¹⁰⁴ Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 6; Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 179 (Exhibit 6) – Protocol for Joint Investigation of Alleged and Suspected cases of Abuse of Vulnerable Adults, July 2009

¹⁰⁵ Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 8; Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 233 (Exhibit 7) – Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016

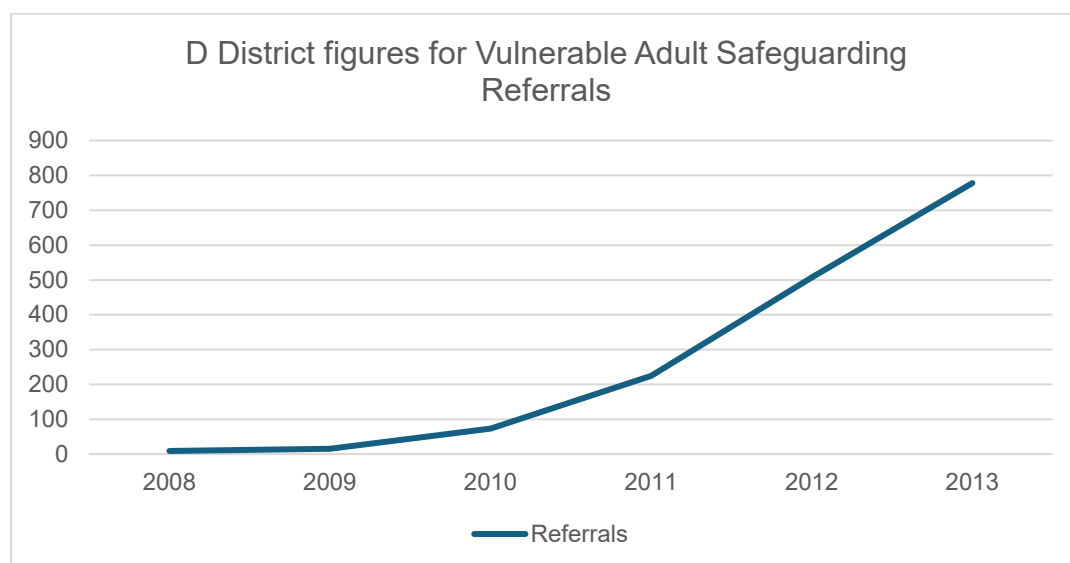
¹⁰⁶ Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 198 (Exhibit 6) - Protocol for Joint Investigation of Alleged and Suspected cases of Abuse of Vulnerable Adults, July 2009

PSNI's public protection units and the establishment of missing and vulnerable persons officers (MVPOs) in each local policing area.

14.95 PSNI is divided into eight geographical areas known as districts (A to H). MAH is located in D District, roughly aligned with the former boundaries of Newtownabbey and Antrim Borough Council and encompassing part of Lisburn. Three hospitals sit within D District: MAH, Holywell Psychiatric Hospital and Lagan Valley Hospital.

14.96 Figure 14.3 shows that D District's figures for vulnerable adult safeguarding referrals rose from nine in 2008 to 15 in 2009, to 73 in 2010, then 225 in 2011, 507 in 2012 and 778 in 2013 (these figures also included referrals arising in the community).¹⁰⁷ It may be that the rise from 2009 was partly due to the requirement under the new 2009 joint protocol that all referrals should be provided on AJP forms (previously it was not unusual for referrals to come in through phone calls).

Figure 14.3 D District vulnerable adult safeguarding referrals 2008-2013



14.97 In 2014, the PSNI established its Public Protection Branch (PPB), geographically aligned to health trusts rather than borough councils, and the MVPO role ceased to exist. A Central Referral Unit (CRU) was set up, with a dedicated team of specialist officers trained in both child and adult joint protocols and in 'Achieving Best Evidence' interviewing. Their role is to work in partnership with other

¹⁰⁷ Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 5

agencies following safeguarding referrals, to determine whether a crime or potential crime has been committed and, if so, to conduct a criminal investigation and prepare a file for the PPS (whether the alleged crime occurred in a domiciliary setting, the community or a hospital).

14.98 On receiving a referral, the CRU officers check the previous history of the alleged offender, and this is considered with the trust partners in the consultation meeting. Following investigations, at the strategy meeting, safety care plans are considered with the trust partners. Health and social care protection plans, or bail conditions can be imposed (the latter only in the most high-risk cases). Where care settings are involved, the RQIA also must be notified.

14.99 No timescales for completion of these investigations are included in the joint protocol. However, there is a requirement that all files be reviewed at 28 days by a sergeant or detective sergeant and at 56 days by the senior investigating officer (an inspector or detective inspector). DCSI Lindsay Fisher, (current interim Head of Public Protection Branch), told us that she would then chair monthly meetings around performance:

*‘That wouldn’t have necessarily been the case in 2016 but certainly over the last four years there would be monthly meetings that will look at performance, file timeliness, our outcome rates and our files over six months old. So once a file that has been reported to us is over six months old, then it will be flagged on our performance paperwork each and every month’.*¹⁰⁸

14.100 When asked proportionately how many of the files get flagged in that way, Lindsay Fisher said that it could be up to 50% of the investigations and indeed that investigations could be flagged over years without being resolved.¹⁰⁹ One of the difficulties is that if a potential crime is seen on CCTV the police, in undertaking their investigation, are likely to have to view all other CCTV available to check whether the alleged perpetrator also appeared elsewhere. This can take a very long time if there is a significant amount of CCTV footage.¹¹⁰ The Head of Public Protection is answerable to the Northern Ireland Policing Board for such issues.

¹⁰⁸ Lindsay Fisher Transcript – 08/10/24 – Pages 37-38

¹⁰⁹ Lindsay Fisher Transcript – 08/10/24 – Page 38 – Line 6

¹¹⁰ Lindsay Fisher Transcript – 08/10/24 – Pages 42-43

MAH safeguarding occurrences

- 14.101 PSNI provided the Inquiry with a spreadsheet that records incidents reported to the police in respect of MAH.¹¹¹ The spreadsheet includes reference to a small number of reports that predate the time frame of the Inquiry's ToR and includes reports up to April 2022. Over 5,000 reported incidents are captured in the period from 1991 to 2022.
- 14.102 The majority of the reports involve patient-on-patient incidents, but over 300 involve staff-on-patient incidents. The staff-on-patient incidents that gave rise to the major police investigation known as Operation Turnstone (and in turn to this Inquiry) were captured on CCTV during an approximate six-month period beginning March 2017. The time frame of the Inquiry's ToR, of course, extends significantly beyond that period and goes back as far as December 1999.
- 14.103 The Inquiry was interested in obtaining a breakdown of allegations of staff-on-patient incidents prior to the period covered by Turnstone, that is from December 1999 up to March 2017, as well as the outcomes of those cases. We asked PSNI to furnish this information. By way of response, in a second statement to the Inquiry, Lindsay Fisher recorded information that had been provided to her by the PSNI Criminal Justice Branch.¹¹² It was, however, very difficult to glean from this information a clear and unambiguous statistical picture of cases and outcomes during the relevant time (even allowing for the margins of error that arise in statistical exercises of this nature).
- 14.104 We were told that in this 'pre-Turnstone' period, 3,890 incidents were recorded as originating at MAH and of these 358 were staff-on-patient incidents (that amounts to approximately 9.2 %). In respect of four incidents, it was 'unclear' whether they could be categorised as 'staff-on-patient'.

¹¹¹ Sean Clarke Statement (Organisational Modules) – 05/09/24 – Pages 5-9 (Exhibit 1) – Muckamore Occurrences Master Sheet, April 2022

¹¹² Lindsay Fisher 2nd Statement (Organisational Modules) – 10/09/24 – Page 3

14.105 The outcome of these cases is presented in Figure 14.4.¹¹³

Figure 14.4: Outcomes of PSNI staff-on-patient safeguarding incident investigations pre-March 2017

Category	Number
No further police action – not sent to PPS	188 (includes 42 passed to social services to review)
Duplicates previously investigated/reported	27
Historical (reported when statute-barred or further investigation could not take place)	25
Enquiries ongoing and/or file to PPS	12
Incidents under investigation by Operation Turnstone	51
No prosecution directed	39
Not guilty verdict	4
Adult caution	3
Pending	4
Prosecution underway	4
Discretionary disposal	1
Total	358

14.106 DCSI Fisher explained that investigation files were sent to the PPS in respect of 104 of the total 358 staff-on-patient incidents noted above. No further police action was recorded for 188 cases (of these 42 were passed to social services to review). The picture is somewhat complicated by the fact that 51 of the total 358 cases appear to have been brought within the remit of Operation Turnstone. Further, a significant number of cases were ‘duplicates’ (27) or ‘historical’ (25). The category ‘enquiries ongoing and/or file to PPS’ (12) is also susceptible to uncertainty.

¹¹³ The statistics presented in Figure 14.4 are derived from Lindsay Fisher 2nd Statement (Organisational Modules) – 10/09/24 – Page 3 (in conjunction with Lindsay Fisher Transcript – 08/10/24 – Pages 63-68)

- 14.107 The Inquiry also explored the issue by means of an alternative route. We highlighted all staff-on-patient cases in the spreadsheet that were recorded as having been referred to PPS within the time frame of our ToR. We subsequently engaged with the PSNI and PPS to identify which of these cases were outside the remit of Turnstone and obtained the 'structured outline of case' in each of these non-Turnstone cases (this is the document that PSNI provides to PPS setting out details of the case).
- 14.108 That exercise resulted in the identification of 48 cases outside the remit of Operation Turnstone that had been referred to PPS. In 26 of those cases, the incident date was prior to March 2017; in the other 22 cases, the incident date was after March 2017. Focusing on the 26 'pre-Turnstone' cases: no prosecution was directed in 16 of those cases; two cases resulted in convictions for common assault and aggravated assault respectively; three cases resulted in an adult caution; one case resulted in a discretionary disposal; and four cases resulted in a not guilty outcome.¹¹⁴
- 14.109 These figures do not marry with the statistics provided by PSNI that we have presented in Figure 14.4. Most glaringly, the two cases that appear to have resulted in conviction are absent from those statistics. Whatever the reason for such discrepancies, it is regrettable that the Inquiry has been unable to obtain a single clear, comprehensive and comprehensible statistical breakdown of pre-Turnstone cases and their outcomes.
- 14.110 Perhaps the most significant point to emerge from the above is that relatively few complaints of staff-on-patient incidents arising in the pre-Turnstone period ultimately resulted in prosecution. This, of course, may be attributable to many factors and it must be borne in mind that the test for prosecution requires an assessment that the evidence is sufficient to provide a reasonable prospect of conviction. One witness, Detective Constable Tracy Hawthorne (an adult safeguarding officer in 2008-2015, seconded to Belfast Trust Public Protection Unit investigation into Muckamore Abbey Hospital from 2019 to 2022), offered the

¹¹⁴ No prosecution was directed in respect of the 22 non-Turnstone incidents after March 2017.

following thoughts on the difficulties in securing a conviction, particularly in respect of the offence of ill treatment of a patient:

'Where patients made allegations against staff members, these rarely progressed to decisions to prosecute. Often the alleged incidents would be deemed "Physical Interventions" for the patient's own safety ... Additionally it would regularly be reported, during multi-agency discussions, that patients making allegations against staff would have a "history of making false allegations" or be "unreliable historians". This made progressing successful cases, which relied on patient evidence, incredibly difficult due to such comments recorded in medical documents which impacted on the patient's credibility as a witness. The few cases that did progress to court were those where staff witnesses had reported wrongdoing'.¹¹⁵

14.111 Tracy Hawthorne also provided some examples of cases that did result in prosecution. In one case, five staff members witnessed a healthcare support worker (HCSW) punch a patient in the head. The police recommended prosecution and the PPS agreed, so the case progressed to Antrim Magistrates' Court. However, on the day of the hearing, the HCSW was offered an adult caution.¹¹⁶

14.112 In another case, an HCSW alleged that she had witnessed another HCSW holding a patient by the jaw, pulling him up after he defaecated in the shower and pushing him into the toilet, threatening him with a dry shave. The matter was investigated and prosecution was recommended, but the witness was deemed unreliable in court.¹¹⁷

14.113 Tracy Hawthorne said that on more than one occasion staff had told her they would be reluctant to report matters again because of how they were treated by colleagues. She said that some felt that they had been ostracised and unsupported.¹¹⁸ A number of staff told the Inquiry that they had felt ostracised by other staff after they had raised safeguarding issues. For example, one staff witness said that after reporting another member of staff for grabbing a patient by their throat:

¹¹⁵ Tracy Hawthorne 1st Statement (Organisational Modules) – 11/09/24 – Pages 13-14

¹¹⁶ Tracy Hawthorne 1st Statement (Organisational Modules) – 11/09/24 – Page 14

¹¹⁷ Tracy Hawthorne 1st Statement (Organisational Modules) – 11/09/24 – Page 14

¹¹⁸ Tracy Hawthorne 1st Statement (Organisational Modules) – 11/09/24 – Page 15

'... 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'.¹¹⁹

14.114 Another witness said that she reported a staff member for rough handling of a patient in the shower and described what then occurred:

'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'.¹²⁰

14.115 Some of the incidents recorded in Figure 14.4 arose from the events in Ennis Ward in 2012. Following the collection of evidence, PSNI sent the Ennis files to the PPS, which directed prosecution of one nurse and one HCSW. The case was heard in Antrim Magistrates' Court on 20 November 2014. The nurse was found not guilty of the offences of common assault and ill-treating a patient, while the HCSW was found guilty of common assault but not guilty of ill-treating a patient.¹²¹ The HCSW appealed; the appeal was heard on 03 February 2015, and the conviction was overturned. There was also a disciplinary investigation that did not ultimately result in disciplinary proceedings being taken against the staff members concerned. Both the nurse in question and the HCSW were suspended but remained employed by the hospital. The 2020 leadership and governance review reported that the HCSW retired at the end of the police investigation and that the nurse returned to the hospital to work for a short time (not on Ennis Ward) and retired shortly after.¹²²

14.116 Detective Sergeant Elaine McCormill (Public Protection Branch), from 2011 to 2022, including holding a senior role in adult safeguarding at the time, recalled her disappointment in the outcome of the Ennis investigation and expressed her own view as follows:

'I felt that the justice system and the judiciary had no appetite for prosecutions for the ill treatment of patients. I believed this was due to their lack of

¹¹⁹ A9 Transcript – 21/02/24 – Page 28 (restricted)

¹²⁰ Paula McCann 2nd Statement – 26/01/24 – Pages 7-8 (restricted)

¹²¹ Tracy Hawthorne 1st Statement (Organisational Modules) – 11/09/24 – Page 10

¹²² Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital – Pages 96-97. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

*knowledge around the complexities of safeguarding those with severe disabilities and unable to protect themselves or communicate in a way that supported what is already a protracted and difficult criminal justice process in NI’.*¹²³

14.117 In relation to the Investigation into events on Ennis Ward, due to the difficulties that Elaine McCormill perceived in getting staff to report other staff, especially as she could see that staff were often close friends and/or family members, she considered there was a need for covert surveillance in Ennis Ward (by means of covert CCTV), but though this was discussed at BHSCT, it was not authorised by the Trust.¹²⁴ This is contrary to the evidence of Aine Morrison (former Operations Manager for North and East Belfast community learning disability teams and the designated officer under the safeguarding vulnerable adults policy and the joint protocol for investigating abuse of vulnerable adults in place at the time), who had been told it was PSNI who had decided against using covert CCTV.¹²⁵

Operation Turnstone and MAH

14.118 Some years later, however, there was agreement that CCTV should be installed and the revelations of the CCTV recordings in 2017 led to Operation Turnstone, as has already been described in Chapter 10 (CCTV, 2017 Revelations and the Response). This generated considerable (and ongoing) work for PSNI.

14.119 The PSNI CCTV strategy document of 01 April 2019 stated that, in relation to PICU Ward and the other three wards where there was CCTV (Cranfield 1 and 2 and Sixmile), the CCTV had generated:

*‘... 151 referrals to PSNI (from PICU). Further checks were commenced in the additional 3 wards. Incidents of staff abuse of patients have been identified in these wards also resulting in referrals to police. To date there are 22 recorded incidents of abuse on Cranfield involving 6 patients and 34 recorded incidents of abuse on Sixmilewater involving 4 patients’.*¹²⁶

14.120 Later in the document it was noted that BHSCT had identified more incidents in Cranfield and Sixmile that PSNI had not yet seen:

¹²³ Elaine McCormill Statement (Organisational Modules) – 20/09/24 – Page 7

¹²⁴ Elaine McCormill Statement (Organisational Modules) – 20/09/24 – Pages 8-9

¹²⁵ Aine Morrison 2nd Statement (Evidence Modules) – 02/02/24 – Page 8

¹²⁶ Jill Duffie Statement (Organisational Modules) – 25/10/24 – Page 18 (Exhibit 5) – Op Turnstone CCTV Strategy

'BHSCT had identified 158 incidents of concern from their initial viewing of Cranfield and Sixmilewater wards prior to PSNI seizing the footage. Of these 158 incidents, 60 were deemed urgent. PSNI obtained footage of these 60 incidents from Critical Data Services to assist BHSCT with their safeguarding. Seventeen of these incidents have been viewed by the BHSCT safeguarding team. Due to the delay in the remainder of the identified incidents being viewed by BHSCT the decision was made by the SIO for the PSNI to view them and refer any concerns to the BHSCT. The viewing of this was carried out at Antrim Road PSNI Station on laptops while awaiting the set up of the viewing rooms at Seapark. To date PSNI have viewed and referred 14 of these incidents to BHSCT'.¹²⁷

- 14.121 From that time onwards, it was decided that BHSCT and PSNI would share the first viewing of the CCTV in the following way, and that they would then share the AJP1 referrals to ensure that both were aware of any concerning behaviour by staff:

'At that time, the primary objective for Police and the BHSCT was safeguarding. Until all CCTV had been viewed, there was a risk that abusive staff were continuing to work. The decision was made for Police to prioritise viewing PICU and Sixmile ward for safeguarding purposes and BHSCT would prioritise viewing Cranfield 1 and Cranfield 2 wards. This decision was taken at senior level within both the Trust and PSNI in order that all CCTV was viewed for safeguarding purposes in the quickest way possible'.¹²⁸

- 14.122 As discussed in Chapter 10, there were tensions over the sharing of data with BHSCT Human Resources (HR), and PSNI became concerned that HR was not aware of all the staff PSNI had referred to BHSCT. This led to the setting up of operational safeguarding meetings, with representatives from HR, adult safeguarding, senior nurse advisors, divisional nursing and central nursing, RQIA and a detective sergeant and constable from the PSNI Operation Turnstone team:

'The Operational Safeguarding Meetings were set up from September 2019. The meetings were attended by representatives from BHSCT, PSNI and RQIA to ensure that adequate safeguarding and safeguarding practices were adhered to. Any staff named in the AJP1's were discussed at the meetings'.¹²⁹

- 14.123 An MAH Safeguarding Governance Group was also established, comprising the PSNI, BHSCT, RQIA, DoH and HSCB. Its purpose was to oversee the assurance

¹²⁷ Jill Duffie Statement (Organisational Modules) – 25/10/24 – Page 21 (Exhibit 5) – Op Turnstone CCTV Strategy

¹²⁸ Jenny Porter Statement (Organisational Modules) – 21/10/24 – Page 3

¹²⁹ Jenny Porter Statement (Organisational Modules) – 21/10/24 – Page 4

of the management of the safeguarding concerns and information-sharing arising out of the viewing of historical CCTV in MAH.¹³⁰

14.124 Nevertheless, tensions remained over other issues. For example, there were the difficulties of staffing the wards when so many staff were being suspended. Moreover, there were high levels of sickness and resignations.¹³¹ PSNI felt these were issues for BHSCT and not issues that could affect the PSNI investigation of potential offences.

14.125 There were additional tensions over the extent to which information on the incidents viewed on CCTV could be shared with BHSCT staff. This was problematic for HR and for those who were supervising staff who had been accused of engaging in staff-on-patient incidents. DCI Jill Duffie (current Senior Investigation Officer in the Operation Turnstone Investigation Team) explained that the matter was eventually resolved:

'Initially, the information shared was at a minimal level; date, time and location of incident, but, in 2021 the scope of the information expanded to include sharing of themes of incidents e.g. forgery of records. This ensured that, at all times, the information shared under joint protocol adult safeguarding arrangements was in-keeping with the requirements of disclosure in the context of the criminal proceedings. I can further confirm that, whilst this was the approach in terms of the information which PSNI agreed could be shared by the Trust with the staff member to whom the allegations referred, the Trust staff who were in charge of supervision arrangements, were informed of the full details of the offences'.¹³²

14.126 PSNI told the Inquiry in its closing statement that the Operation Turnstone investigation had examined over 300,000 hours of CCTV. By March 2025, 274 members of MAH staff had been triaged, 97 had been interviewed, 68 files had been submitted to the PPS and there were two further files awaiting submission. The first eight staff members to be charged had been committed for trial in the Crown Court and a further eight were awaiting committal to the Crown Court in the coming weeks.¹³³

¹³⁰ Jenny Porter Statement (Organisational Modules) – 21/10/24 – Page 5

¹³¹ Jenny Porter Statement (Organisational Modules) – 21/10/24 – Page 7

¹³² Jill Duffie Statement (Organisational Modules) – 25/10/24 – Page 6

¹³³ PSNI Closing Statement Transcript – 04/03/25 – Page 5 – Line 21

14.127 The multiple issues that arose as a result of the safeguarding investigations triggered by the CCTV revelations is examined in some detail in Chapter 11.

Conclusions

14.128 Despite the existence of a number of external agencies, none identified the abuse before it came to light in August 2017. Some of the organisations admitted that they very rarely heard from patients or their families about MAH (for example, HSENI and PCC) and families often seemed unaware of them.¹³⁴ MHC inspected MAH a number of times, but the Inquiry was not told of any worries about abuse. Even in 2008, when MAH clearly seemed to be a failing hospital (see para 14.28), MHC appeared to take no action.

14.129 RQIA made very many inspections of MAH. From 2009 until 2019, there were over 100 inspections of the various wards in MAH. Complaints from families sometimes triggered RQIA inspections (see para 14.63). It seemed that the RQIA spent a great deal of time examining paperwork on inspections and much less time talking to patients or relatives and carers. Moreover, RQIA admitted that its arrival on inspections, even when unannounced, changed the dynamics of the ward.¹³⁵ As a result, inspectors did not see what was 'normal' on the ward (see para 14.77).

14.130 While it is accepted that review of CCTV footage may not form a part of every inspection, where concerns are raised the RQIA should be in a position and willing to ask to review a sample of the CCTV. Its failure to view samples of CCTV when there were major concerns appears to have been a failure resulting from what may be considered an overcautious approach to the requirements of privacy and data protection regulations. Those considerations require proportionate action to be taken, proportionate to the risk of harm to a highly vulnerable patient group. Such considerations do not appear to have taken place or, if they did, the emphasis appears to have been wrongly applied.

14.131 In its reports, the RQIA made numerous recommendations about what it saw as failings, and yet it did not detect the abuse that was discovered both in Ennis Ward

¹³⁴ AFM and SPFM Closing Statement Transcript – 03/03/25 – Page 61 – Line 3

¹³⁵ Alan Guthrie Transcript – 20/06/24 – Pages 92-93

in 2012 and in PICU, Cranfield and Sixmile wards in 2017. It was only after the abuse was uncovered in each case that RQIA made very critical inspections, and the most critical in 2019 followed the serious case review 'A Way To Go'.

- 14.132 Many services users appeared unaware of the assistance the PCC was able to provide in relation to the making of complaints.
- 14.133 PSNI's role in relation to MAH was, of course, rather different from that of RQIA: its statutory responsibility is 'to protect life and property, preserve order, prevent crime, and, where a criminal offence has been committed bring offenders to justice'.¹³⁶ PSNI was required to do this through the joint protocol, in partnership with BHSCT staff.
- 14.134 Prior to 2017, there were 358 staff-on-patient incidents notified to PSNI (see para 14.104). Relatively few criminal prosecutions took place as a result, however, and even when prosecutions did take place the alleged offenders were often found not guilty (see para 14.108). Some staff reported feeling ostracised for speaking up and reluctant to report incidents (see paras 14.113 and 14.114). This should have been seen as a sign of a toxic safety culture.
- 14.135 As we have seen, the revelations in 2017 led to an investigation that examined hundreds of thousands of hours of CCTV, with multiple staff being interviewed and charged. By March 2025, however, almost eight years after the events at the hospital had been uncovered, no resulting criminal proceedings had reached a conclusion.¹³⁷
- 14.136 Since the start of the investigation in 2017/2018 not a single defendant has faced Crown Court trial by the time of writing this Public Inquiry report, which started hearing evidence in 2022. This is inevitably a multifaceted failure but it is recognised by the Panel that many, if not all, of the relatives of those patients where allegations of abuse have been made must be deeply frustrated and bewildered at such a failure of the system of justice.

¹³⁶ Lindsay Fisher 1st Statement (Organisational Modules) – 27/08/24 – Page 6

¹³⁷ PSNI Closing Statement Transcript – 04/03/25 – Pages 5-6

Recommendations

R82	RQIA should consider developing a risk-based way of predicting which services are in difficulty. It is well known that certain aspects of services tend to be associated with abuse: service users who are vulnerable, who have few communication skills; service users with behaviour that challenges; services with poorly trained staff, insufficient staff, poor staff management, high sickness levels and high use of agency staff. Every inspection in services for these vulnerable populations must include a line of enquiry focusing on the possibility of abuse. This would be informed by a live dashboard, which should include warning signs such as staff shortages, the high use of agency staff and peer-on-peer abuse, by way of example.
R83	The RQIA needs to reconsider whether to make use of CCTV when it is in operation in a service it is inspecting where concerns have been raised.
R84	RQIA needs to consider adopting a measure of service culture specific to learning disability services for use in its inspections. Such measures have already been developed for learning disability residential settings.
R85	RQIA needs to spend proportionately more time talking to patients/residents, and its staff need to be trained in specific communication techniques such as Makaton and Talking Mats.
R86	The PCC should support service users/families and provide information on what constitutes good quality care for people with learning disabilities and autistic people, and how to spot when care is falling short.
R87	The PCC should take further steps to ensure that health service users, including carers and families of people with learning disabilities and autistic people, are aware of its statutory functions and the assistance it is required to provide with respect to complaints.
R88	PSNI needs to improve its processes for the review of live investigation files and have an effective escalation process when progress is delayed. PSNI should consider how it assures the quality of the reviews of live investigation files. Senior officers should assess a significant sample of reviews to ensure all possible action has been taken to conclude the investigation and that delays are escalated promptly.
R89	The Department of Justice should review the timeliness of the handling of each aspect of the prosecution system that has led to the delay in bringing those accused of causing harm to patients to trial.

Patients are people first

'My son was fit and healthy and enjoyed cycling and could cycle eight to 10 miles in a day'

'He has a routine of music programs that he loves to listen to every day. Due to his autism, routine is extremely important to him.'

'He was brought shopping, and being a typical man, he did not enjoy shopping. He was brought to Nutts Corner Market, and he enjoyed fresh air.

His favourite part of getting out was going in the car, and he was car mad. He would motion with his arms to go faster and laugh.

My brother would always be watching for us coming and loved to see us. He was very placid and loved his nieces and nephews. He was very good natured and had a mischievous personality. He was good at swimming and we as family hoped that he was able to use the swimming facility at MAH'

Chapter 15

Resettlement

15.1 When Muckamore Abbey Hospital (MAH) first opened in 1949, it had only four beds for young women, but it quickly grew, so that by 1952 it housed 74 people.¹ The numbers then began to grow very rapidly and by 1973 it housed almost 900 people, although by the end of 1984 that number had fallen to 789 people. MAH numbers continued to drop in the 1990s and had fallen to 618 by the end of 1991, were down to 558 by 1993 and in 2001, two years after the start of our Inquiry's Terms of Reference (ToR), it was recorded that MAH housed 357 people.²

15.2 In the early days – the 1950s to 1980s – and even into the 1990s, MAH seemed to be the only residential provision (outside the family) in Northern Ireland for children and adults with learning disabilities and/or autism who had additional needs, because community-based provision was so poor. In some cases, MAH was used for respite care, and families were often told there was nowhere else their son or daughter could go when the family was no longer able to provide full-time care:

'P149 was largely non-verbal and she suffered from epileptic fits ... When my mother became pregnant with her third child, my sister P149's other sister, she found it difficult to manage the 24-hour care. My mother was 7 months pregnant when the doctor got P149 a place at MAH. I was 12 at this time. This was supposed to be respite care for 9-10 weeks until the baby was born'.³

'When Martin was 16, we were told by MAH that he needed to attend on a full-time basis as this was the only option due to him self-harming. Martin moved into Conicar where he lived during the week, coming home at weekends'.⁴

'Michael was 9-years old when he was admitted to MAH. He was a voluntary patient. He went in on 5th May 1989 and was there until the end of August 1999 ... Michael was admitted to the Conicar Ward. This is an adult ward and Michael was the only child on the ward. We were told there was nowhere else for him to stay'.⁵

¹ I. Montgomery and J. Armstrong (2009) From Special Care to Specialist Treatment: A History of Muckamore Abbey Hospital. Ulster Historical Foundation, Belfast (ISBN:978-1-903688-41-0) – Pages 4, 60 and 72 – <https://ulsterhistoricalfoundation.com/library/from-special-care-to-specialist-treatment-a-history-of-muckamore-abbey-hospital>

² Figures taken from From Special Care to Specialist Treatment (Montgomery and Armstrong) – Pages 110, 120, 127 and 162.

³ P149's Sister Statement – 28/02/22 – Page 2

⁴ P1's Sister Transcript – 28/06/22 – Page 18 – Line 12

⁵ P11's Father Transcript – 06/07/22 – Pages 12-13

15.3 However, by the late 1980s there was some belated recognition and policy direction in Northern Ireland that large hospitals were not a good model of service provision for people with disabilities, given the earlier Ely Hospital scandal⁶ in Wales and the UK Government guidance 'Better services for the mentally handicapped' that followed.⁷ In 1995 the Department of Health and Social Services (DHSS) in Northern Ireland issued further policy guidance that: 'the resettlement of those in hospital should be pursued with the utmost vigour', the aim being 'to reduce to zero by 2002 the number of long stay patients in hospital'.⁸ Nevertheless, progress towards this target was very slow and by 2002 MAH still had more than 350 beds,⁹ with less than half of these being 'treatment beds' and the remainder of patients awaiting resettlement and discharge.¹⁰ According to a review in 2000 of 68 people who had been resettled from MAH, some had been in MAH for 40 years, and the median length of stay of those leaving was eight years, while the median length of stay of those still in MAH was 32 years.¹¹

Bamford Review

15.4 In October 2002, Northern Ireland's DHSS initiated a 'major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland', known as the Bamford Review. Its terms of reference were to: 'carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986' (MHO 1986). It was also asked to: 'make recommendations regarding future policy, strategy, service priorities and legislation, to reflect the needs of users and carers'.¹²

⁶ Department of Health and Social Security (1969) Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other irregularities at Ely Hospital, Cardiff. DHSS.

⁷ Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other irregularities at the Ely Hospital, Cardiff. Presented to Parliament by the Secretary of State of the DHSS – March 1969. Cmd 3975, Hansard – <https://api.parliament.uk/historic-hansard/commons/1969/mar/27/ely-hospital-cardiff>; Department of Health (1971) Better services for the mentally handicapped – <https://navigator.health.org.uk/theme/better-services-mentally-handicapped-white-paper>

⁸ DHSS (NI) (1995) A regional strategy for the Northern Ireland Health and Personal Social Services, 1997-2002. DHSS (NI), Belfast; The Health and Personal Social Services (Amendment) (Northern Ireland) Order 1995 – <https://www.legislation.gov.uk/nisi/1995/2704/contents>

⁹ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 184

¹⁰ R. McConkey (2004) Validation of Learning Disability Hospital Services – Page 15

¹¹ Roy McClelland Statement (Evidence Modules) – 03/03/23 – Page 1881 (Exhibit T04.05) – Moving on from MAH (December 2000)

¹² Department of Health (2002) Bamford Review of Mental Health and Learning Disability. DoH, Belfast – <https://www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability>

- 15.5 The Inquiry heard evidence from Professor Roy McConkey (Emeritus Professor of Developmental Disabilities at Ulster University), who was a member of the Bamford Review team, and from Professor Roy McClelland (Consultant Psychiatrist and Emeritus Professor of Mental Health at Queen's University Belfast), who took over as the review Chair on the untimely death of Professor David Bamford. The Bamford Review informed the development of learning disability services in Northern Ireland and the supporting legislation, the Mental Capacity Act (Northern Ireland), which was eventually to follow in 2016.
- 15.6 A series of reports were subsequently published relating to various aspects of the Bamford Review, one of which – and central for our purpose – was 'Equal Lives' (2005), a review of policy and services for people with a learning disability.¹³ The report quoted the United Nations statement on disabilities of 1994: 'Persons with disabilities are members of society and have the right to remain within their local communities. They should receive the support they need within the ordinary structures of education, health, employment and social services'.¹⁴
- 15.7 The importance of a clear distinction between the work of the rest of the Bamford Review report on mental health and that of the group working on learning disability was well recognised. As was said in the Equal Lives report:
- '... coupling learning disability with a mental health review may create confusion about the nature of mental ill health and learning disability, which are two very distinct conditions. In particular learning disability is usually present from birth, it is a life-long condition that cannot be cured and people with a learning disability require educational and social supports as well as health and social services. We would recommend that in future such an approach to addressing needs should be avoided'.¹⁵*
- 15.8 Prior to the central work of the Bamford Review, a research project was undertaken to monitor all admissions and discharges to MAH over a two-year period between approximately 2000 and 2001.

¹³ Review of Mental Health and Learning Disability (Northern Ireland) (2005) Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland. Department of Health, Social Services and Public Safety, Belfast – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Equal%20Lives%20Report.pdf>

¹⁴ United Nations (1994) Standard Rules on the Equalization of Opportunities for Persons with Disabilities – <https://www.ohchr.org/en/instruments-mechanisms/instruments/standard-rules-equalization-opportunities-persons-disabilities>

¹⁵ Roy McClelland Statement – 03/03/23 – Page 323 (Exhibit T02.02) – Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

- 15.9 The research revealed a number of high-level findings. Firstly, there seemed to be a revolving door of the same people being admitted, discharged into the community and admitted again, which seemed to be an indicator of the fragility of community services for this cadre of patients. Secondly, many patients had a mild or borderline learning disability but were nevertheless being admitted to the full hospital setting of MAH. Thirdly, once admitted the treatment was largely medication focused, with little evidence of other forms of therapy to address patients' behavioural difficulties, thus once discharged from the medicalised environment of MAH they reverted to previous behaviour. Fourthly, many people admitted to MAH came from congregated (group) living models of care such as nursing or residential homes.¹⁶
- 15.10 The Learning Disability Working Committee that wrote Equal Lives noted that the last review of policy for people with a learning disability in Northern Ireland by the DHSS in 1995 had stated that: 'the aim of Government policy for people with a learning disability should be inclusion ... which stresses citizenship, inclusion in society, inclusion in decision-making, participation so far as is practicable in mainstream education, employment and leisure, integration in living accommodation and the use of services and facilities, not least in the field of health and personal social services'.¹⁷ However, the committee also noted that 'these aspirational statements have not fully been translated into practice', even though it did seem that the three Northern Ireland hospitals for people with learning disability (of which MAH was one) had reduced somewhat in size, and some people had been resettled in the community, as more community provision was beginning to be seen.¹⁸ The Learning Disability Working Committee put this failure to achieve what was hoped for down to insufficient resources to build community infrastructure (a theme we have seen repeatedly), a lack of robust implementation strategies and underdeveloped involvement of people with learning disabilities and their carers.¹⁹

¹⁶ Roy McConkey Transcript – 21/03/23 – Page 14 – Line 5

¹⁷ Mark McGuicken Statement (Evidence Modules) – 13/02/23 – Pages 1412-1521 (Exhibit MMcG/36) – DHSS Review of Policy for People with a Learning Disability (1995)

¹⁸ Roy McClelland Statement (Evidence Modules) – 03/03/23 – Page 1881 (Exhibit T04.05) – Moving on from MAH (December 2000)

¹⁹ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005)

- 15.11 These early attempts at resettlement had mostly involved discharge to nursing homes. There were few alternatives of the less restrictive kind, with supportive living and direct payments not appearing in Northern Ireland until later, despite some families wanting their relatives discharged home but with some extra help:

'In 1997 Bryan's Consultant advised us that Bryan was medically fit for discharge from MAH. Our mother was still alive, and we breathed a sigh of relief when we were told that Bryan was at long last fit for discharge. We had originally been led to believe by MAH that Bryan would return to the family home with support. Not only am I a trained nurse but my sister Anne-Marie is also a trained nurse, and we believed that it would have been feasible for the family to look after Bryan with support. So, when we were told that Bryan was medically fit for discharge, we thought this meant he would be able to return to the family home and once again be cared for by his loving family. However, it was made clear that this was not an option, and Bryan would be re-settled in a facility in the community. This was about nine years after his admission. We never thought that it would take approximately 26 more years before a suitable placement would be secured for Bryan'.²⁰

- 15.12 The Equal Lives report identified some fundamental plain truths with which the Department of Health (DoH) needed to grapple:

'People with a learning disability in Northern Ireland do not enjoy equality of opportunity and are often excluded from the opportunities that other citizens enjoy. Their families frequently suffer high levels of social disadvantage and their caring responsibilities can place them under almost unbearable levels of stress. There is evidence of progress having been made, but in order to fully tackle these difficulties there is a need for major co-ordinated developments in support and services and a continuing change in attitudes over at least the next 15 years. We believe this will be best achieved through the adoption of a shared value base, a focus on shared core objectives and rigorous efforts across Government departments and agencies in the community to implement the change agenda that is detailed in the Equal Lives Review'.²¹

Whether such a focus or rigorous effort in fact transpired we will examine in due course.

- 15.13 The vision that was developed in Equal Lives, after consulting people with learning disabilities, their carers and other stakeholders, as well as considering the evidence base, was of comprehensive community-based services, challenging the

²⁰ P90's Sister Statement – 02/10/23 – Page 27

²¹ Roy McClelland Statement – 03/03/23 – Page 324 (Exhibit T02.02) – Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

medical model of disability, recognising the social model and adopting overall a biopsychosocial model. Two of the 12 Equal Lives objectives were:

- 'To ensure that all men and women with a learning disability have their home, in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need (objective 5)
- To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability' (objective 7).²²

This meant that there was a major need to increase community-based provision and resettle people from the hospitals.

15.14 Equal Lives reported that 16,366 people (adults and children) with a learning disability were known to services in Northern Ireland (approximately 1% of the total population). It was thought that as many again were living in Northern Ireland but not known to services (given that the usual prevalence figure when all members of a population are assessed is 2%), and this was later proved correct in the 2011 census in which 40,000 people were identified as having learning disabilities of one kind or another.²³ Equal Lives considered that these numbers were likely to rise for various reasons, and it was recognised that the influence of social deprivation and the 'Troubles' was likely to have been considerable, such that the number of people with learning disabilities needing services might be proportionately higher than in more affluent, settled areas of the UK.²⁴ According to Equal Lives, in 2003, 455 men and women with a learning disability in Northern Ireland had no home outside a hospital, despite the fact that hospital resettlement had been the cornerstone of government policy in Northern Ireland since 1995.²⁵

²² Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 8

²³ Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Page 27

²⁴ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Pages 20-23

²⁵ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 61

- 15.15 Equal Lives also considered the financial aspects of resettlement. The overall budget for learning disability services from the 1990s moving into the early 2000s was around 7-8% of the total health and social care budget; when considered together with mental health services, the budget rose to around 16% of that total. We examine the funding and commissioning of such services in more detail in Chapter 16 (Planning and Funding of Learning Disability Services in Northern Ireland). This was, however, the only available money in Northern Ireland for these services, in contrast with the rest of the UK, where local authority funding was available alongside that of central government. It appeared when compared in that way, that Northern Ireland was underfunded in terms of learning disability services when compared with the rest of the UK.²⁶
- 15.16 The Learning Disability Working Committee estimated that in 2002-2023 nearly £33 million had been spent on hospital provision for people with learning disabilities in Northern Ireland. It noted that there was a mismatch between the proportions of monies spent on hospital provision and the number of people in hospital settings (24% of the learning disability budget went on hospital provision, whereas only 4% of the people with learning disability were within such provision).²⁷ The committee also noted that Northern Ireland had the highest proportion of people with learning disabilities resident in long-stay hospitals, with 222 places in hospitals per million of the general population in Northern Ireland (compared with 163 places per million of the general population in Scotland and even fewer in England and Wales). There were also proportionately more nursing home places (resulting in a new long-stay population), and fewer supported living places in Northern Ireland, than in the rest of the UK, and families reported difficulty accessing respite care in emergencies. Equal Lives noted a series of difficulties that needed to be overcome, particularly the lack of bridging finance (compared with Great Britain) to enable people to be resettled from hospitals, and the lack of a commitment to the resettlement of all long-stay patients by a designated date.²⁸ The review asserted that: 'People should not live in hospital accommodation.'

²⁶ Roy McConkey Transcript – 21/03/23 – Pages 16-17

²⁷ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 26

²⁸ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 63

Some may have to be admitted for short periods (of up to 6 months) of acute assessment and treatment, but no one should remain there for long periods (12 months+) due to their specialist needs'.²⁹

15.17 Roy McConkey highlighted another factor that influenced the discharge of patients from MAH to a congregated model of residential care. That was the requirement that patients at MAH were under the care of a psychiatrist who had to sign off their discharge to a place which that psychiatrist deemed as suitable to the person's needs. This suitable place was often thought to require full-time nursing staff, which in turn led to high numbers of people living in nursing homes.³⁰ Thus the medical model of care continued into discharge settings.

15.18 The Equal Lives review considered different models for learning disability care (including the traditional medical model and the social model) and favoured a holistic person-centred approach. In the preface to the report Professor Bamford said:

'The Equal Lives Review has concluded that progress needs to be accelerated on establishing a new service model which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else'.³¹

The preface concluded with these words:

'The success of implementing the Equal Lives recommendations depends on the contribution of many stakeholders, but most of all Government, who must give a lead on implementing the process of change. We fully recognise the resource implications and urge Government, in particular the Department of Health, Social Services and Public Safety, to begin the necessary process of reform and modernisation of these services immediately'.³²

15.19 Recommendation 27 of Equal Lives was that: 'Resettlement of long-stay patients from hospitals within the context of supported living principles must be progressed

²⁹ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 64

³⁰ Roy McConkey Transcript – 21/03/23 – Pages 18-19

³¹ Roy McClelland Statement – 03/03/23 – Page 318 (Exhibit T02.02) – Foreword Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

³² Roy McClelland Statement – 03/03/23 – Page 318 (Exhibit T02.02) – Foreword Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

as rapidly as possible. By June 2011, all people living in a learning disability hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the five year period from 2006 to 2011'.³³ Other recommendations included that: there should be both emergency support and accommodation in the community (Recommendation 28); housing support should be provided for five or fewer people per house (i.e. there should be no more large nursing homes) (Recommendation 29); access should be established to mainstream mental health services for those with mental health needs (Recommendation 46); and there should be community-based assessment and treatment services (Recommendation 47). The report also recommended an increase of 100 supported living places every year for the next 15 years.³⁴

15.20 The review team acknowledged that achieving the objectives set out in the report would require a major programme of work, including additional resources, leadership and reconfiguring the workforce.³⁵

15.21 The value of resettlement into the community had been proved in Great Britain and there was evidence it had been adopted in a small way in Northern Ireland, where it had been demonstrated to have successful outcomes and few people needing to be readmitted to hospital.³⁶ This was despite the original opposition of relatives and family carers to the removal of their loved one from a hospital setting.³⁷ Roy McConkey also told the Inquiry this:

*'Then, sad to say, we also had a growing awareness that there was a higher risk of abuse happening in these types of long-stay hospitals, and that goes back quite a number of years in England and in Wales, and, indeed, I remember a colleague of mine in the past working in Wales had said to me, "Do you know, maybe the only way we'll ever close long-stay hospitals is when there's abuse proven to have occurred and on a systemic basis". I thought at that time that was a bit of an exaggeration, but, sad to say, I think his words were quite percipient in that way'.*³⁸

³³ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 64

³⁴ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Pages 130-131

³⁵ Roy McClelland Statement – 03/03/23 – Page 327 (Exhibit T02.02) – Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

³⁶ Roy McConkey Transcript – 21/03/23 – Page 33 – Line 14

³⁷ Roy McConkey Transcript – 21/03/23 – Page 34 – Line 1

³⁸ Roy McConkey Transcript – 21/03/23 – Page 34 – Line 12

- 15.22 Roy McConkey admitted that the issue of abuse had barely been referenced in the Equal Lives report.³⁹ It was plainly not considered then to be a significant danger.

Delivery of the Bamford vision of resettlement

- 15.23 In 2005, when Equal Lives was published, MAH had 318 patients and a target was set to reduce that number to 87 patients by 2011; it was thought that those 87 people would need short-term active assessment and treatment rather than long stays.⁴⁰ In order to monitor progress on the commitment to resettle long-stay patients, a priority target list (PTL) of those patients living in a long-stay learning disability hospital for more than a year at 01 April 2007 was established.⁴¹
- 15.24 There followed a number of reports by the Northern Ireland Executive and the DoH about the delivery of the 'Bamford vision', which encompassed mental health services as well as learning disability services.⁴² For learning disability services, the 2009-2011 'Delivering the Bamford vision' action plan included wide-ranging recommendations for better child and family support, education and transition services for children, while for adults the recommendations included new legislation (on mental capacity), increased day opportunities and employment, better community-based health services, and increased advocacy and respite services, as well as resettlement from hospitals. When considering resettlement, the 2009-2011 plan asserted that:
- 'A patient is identified for resettlement only when it is clinically appropriate and it is clear that the patient's needs can be met and quality of life can be improved by the placement – the concept of 'betterment'.*⁴³
- 15.25 The 2009-2011 plan listed about 70 actions for services for people with a learning disability, one of which was a 25% reduction in the number of long-stay patients in learning disability hospitals by 2011.⁴⁴ This was already a major reduction in the

³⁹ Roy McConkey Transcript – 21/03/23 – Pages 34-35

⁴⁰ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 175

⁴¹ B. Mongon and I. Sutherland (2022) Independent Review of the Learning Disability Resettlement Programme in Northern Ireland – Pages 13-14 – <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-ind-review-ld-resttlement-july-2022.PDF>

⁴² Department of Health, Social Services and Public Safety (2009) Delivering the Bamford Vision: The response of Northern Ireland Executive to the Bamford Review of Mental Health And Learning Disability. Action Plan 2009-2011 – <https://www.niassembly.gov.uk/globalassets/documents/employment-and-learning/inquiries/post-sen/government--academic-papers/delivering-the-bamford-vision---action-plan-2009---2011.pdf>

⁴³ Delivering the Bamford Vision: Action Plan 2009-2011 (DHSSPS, 2009)– Page 99

⁴⁴ Delivering the Bamford Vision: Action Plan 2009-2011 (DHSSPS, 2009) – Page 119

resettlement ambitions of the DHSS 1995 regional strategy and Equal Lives review (see paragraphs 15.3 and 15.10). Disappointingly, in 2012 there were still 225 beds available.⁴⁵ As one member of the Belfast Health and Social Care Trust (BHSC) social work staff told the Inquiry:

'There has never been a proper implementation of the Equal Lives Report. The implementation was stop-start and subject to financial constraints'.⁴⁶

15.26 In 2011, there was another review of health and social care going on in Northern Ireland: 'Transforming Your Care: A Review of Health and Social Care in Northern Ireland' (TYC) was published by the Health Minister on 13 December 2011. It set out 99 proposals for the future of health and social care services in Northern Ireland, concluding that there was 'an unassailable case for change and strategic reform'. TYC was concerned with all parts of the population of Northern Ireland, not just those with mental health needs or learning disabilities. However, its goals for those with learning disabilities were commensurate with the goals in Equal Lives:⁴⁷

- Move clients into community-based options such as supported housing and, as a consequence, reduce the number of people in institutional care
- The service will resettle all people with a learning disability living in hospital by March 2015 to community living options with appropriate support
- Provide support for families and carers including short breaks/respite and day opportunities to enable people with a learning disability to remain at home with appropriate support.

15.27 The next Bamford action plan, for 2012-2015, listed 76 planned actions but most of these were for mental health services.⁴⁸ It noted that a learning disability service framework had been published by the Department of Health, Social Services and Public Safety (DHSSPS) in 2013 (revised 2015), but reported that, while the previous plan had been to allocate £17 million more funding to learning disability services, in fact this had to be reduced to approximately £12 million. It was also

⁴⁵ Internal Inquiry Analysis of Data provided by BHSC

⁴⁶ John McCart Transcript –16/11/23 – Page 15 – Line 23

⁴⁷ Brona Shaw 1st Statement (Evidence Modules) – 06/04/23 – Page 1317 (Exhibit T02.14) – October 2012 Health and Social Care Board, Transforming Your Care, Draft Strategic Implementation Plan

⁴⁸ Department of Health, Social Services and Public Safety (2012) Delivering the Bamford Vision: The response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015 – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf>

noted that there were still over 200 patients in hospital, and this time it committed to resettling them all by 2015 – another move of the goalposts. This action plan again proposed only a 25% reduction in long-stay patients.⁴⁹

15.28 The various health and social care trusts (HSCTs) in Northern Ireland differed in their provision of community services, though they all had a community learning disability team. The Northern Health and Social Care Trust (NHSCT), for example, had developed day-care and day opportunity services and an intensive support service,⁵⁰ whereas other trusts did not necessarily have these services, and the Regulation and Quality Improvement Authority (RQIA) in its 2013 report on Northern Ireland community services considered the support in the different areas to be very variable (see paragraph 15.30).

15.29 The lack of appropriate community support and accessibility of day care in some parts of Northern Ireland was reflected also in the family experience.

'I regard this as a serious failing in the system of discharging patients from MAH, as even when an appropriate placement is finally found in the community, the supports that are required to enable them to keep them safe and to allow them to live as full and enjoyable a life as possible are very often not there.

BHSCT is aware of P119's requirements for external day care. They will have known that from when P119 was five years old that she has had access to a day care placement external to where she lived as part of her daily routine. This continued even when she was in MAH, and we were assured that it would be provided as part of the BHSCT's arrangements for her discharge and placement in August 2020, but it is not. P119 was 33 years old when she was discharged from MAH and, therefore, external day care had been part of her life for nearly 28 years. It provided P119 with a structure to her day and routine, and I believe that without it P119 would have lost her sense of purpose and access to her peer group in the learning disability community. I believe that that loss of this important part of her life led P119 to suicidal thoughts and attempts to take her life, because she was so lonely and saw it as a way of being reunited with her friend who had died'.⁵¹

15.30 In 2013, the RQIA conducted a review of community services for people with learning disabilities and/or autism in the five Health and Social Care Trusts (HSCTs). The RQIA recognised that HSCTs were trying to reduce the need for

⁴⁹ Roy McConkey Transcript – 21/03/23 – Page 54 – Line 26

⁵⁰ Petra Corr Transcript – 05/04/23 – Page 59

⁵¹ P119's Mother Transcript – 28/09/23 – Pages 31-32

hospital-based care by developing community-based personalised support. However, RQIA reported that this seemed to be hampered by inadequate funding. It also reported that community-based services were difficult to compare across HSCTs because they had different structures and strategies, which seemed to have arisen historically rather than being evidence-based, and there were varied behavioural supports available.⁵²

- 15.31 Around 2015 the focus shifted towards the use of service frameworks for learning disability.⁵³ Three service standards were particularly relevant. First, that people of all ages should be safeguarded from harm through abuse, exploitation or neglect. Secondly, individuals with a learning disability who have behavioural challenges should be able to receive support locally. Thirdly, health professionals should work in partnership with other agencies to meet the accommodation needs of individuals with a learning disability.⁵⁴
- 15.32 A key performance indicator was the proportion of individuals living in settings with fewer than five unrelated individuals. This metric was drawn directly from the Bamford Review.⁵⁵ However, when asked how easy it was for working groups to monitor what was actually happening in terms of implementation, Roy McConkey told the Inquiry: 'The information went up rather than any coming down'.⁵⁶
- 15.33 In 2016, the RQIA conducted a second review of community-based services to examine the progress of the five HSCTs in the implementation of 34 standards relating to a service framework for adults with a learning disability.⁵⁷ This found improvements in the safeguarding of vulnerable adults, access to a better choice of day activities, improved GP service and establishment of specialist teams for supporting the management of challenging behaviours. Nevertheless, the RQIA made 25 recommendations for improvements, including: more co-production (with carers and people with learning disabilities), better access to advocacy, increases

⁵² RQIA - A Baseline Assessment and Review of Community Services for Adults with a Learning Disability - August 2013

⁵³ Roy McConkey Transcript – 21/03/23 – Page 55 – Line 24; Roy McConkey Presentation Notes – 21/03/23 – Page 6

⁵⁴ Roy McConkey Transcript – 21/03/23 – Page 56 – Line 27

⁵⁵ Roy McConkey Transcript – 21/03/23 – Page 57 – Line 8

⁵⁶ Roy McConkey Transcript – 21/03/23 – Page 58 – Line 29

⁵⁷ RQIA (2016) Review of Adult Learning Disability Community Services (Phase II), October 2016

in direct payments, better focus on improvements in health (such as in smoking and obesity), better inclusion for people with mild learning disability into mainstream mental health facilities, improved employment opportunities for people with learning disability, collection of evidence on the activity and effectiveness of challenging behaviour teams (for example, using the NHSCT outcome model), and a number of other matters.

- 15.34 Both Mairead Mitchell (former Head of Learning Disability Services at BHSCT 2016-2019) and Esther Rafferty (former service manager and former Associate Director of Nursing Learning Disability Services for the BHSCT in 2012) felt that in 2016 the main priority as regards MAH was for resettlement.⁵⁸ Both also clearly felt that the poor resources in the community led to admissions and readmissions to MAH, as well as difficulty resettling patients from MAH, and both were concerned about the lack of allied health professionals to assist in MAH:

[Ms Mitchell:] 'Because the resources in the community weren't enough for the complexity of the patients that were being discharged. There was poor support mechanisms in place, and when there was, for instance, a crisis in the community, patients were then admitted to Muckamore, and in many instances they may not have needed to be admitted to Muckamore. If there had have been more resources in the community, we could have kept people in the community'.⁵⁹

- 15.35 One of the advances in relation to resettlement had been the provision of the Supporting People (SP) programme fund, operated by the Northern Ireland Housing Executive (NIHE) (see paragraphs 15.41 and 15.59). Between 2012 and 2016 this had provided 79 new tenancies in Belfast, but in 2016 there was a freeze on the SP funding, and 38 new tenancies were at risk.⁶⁰ By September 2017, there were still 93 residents in MAH awaiting resettlement.⁶¹ By 2019 this had reduced to 56 residents. At this point, in the summer of 2019, the DoH announced yet another new target – to close the hospital completely within six months:

'The intention to resettle the patients in MAH and close the hospital by December 2019 was announced by the Department of Health'.⁶²

⁵⁸ Mairead Mitchell Transcript – 16/09/24 – Page 99 – Line 4; Esther Rafferty Transcript – 15/10/24 – Page 13 – Line 24

⁵⁹ Mairead Mitchell Transcript – 16/09/24 – Pages 103-104

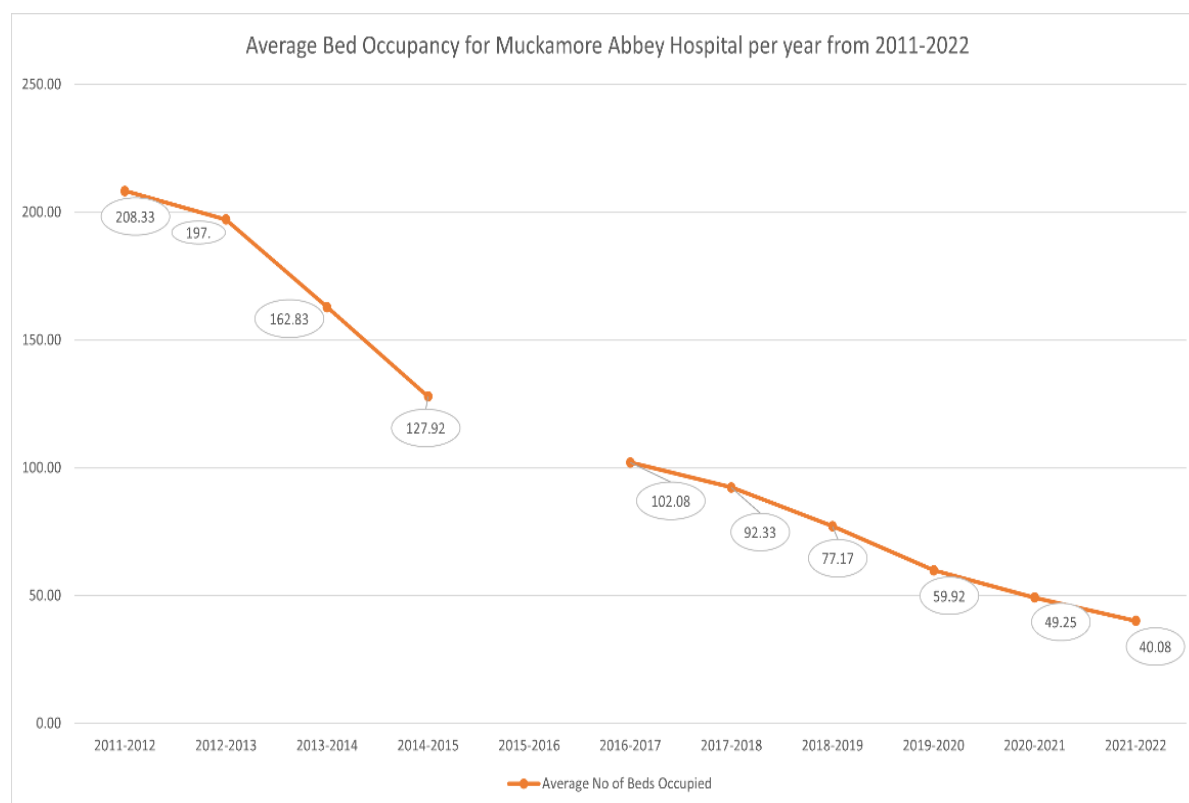
⁶⁰ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Page 240

⁶¹ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Page 42

⁶² Fiona Rowan Transcript – 24/06/24 – Page 99

Like all the previous targets, this was not achieved. The graph in Figure 15.1 shows the bed occupancy in MAH between 2011 and 2022 (2015-2016 figures were unavailable).⁶³

Figure 15.1: MAH bed occupancy by year



15.36 Roy McConkey told the Inquiry that, in 2021, the Health and Social Care Board (HSCB) launched a regional learning disability model. However, the outputs from this initiative have yet to be published.⁶⁴ He said:

*‘There was some concern that the five trusts had developed very diverse models of provision into things like day opportunities, in types of accommodation and so on. And it was a bit of a bemusement to us that, having had the Equal Lives Review, that there was the need to do what almost seemed to be a repeat of the Equal Lives Review. And the report that they have submitted to the Department has not been made public, as yet, but it was widely consulted by the Board and the people leading that review and they came up to all intents and purposes that there would be the need for a much more coherent model of service provision so that the people, wherever you lived in Northern Ireland, you would have the opportunity of having the same type of supports that you would get if you were living in another part’.*⁶⁵

⁶³ Internal Inquiry Analysis of Data provided by BHSCT

⁶⁴ Roy McConkey Transcript – 21/03/23 – Page 62 – Line 20

⁶⁵ Roy McConkey Transcript – 21/03/23 – Page 62 – Line 24

- 15.37 It was plainly Roy McConkey's view that if the Bamford recommendations had been fully implemented, this Inquiry and its associated outlay of costs, might never have been necessary. Roy McConkey summarised his view as follows:

'I think I also have to realise I've learned a lot about how the lack of commitment to implementation there was within statutory systems [sic]. The status quo seemed to be something that they valued -- it needed to be protected more than what implementation of new things could offer -- and make life easier for everyone, in the end. So your question earlier, Chair, when you said about implementation, I think I now appreciate how, maybe, any review needs to be really conscious of right at the outset thinking: Well, how are we going to change the system? How are we going to make that happen? And I've already said that I think the value for money has been rarely considered and we didn't do sufficient attention to that element. And the economics and the financial arguments that now are so topical within the Northern Irish health and social care system, that value for money. And, yet, we've had the Bengoa Report, we've had the Transforming Your Care Report, and those equally have met similar fates to the Bamford Review.

So I think there's a lot of lessons that we can draw for future reviews and inquiries in Northern Ireland about all the effort that we expend and all the talent we bring together and all the great minds that we, hopefully, try to address pressing issues, can easily, apparently, not come to very much. So I hope you are spared that outcome from your particular inquiry'.⁶⁶

- 15.38 Roy McClelland believed that, had the Bamford Review recommendations been implemented, MAH would not have existed in 2017. At most, he suggested, it might have remained only as a small acute assessment and treatment facility, which he considered would likely always be required.⁶⁷ Nevertheless, the (hopefully rare) detention of people with learning disabilities will inevitably continue when emergency situations arise, and the challenge is to ensure a high-quality service is available. The Inquiry noted that in a recent (23 September 2025) response to a question from Gerry Carroll, a Member of the Legislative Assembly (MLA), the Minister of Health revealed that since the closure of MAH to new admissions in 2018, there have been 187 adults with learning disabilities detained under the MHO 1986.⁶⁸

⁶⁶ Roy McConkey Transcript – 21/03/23 – Page 65 – Line 26

⁶⁷ Roy McClelland Statement – 03/03/23 – Page 3

⁶⁸ Northern Ireland Assembly (2025) AQW 31801/22-27 – <https://aims.niassembly.gov.uk/questions/writtensearchresults.aspx?&qf=0&qfv=1&ref=AQW%2031801/22-27>

The process of resettlement

15.39 In Great Britain, resettlement of people with learning disabilities from large hospitals into the community began to occur in the 1970s, and some large hospitals, in counties like Kent (such as Darenth Park Hospital and Leybourne Grange Hospital), closed in the late 1980s and early 1990s.⁶⁹ Yet in Northern Ireland resettlement had hardly begun before the Bamford Review in the early 2000s. As one senior member of social work staff told the Inquiry:

'I think Northern Ireland has been behind in a lot of its social care, the development of its social care, and has relied and still relies on too much institutional care'.⁷⁰

15.40 Nevertheless, the process of resettlement was broadly similar in Great Britain and Northern Ireland. As MAH was a regional setting, its residents came from different HSCTs around Northern Ireland, and (at least in recent years) in Belfast there was a community integration coordinator who 'provided the link between the hospital and community services, with a regional coordination role, and reported to Belfast Trust community services and the HSCB on discharges'.⁷¹ There was also a trust planner, who had a similar role in relation to the resettlement plans and housing, coordinating with HSCTs, the HSCB and NIHE.⁷² Both of these posts were managed by the Adult Social and Primary Care Services manager.

15.41 For the individual residents of MAH, it was the job of the local HSCT of origin (normally this would mean the area in which the patient was originally resident) to resettle its own residents. This meant that for each person to be resettled there was a need for considerable joint working and liaison between MAH nursing and/or social workers, and community-based nurses and/or social workers/care managers in the HSCT of origin.⁷³ Hypothetically, the resettlement process was supposed to involve person-centred assessments of individual hospital residents by social workers/care managers from their HSCT of origin, with commissioning of community placements to suit their needs (though all too often community placements were commissioned and then hospital residents were slotted in).⁷⁴

⁶⁹ E. Emerson and C. Hatton (1994) *Moving Out: Relocation from Hospital to Community*. London, HMSO.

⁷⁰ John McCart Transcript – 16/11/23 – Page 58 – Line 15

⁷¹ Fiona Rowan Transcript – 24/06/24 – Page 29 – Line 13

⁷² Fiona Rowan Transcript – 24/06/24 – Page 38 – Line 9

⁷³ Fiona Rowan Transcript – 24/06/24 – Page 29 – Line 25

⁷⁴ Fiona Rowan Transcript – 24/06/24 – Page 31 – Line 14

The person with a learning disability and their family and/or advocate should of course have been consulted during the process of selecting a placement, but this was certainly rare in the early days.⁷⁵ Once a possible setting had been identified, funding needed to be agreed and this was a major difficulty, and often a cause of delays, as funding for staff and support needs came from the DoH but funding for capital building and for supported housing came from the NIHE. Fiona Boyle (an independent report writer) told the Inquiry:

[Counsel]: *'You have made reference there to the Supporting People Programme. Can you tell us what that is or what that was?*

[Ms Boyle]: *So the Supporting People Programme is very much revenue that is provided to providers who are supporting people in supported housing ... The schemes, the supported housing, the capital element of that is supported by Housing Association Grant, HAG as it is known, and that is provided by the Department for Communities. That has been in place, I would say, for at least 30 years, maybe more. The first housing associations were operational from the 1970s. So the scheme, or a scheme, would be built through HAG, that's the capital element; then housing benefit, if the person is a tenant who is eligible for that, there's the housing benefit element; then the Supporting People element is really for housing-related support; and then alongside that a fourth element would be from the Health and Social Care Trusts ... they would be providing the ... support staff, for any domiciliary or personal care'.⁷⁶*

- 15.42 Once funding was agreed, staff from the community setting would come to the hospital to get to know the person to be resettled (in-reach) and then the person would go out to the identified setting (often with hospital staff they were familiar with), for increasing lengths of time, until they felt ready to stay in their new setting (out-reach).⁷⁷ In Northern Ireland, as elsewhere in the UK, the vast majority of community settings were run by independent organisations (i.e. not by statutory organisations) and typically they were staffed by social care staff (nursing homes would employ some nurses but most community settings did not employ nursing staff). Community-based services were on average consistently cheaper than hospital services in Northern Ireland, a finding commensurate with studies in other countries.⁷⁸

⁷⁵ Roy McClelland Statement (Evidence Modules) – 03/03/23 – Page 1881 (Exhibit T04.05) – Moving on from MAH (December 2000)

⁷⁶ Fiona Boyle Transcript – 24/06/24 – Pages 108-109

⁷⁷ Fiona Rowan Transcript – 24/06/24 – Pages 26-27

⁷⁸ J. Beecham, M. Knapp, S. McGilloway, M. Donnelly, S. Kavanagh, A. Fenyo and N. Mays (1997) The cost-effectiveness of community care for adults with learning disabilities leaving long-stay hospital in Northern Ireland, *Journal of Intellectual Disability Research*, 41(1), pp. 30-41 – <https://doi.org/10.1111/j.1365-2788.1997.tb00674.x>

- 15.43 A 1996 census of patients placed all patients into one of three categories: hospital treatment; community treatment; and continuing care (but not active treatment). This informed a 1998 reprofiling exercise to establish wards as either core treatment or resettlement wards⁷⁹ and 180 MAH patients were moved to other wards that matched the category they had been given.⁸⁰ As patients were discharged and wards closed, further moves were necessary and wards changed their purpose. Following the opening of the assessment and treatment wards in the new 'core hospital' in 2006, a PTL of patients who had been in MAH for more than one year by 1 April 2007 was created to monitor progress on the commitment to resettlement of long-stay patients.⁸¹
- 15.44 The decision as to when a patient should be considered for a resettlement ward, – that is whether they ready for discharge – was made primarily by their consultant psychiatrist, with some advice from the multidisciplinary team (MDT). The patient was then notified to HSCB and moved into a resettlement ward, and discharge planning would begin. The resettlement wards had even less input from the MDT (such as psychologists) than the other wards, and they were often in run-down parts of MAH. The plan was to gradually close these wards as patients were resettled; the wards included Finglass, Mallow, Rathmullan, Oldstone, Greenan and Moylena, and in some of them closure was hastened by, for example, failure of the heating system or an electrical fire.⁸² Resettlement of people on both the PTL and the delayed discharge list was very slow, however, so that patients' stays in MAH were often very long. The graph in Figure 15.2 shows how long patients remained in MAH between 2012 and 2023 (this data was provided by BHSC; data was unavailable for years 2015, 2019 and 2021).⁸³

⁷⁹ From Special Care to Specialist Treatment (Montgomery and Armstrong) – Page 146

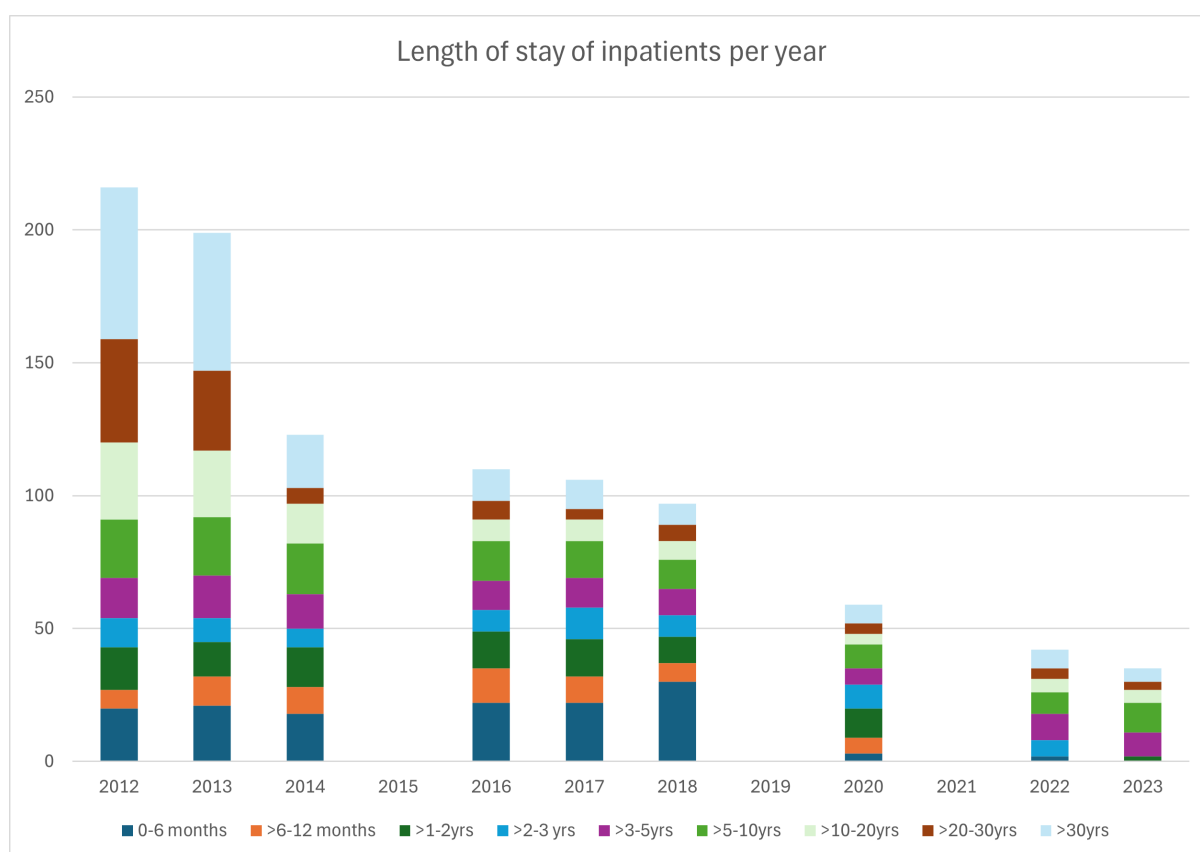
⁸⁰ Eilish Steele Statement – 23/05/24 – Page 38

⁸¹ B. Mongon and I Sutherland (2022) Independent Review of the Learning Disability Resettlement Programme in Northern Ireland – Pages 12-13 – <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-ind-review-ld-resttlement-july-2022.PDF>

⁸² Esther Rafferty Statement – 27/06/24 – Page 10-11

⁸³ Internal Inquiry Analysis of Data provided by BHSC

Figure 15.2: Average length of stay at MAH



15.45 A number of staff talked to the inquiry about how well, or otherwise, the process for resettlement worked. For example, a senior social worker, who was responsible from 2006 to 2012 for resettlement of patients originating from Belfast, told the Inquiry:

'Families within that area were already socially deprived and if they had a child with learning disabilities this added to their situation. When families admitted their children to Muckamore it was because they had no alternative ... Learning disability services were never a priority in health and social care. It was always poorly resourced. There was little consideration given to learning disability services. They were passive receivers and never seen as an area that should be provided with funding'.⁸⁴

15.46 Despite the drive towards resettlement, MAH still had 225 beds in 2012, and this social worker recalled a cohesive and settled social work team in MAH, who were welcomed on the wards during his time (2002-2012). The social work team had monthly team meetings with Miriam Somerville, (former BHSCT Co-Director of Learning Disabilities 2006-2011), along with consultant psychiatrists, senior

⁸⁴ John McCart Transcript – 16/11/23 – Pages 8-9

nurses and other healthcare professionals, in which individual patient resettlement was discussed:

'A care manager was appointed for a patient and the care manager was responsible for co-ordinating all of the patient's requirements so that they could be resettled. There was a dowry system in place at this time whereby a patient would be allocated a budget for their resettlement. The first option explored whether the patient could return home to their parents. If that was not viable then accommodation was sourced from the statutory, private or independent sector. Resettlement is a difficult role as it is very patient specific and the funding is not always adequate for the patient's requirements. The Eastern Health Board, via the Department of Health, would identify a pot of money available to the Belfast Trust which could be spent on resettlement. However, if there was a delay in a patient being resettled, for whatever reason, there was no guarantee that this money would be available for that patient in the future'.⁸⁵

- 15.47 Each year the HSCB set a target for each of the five HSCTs for the number of their patients to be resettled from MAH:

'[The] Trusts tried to work together to develop plans so costs could be managed as well. All [of] the Trusts developed new schemes of supported living and residential care in their localities. The HSCT dowry for a resettlement patient was £85,000. Some placements costed £15,000 - £25,000, whilst others [cost] £85,000, and a few £150,000plus'.⁸⁶

- 15.48 For MAH:

'There was a target set each year in relation to the number of priority target list patients that had to be resettled. And then there was also a number of delayed discharges each year. And year by year there was sometimes more of one than the other that was achieved ... But we worked towards that target'.⁸⁷

The graph in Figure 15.3 shows the numbers of patients with delayed discharge in each year between 2012 and 2022.⁸⁸

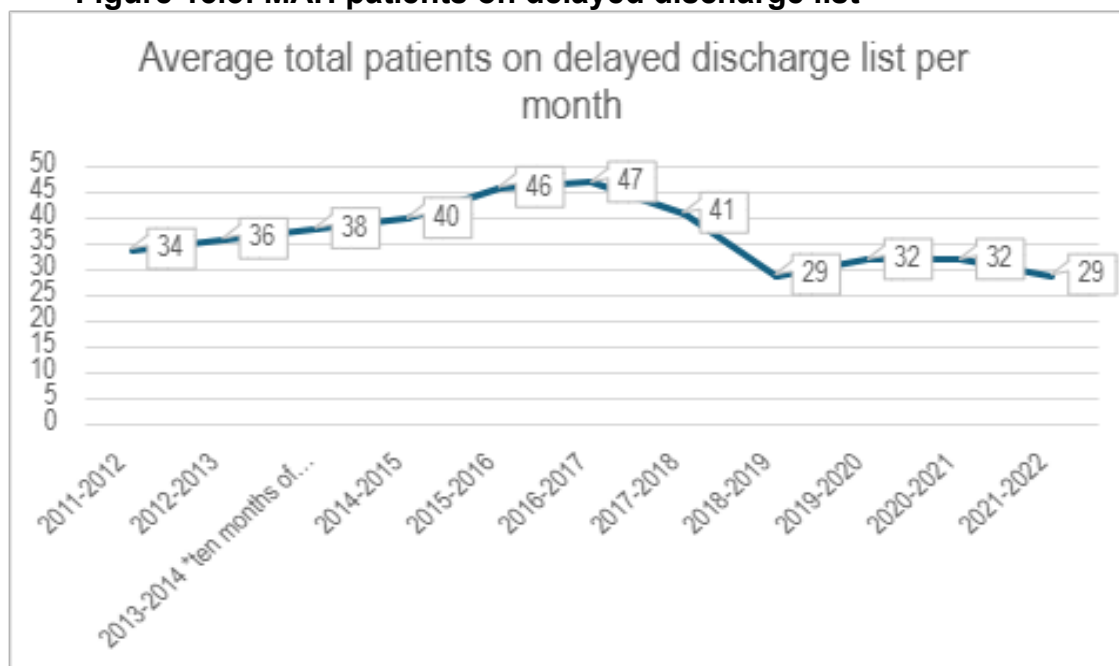
⁸⁵ John McCart Transcript – 16/11/23 – Pages 13-14

⁸⁶ Esther Rafferty Statement – 27/06/24 – Page 9

⁸⁷ Esther Rafferty Transcript – 15/10/24 – Pages 13-14

⁸⁸ Data provided by BHSCT and analysed by the Inquiry

Figure 15.3: MAH patients on delayed discharge list



15.49 Some patients waited 10 years or more for their discharge to the community.⁸⁹ As time went on, the hospital residents remaining were the more complex cases and for these the Inquiry was told that delays were very likely:

[Counsel]: *'So someone's name might have been on the resettlement list and they might have been identified for a particular scheme, but are you saying that the timeframe actually for the development of that scheme then was unrealistic?*

[Ms Rowan]: *In a number of cases, yes. But I suppose this is probably going back to more, you know, the planning for something is incredibly important because it's going to take several years to actually achieve ... usually around 3 years from SOC to OBC planning.*

[Counsel]: *Can you just explain what those refer to?*

[Ms Rowan]: *That's strategic outline cases to full business cases. So that's there's -- that's the Housing Executive process in conjunction with the Trust that the planner would have been involved in.*

[Counsel]: *So is it right then to say that some -- a patient's name could have been on the resettlement list with a scheme identified as their potential place of resettlement, but if that scheme was yet to be built, it was likely that it would take around three years for that to come to fruition?*

[Ms Rowan]: *Yes. Absolutely'.⁹⁰*

⁸⁹ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 9

⁹⁰ Fiona Rowan Transcript – 24/06/24 – Page 72 – Line 5

15.50 The Inquiry heard of a number of examples where significant preparation and ensuring the staff who would look after the resettled patient were known to them paid dividends. One example was P96, whose father told the Inquiry

'They had in reach, an in reach team came up to meet him. Now initially the Praxis Operations Manager said, you know, we have never put the amount of work getting to know a patient, we normally come up, do in reach, get to know them, get their feeding plans, risk assessments and discharge them. She says we have really exceeded that quite far. But once he actually moved they actually told me that that's going to be their template for moves. They says the extra work actually paid off dividends because the phrase I was told when P96 was moving from Muckamore to this new facility to new staff, you are going to have to ride the storm. Right, fair enough. And relatively, he settled in very easily. As a matter of fact after two weeks a senior personnel from Muckamore who was down with him told me I can't keep my staff any longer, he's that good and it went that well, I couldn't justify to my bosses keeping us here any longer, it is going way, way better than we dared hope which was good'.⁹¹

15.51 But the Inquiry also heard a number of accounts where resettlement had proved a difficult and lengthy process. P90 (a patient of the NHSCT residing in MAH) was still in MAH when his sister gave evidence to the Inquiry:

'In 1997 Bryan's consultant advised us that Bryan was medically fit for discharge from MAH. Our mother was still alive and we breathed a sigh of relief when we were told that Bryan was at long last fit for discharge. We had originally been led to believe by MAH that Bryan would return to the family home with support. Not only am I trained nurse but my sister, Annemarie, is also a trained nurse and we believed that it would have been feasible for the family to look after Bryan with support. So, when we were told that Bryan was medically fit for discharge, we thought this meant he would be able to return to the family home and once again be cared for by his loving family. However, it was made clear that this was not an option and Bryan would be resettled in a facility in the community. This was about nine years after his admission. We never thought that it would take approximately 26 more years before a suitable placement would be secured for Bryan'.⁹²

15.52 Proper preparation for resettlement was often lacking and led to failure:

'P34 had remained almost entirely in MAH from 2 December 2017 to March 2019. Although P34 was in MAH from December 2017 he still had a placement in the resettlement facility which was being paid for. It is my understanding that staff from the resettlement facility were therefore supposed to come to MAH and work with P34. However, they did not come frequently enough or for long enough periods and did not work closely enough with the staff who were caring

⁹¹ P96's Father Transcript – 11/10/23 – Page 64 – Line 17

⁹² P90's Sister Transcript – 11/10/23 – Page 114 – Line 28

*for P34 in MAH at the time. Instead, they seemed to come to MAH only on a rare occasion. This was not just my own perception as staff in MAH also indicated that this was the case to me and at least one Staff Nurse expressed sympathy to me about this. The failure to undertake sufficient work with P34 in advance by the resettlement facility staff was one of the key reasons the placement ultimately failed ... I do not feel that P34 had been properly prepared for his re-transition from MAH to the resettlement facility. Also, there were other issues with the placement. By way of example, when P34 returned to the resettlement facility, he was sharing the unit with a female who self-harmed by banging her head off the walls, which I believe was distressing for P34 to witness. When I spoke with management about the incompatibility of P34 and this other female resident, I was simply told that they needed to fill the beds’.*⁹³

*‘P34 has been let down at every stage of what should have been assessment, treatment, and care, no less than the professional standard of care for a vulnerable person within a specialist hospital, along with full compliance to the policies and procedures that should have ensured that standard was met. The Belfast Trust has apologised to all patients and their families who have been involved in the allegations of abuse and mismanagement at MAH. The Belfast Trust and the Northern Trust have, however, continued to let P34 down over the arrangements for his resettlement from MAH. He was left in MAH where a culture of abuse was allowed to develop and where he had been abused. It took a judicial review to expedite his resettlement. The lack of meaningful preparation to ensure a successful transfer to a suitable facility is an important issue as the consequences of a placement failure were not only serious for P34 in terms of his health and an unnecessarily prolonged stay in MAH but it also affects the likelihood of a successful transfer to an alternative facility’.*⁹⁴

- 15.53 From the families’ point of view, the limited availability of appropriate supported living placements was a cause of prolonged delays in discharge, and this sometimes led to inappropriate placements (often against the families’ wishes) that failed, and the person was readmitted to MAH:

*‘It could be 2025 before he moves on, because the building has to be put together ... And I mean that’s just an estimate ... they did try a resettlement with him before, and it was in Loughshore, and it was a new build, and he was the first patient there with the staff, and they didn’t really have much confidence with him and they wouldn’t take him out’.*⁹⁵

- 15.54 The Inquiry also heard from a few families who had fought to access direct payments (a budget that families could use to organise bespoke care support), allowing them to bring their loved one home. However, this was not an option that was actively promoted to families:

⁹³ P34’s Mother Transcript – 09/10/23 – Pages 29-30

⁹⁴ P34’s Mother Transcript – 09/10/23 – Page 39 – Line 14

⁹⁵ P18’s Mother Transcript – 21/09/22 – Page 29 – Line 12

'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'.⁹⁶

- 15.55 Lack of resources frequently delayed discharge, even after the CCTV revealed fresh safeguarding concerns:

'The resettlement did not proceed as planned in March 2018 as Autism Initiatives did not have the necessary funding or staffing levels. There were ongoing meetings between Autism Initiatives, MAH and I. There were two psychologists working on the resettlement in MAH but they both left MAH before the resettlement took place. I was working fulltime myself and was being asked to attend constant meetings and phone calls at MAH. At the same time, I was also receiving phone calls from Barbara McMeekin, a social worker in safeguarding in the Belfast Trust, regarding safeguarding issues with P77 in MAH'.⁹⁷

Did resettlement lead to betterment?

- 15.56 An early study of resettlement in Northern Ireland showed that, when compared with hospital-based care, community-based care for people with learning disabilities was on average about half the cost of a hospital place, with nursing homes being the most expensive alternative and supported living the least expensive.⁹⁸ It also seemed, in those early days, that most resettlement was successful: for example, a study of over 200 leavers from Northern Ireland learning disability hospitals in the late 1990s showed that 197 were still in the community one year later, and only 14 had returned to the hospital and needed a further resettlement.⁹⁹ Of course, it might be expected that the early resettlements would relate to those patients most likely to cope well with resettlement.

⁹⁶ P55's Father Transcript – 18/10/22 – Pages 91-92 (restricted)

⁹⁷ P77's Mother Statement – 19/04/23 – Pages 27-28

⁹⁸ Beecham et al. (1997) The cost-effectiveness of community care for adults with learning disabilities leaving long-stay hospital in Northern Ireland

⁹⁹ M. Donnelly, S. McGilloway, N. Mays, M. Knapp, S. Kavanagh, J. Beecham and A. Fenyo (1996) One-year and two-year outcomes for adults with learning disabilities discharged to the community, British Journal of Psychiatry, 168(5), pp. 598-606 – <https://doi:10.1192/bjp.168.5.598>

15.57 Another study, in 2000, of 68 people resettled from MAH obtained largely positive feedback from the people with learning disabilities and their families. The residents were mostly glad they had left the hospital (85% said they were glad), and they could name more things they liked about their new home in the community than about MAH. They also had fewer dislikes of aspects of their new home than they had of MAH. As for their families, 82% rated the new service as 'very much better' than the hospital and 97% of families rated their relative as happy and content in their new home (despite the fact that many homes fell well short of the Equal Lives recommended size of five residents and were very large).¹⁰⁰

15.58 A later review in 2016 by care provider Bryson House and the learning disability charity Mencap examined quality of life in 84 individuals resettled from MAH. They collected information from the individuals and their families before resettlement, and then at 6 weeks, 3 months, 6 months and 12 months after resettlement (though their data was not by any means complete for all these periods). They reported to the HSCB, which commissioned the work:

'At a glance, the overall opinion is an extremely positive one. In almost all assessments a major theme has been the feeling from individuals and their families that betterment has been met through the move to the community. It should be noted that in the initial questionnaires almost all families and carers were very pessimistic and negative about moving their family member out of the hospital setting ... These feelings changed dramatically in the follow up questionnaires where family members noted how they had seen vast improvements in their loved one's quality of life and communication with other residents and staff ... (as well as) a lot more choice in the community than they did in the hospital with regards to the food they want to eat, clothes they want to wear and things they like to do. The individuals have also indicated that they have much more opportunity to get out and socialise with others in the community and pursue interests and activities which has improved their overall quality of life'.¹⁰¹

15.59 Similarly, a review commissioned by the NIHE from a group of independent experts reported in 2017 that it found that people with learning disabilities from MAH who had been resettled into the community, and their families, all said they had

¹⁰⁰ Roy McClelland Statement (Evidence Modules) – 03/03/23 – Page 1881 (Exhibit T04.05) – Moving on from MAH (December 2000)

¹⁰¹ Brendan Whittle Statement (Organisational Modules) – 07/06/24 – Page 1746 (Exhibit BW/24) – Quality of Life Questionnaires – Overview Report

experienced 'betterment' in terms of more choice about their lives and their personal possessions. Most had more access to the community, and better contact with their families (no individuals whose placement had failed were interviewed, so the picture painted was perhaps rosier than it should have been). However, not all had access to day services or good local transport, and the size of residences was rather larger than Equal Lives proposed: 32% contained 11 or more bed spaces, suggesting a rather more institutional model than was desirable. The study also found that BHSCT was lagging way behind the other four HSCTs in terms of its number of SP-funded bed spaces.¹⁰²

- 15.60 The Inquiry heard from a number of relatives who described the specific benefits to former MAH patients once they had been resettled. The following are just a few examples.

Joe was resettled in 2013, having been in Muckamore since he was a child:

'Joe was about 53 years old and he had been in MAH for around 50 years. As Joe was not a detained patient in MAH, my family and I want to find out why it took so long to find Joe a suitable placement and for him to be moved out of MAH. We never asked before he was resettled as we never knew it was an option'.

*'Joe settled very well in the supported living accommodation and my family believes that Joe could have moved out of MAH much earlier if an appropriate placement had have been looked for or provided. In my view and from what my family was told, Joe's move from MAH only happened because a decision had been taken by those higher up to get all the patients who lived at MAH resettled in the community. Joe is completely different in his new town. My family have been able to involve Joe much more in their lives since this move as he is closer to where we reside. There is no comparison whatsoever between Joe's life in MAH and his life now'.*¹⁰³

- 15.61 Other witnesses explained how their patient relative had flourished following resettlement and how communication was significantly improved.

*'Since P8 was discharged from Muckamore, he flourished. He mows the lawns and cleans the cars of our neighbours. He is learning to drive. He is very good at home and looks after me. He has put Muckamore behind him and he continues to spend time with H518, a former nurse from Muckamore, and her husband. P8 loves animals and listening to music'.*¹⁰⁴

¹⁰² Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Pages 9-10 and Page 65; Fiona Boyle Transcript – 24/06/24 – Page 122

¹⁰³ P102's Brother Transcript – 14/09/23 – Page 72 – Line 2

¹⁰⁴ P8's Mother Transcript – 26/09/23 – Page 28 – Line 22

'If P128 has even a wee nick on his knee, now we hear on the telephone straight away. There was nothing like this from MAH. We did ring every day, or every other day, but the way staff spoke to us was like something repetitive. They would say, "he's eating well, he's sleeping well". They were never telling us anything. We are happy with the care that P128 gets now in the resettlement location. We feel very fortunate that P128 is happy where he is'.¹⁰⁵

'How I like to remember P63: P63 had a really deep laugh and was full of devilment. When he got released from Muckamore [in 2018], when he was 43 years old, he moved into another facility which was a supported living place. Dr. H49 actually came to my house and she told me that another facility would be a good choice for P63. She was very good. This was a big adjustment for P63 and for us but P63 got somewhat better and eventually there was something about him more like his old self, although physically he was never ever the same and he still needed a lot of help with his behaviours. But P63 would want to join in on conversations and I thought that was a great sign for him after he got out a while and some of the staff were so brilliant with him'.¹⁰⁶

15.62 After three years in MAH, P115 moved to supported living. His father told the Inquiry:

'I live within a 10-minute walk of the supported living home where Eoin was placed during this time. Eoin was in a downstairs room, which was nice. I would see Eoin regularly and we would spend time together. I raised a concern that he had access to a stairwell and the staff were very co-operative in adjusting Eoin's room and bathroom to meet his needs and keep him safe.

Eoin was happy during the seven years that he was in the supported living home. The relationship between staff and Eoin was friendly and they co-operated fully in trying to make Eoin's placement enjoyable. The staff brought Eoin out in a Volkswagen Caddy. Eoin also got a motability car so that he could go out for trips. The staff in supported living room home brought him out regularly to Helen's Bay and Newcastle and out for food. Eoin also came home from Monday to Wednesday each week. During this time I took Eoin to Dungloe in Donegal once per month, and he was very happy when he visited there.

After Eoin died, the supported living home organised a day where they put up all the pictures of Eoin from his time there. It was clear that he was really happy there. In the seven years that Eoin was in that home he only had two outbursts when he was at home, which I believe was an indication of how much happier and settled Eoin was there compared to MAH. I have a copy of Eoin's death certificate which records his death on 25th April 2017 as sudden unexpected death in epilepsy (Exhibit 3).

¹⁰⁵ P128's Father Transcript – 25/09/23 – Page 17 – Line 25

¹⁰⁶ P63's Mother Transcript – 30/11/22 – Page 46 – Line 23

I have had to attend counselling as a result of the impact of everything regarding Eoin's treatment and care. My only regret in life is that Eoin ever set foot in MAH. He had to endure three years in MAH to get seven years in the supported living home'.¹⁰⁷

15.63 There were, however, contrary views about resettlement expressed by Billy, the Chair of the Society of Patients and Friends of MAH (SPFM) who told the Inquiry:

[P107's Brother]: 'Now in Muckamore, as I say it wasn't perfect, but they had company. So they're putting them into residential areas, they're putting them into associated living, they're supervised from nine to five and then they go home and they're stuck in a room on their own. They've nothing!

[Counsel]: Billy, in contrast to that, those sorts of experiences, you've told us in very moving detail your family's experiences around John and then what has worked out to be I think on balance what we can say was a positive experience of resettlement eventually. Would that be fair to say?

[P107's Brother]: My brother's experience of where he is now, he's two hours journey away from where I live.

[Counsel]: Yes.

[P107's Brother]: And I wouldn't care if it was four hours journey.

[Counsel]: Yes.

[P107's Brother]: I picked it and went to look and got the vibes from the manager and deputy manager and the head nurse, and when we moved him there, I never signed him off for a year. I had to make sure -- it was the biggest decision that I have ever made in my life, because I had never told my mother I moved him.

[Counsel]: Yeah. Yeah. It's a big responsibility.

[P107's Brother]: Tell me about it!

[Counsel]: Yeah.

[P107's Brother]: But I had -- it got to the point -- I was against resettlement! I can tell you that now. Totally!

[Counsel]: In principle, or what was the objection that you had?

[P107's Brother]: My objection was because they were taking people, and there's residents in Muckamore at the minute who don't want to leave'.¹⁰⁸

[Professor Murphy]: 'It sounds like, and I think you said exactly this, that you object to resettlement on principle. Have I understood you right?

[P107's Brother]: That's right, yeah. Because we had gone through 15 different places, nursing homes, facilities. I mean if you're going to put somebody out in resettlement, the personal centred planning which they were driving as a leader, you've got to make the facility - should you have to build it? You have to build a home for somebody to bring them into society. Now, as we well know in reality, society doesn't want people like my brother. They would walk to the -- if you went down the road, they'll walk to the other side of the street, an awful lot of people. So if you're going to move somebody out into resettlement to go have a home, is what they always said, a home in the community, then you have got to give them a home that suits them and is built round them. Now,

¹⁰⁷ P115's Father Transcript – 27/09/23 – Pages 65-67

¹⁰⁸ P107's Brother Transcript – 27/09/23 – Pages 131-132

the resettlement situation that we were involved in, I don't know many. They either put them in facilities, nursing - the majority of them are in nursing homes. So they went from an institution into an institution, and I think everybody would agree that a nursing home is an institution. And that's really what happened. So unless they done it right.

[Counsel]: Aren't you saying really that you don't think the process of resettlement was right?

[P107's Brother]: Yeah.

[Counsel]: Not the principle, but the process. And they are two different things?

[P107's Brother]: Well, if you want to sort of nit-pick. Basically, yeah. But if they'd of done it right and put the facilities -- plus you need staff'.¹⁰⁹

The problems of resettlement

- 15.64 Resettlement was very much slower than the 1995 DHSS policy document and the Equal Lives report had proposed (their targets for resettlement of long-stay patients had been 2002 and 2011 respectively), but as mentioned already, in 2012 there were still 225 beds in MAH.¹¹⁰ The resettlement review commissioned by NIHE in 2014 noted that:

'Planning and delivery of the learning disability resettlement programme involved two NI Government Departments (DHSSPS and DSD [Department for Social Development], now DfC [Department for Communities]), the Health and Social Care, the five Health and Social Care Trusts, the Housing Executive (both the capital planning and programme delivery team, and the Supporting People team), RQIA, selected housing associations and independent sector care and support providers as well as the private sector. Service and business plans, and investment proposals, were assembled at HSC Trust level, and were then subject to scrutiny and approved at NI level. Given the complexity of the programme and the number of stakeholders involved at both programme and scheme levels from the 1990s onwards, it is surprising that the research found no evidence of a joint resettlement plan and commissioning strategy being adopted with clear criteria and guidelines for potential services providers in the independent sector'.¹¹¹

- 15.65 The NIHE commissioned review went on to conclude that the delays were down to poor coordination between Department of Health Social Services and Public Safety (later DHSS) and Department for Social Development now Department for Communities (DfC), with a lack of an overall resettlement plan, insufficient funding, misalignment of health and housing funding streams, no system to monitor the progress against targets or to hold government departments and agencies to

¹⁰⁹ P107's Brother Transcript – 27/09/23 – Pages 138-139

¹¹⁰ Data provided by BHSCT and analysed by the Inquiry

¹¹¹ Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Page 27

account, poor co-production with families and a number of other factors.¹¹² The complexities of commissioning were very considerable.¹¹³ However, during 2012-2015 there were a number of improvements, such as coordinated funding between DHSS and DfC, the 2012-2015 action plan, the new learning disabilities service framework (2013) and better performance management in relation to annual targets.¹¹⁴ A remodelled Northern Ireland-wide Supporting People Partnership Board was established with representatives of the HSCB, the five HSCTs, NIHE, DHSS and DfC. There were then better coordinated ongoing attempts to increase community-based provision (though not without challenges, such as the freeze on SP funding in 2016), and bed numbers in MAH continued to fall, so that by March 2022 there were 42 residents in MAH (of whom 11 had been resident for over 20 years),¹¹⁵ with 36 still resident by July 2022.¹¹⁶

- 15.66 One of the other issues that made resettlement targets hard to achieve was that new admissions would be occurring at the same time. One service director, who worked in MAH from 2012 to 2018, told the Inquiry that there were limited behaviour management services in the community, no intensive support teams, and respite services were in very short supply (they were used for planned respite only), so that there was no emergency respite available for when families or services suddenly had a crisis, for example in relation to challenging behaviour. Then the person in crisis had to be admitted to MAH:

'70% of admissions could have been avoided. They could have been avoided if the community resources had been sufficiently developed to even possibly the level of Mental Health. And even, I mean Mental Health isn't where it should be, but, a home treatment or crisis response service in the community that operated out-of-hours could have possibly picked up on some of those cases and supported them for a couple of days, that would have avoided an admission. But ... those services were not available or commissioned'.¹¹⁷

- 15.67 This MAH service director and other senior staff repeatedly raised this with the HSCB in meetings, but for years resources were not sufficient to create intensive

¹¹² Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Page 28

¹¹³ Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Pages 53-54

¹¹⁴ Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Page 45

¹¹⁵ Internal Inquiry Analysis of Data provided by BHST

¹¹⁶ Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (Mongon and Sutherland, 2022) – Page 12

¹¹⁷ Esther Rafferty Transcript – 15/10/24 – Page 30 – Line 7

support teams to prevent admissions to MAH.¹¹⁸ However, the HSCB insisted in its evidence to the Inquiry that:

*'The HSCB ensured that appropriate levels of funding were made available to underpin the resettlement process. The financial model for resettlement included funding service development for community infrastructure as well as the community packages required for the patient's resettlement'.*¹¹⁹

15.68 Brendan Whittle, Director of Hospital and Community Care at the Strategic Planning and Performance Group (SPPG) of the DoH since July 2022, provided evidence that from 2018 to 2022 an additional £2,295,000 was provided for learning disability community infrastructure for out-of-hours crises.¹²⁰ However, Sean Holland (Chief Social Work Officer from 2010 to 2022) explained to the Inquiry that although specialist support teams and crisis teams existed, there were continuing gaps, particularly in out-of-hours support. He told the Inquiry that a lack of funding was still an issue in addressing that gap.¹²¹

15.69 There were also budgetary difficulties with the Northern Ireland resettlement programme. For example, part of the budget for resettlement came from the DoH but part came from the NIHE (as the NIHE-commissioned review had also noted):

'The funding of the resettlement programme was also complicated, well, complicated by the fact that not all of the resources should have or could have come from within the health and social care budget. For example, some of the resources ... the housing resources where a person is moving into supported living, some of the financial resources should have come from and did come from the Housing Executive budget ... they worked through, typically worked through housing associations who provided housing. So for example, if a third sector provider, for example, Positive Futures, who were and still are one of the biggest providers of Learning Disability Service in the supported living sector in Northern Ireland, if they were identified as someone who could provide a package of support for an individual patient who was coming from Muckamore, they would work up the cost of, you know, the staffing cost, how they could support that person. Now, some of that would have been a housing cost, and they also had to identify a location where the person should live. So that would typically, Positive Futures always worked through housing associations. So a housing association might be identified but one of the questions with that was the capital cost, if there wasn't a house ... available the capital cost to build the house was coming from the housing budget and also a

¹¹⁸ Esther Rafferty Transcript – 15/10/24 – Page 35 – Line 4; Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 26

¹¹⁹ Brendan Whittle Statement (Organisational Modules) – 07/06/24 – Page 46

¹²⁰ Brendan Whittle Statement (Organisational Modules) – 07/06/24 – Page 2051 (Exhibit BW/46) Learning Disability Community and Resettlement Recurrent Investments 2011/12 to 2021/22

¹²¹ Sean Holland Transcript – 21/10/24 – Page 133 – Line 26

proportion of the support costs would be housing support costs and that would come from the supported people budget within the housing finance ... So one of the issues there was to co-ordinate the streams of funding'.¹²²

- 15.70 Another difficulty was a logistical one of resettling patients from some MAH wards while other patients were not yet resettled. At one time, the intention was to resettle all the patients from one ward (for example, Moyola), and then move on to the next ward (for example, Finglass):

'It was proposed that one ward per year would be dealt with by way of resettlement ... The problem came when the wards were left with only six or seven patients'.¹²³

- 15.71 At that point the half-empty ward would be closed (for financial reasons) and the patients moved to another ward, potentially upsetting both the new and the existing patients on that ward. On one occasion, this resulted in a patient's family complaining to the Patient and Client Council (PCC) in 2011. Eilish Steele (senior nurse manager) told the Inquiry:

[Counsel (quoting Ms Steele's Statement)]: *'Fairview was reduced in patient numbers from 20 to eight or nine patients. This was a resettlement ward, and Miriam Somerville and you received a Trust level order to close the ward. Miriam and you were able to locate a number of beds on Ennis Ward.*

[Ms Steele]: *But we only had two weeks to move the patients and that was done without engagement with the families. It was very different to how we had worked in the past but it was for acute financial reasons ... Previously there would have been a -- families would have been informed. Patients obviously who could understand would be informed, families would have been informed that we were going to do this. I don't recall any big issue in the previous way we did it, and families would have understood that, you know, we negotiated that people were moving with their friends and with staff and got to see the new ward they were going to et cetera, but we didn't have the time with this ... We are now in this save money, do this, there's beds there, it's not, you know..... And the feedback from the particular family who raised the concern with the PCC, and myself and the Clinical Director had to meet with the family and try and justify something that I didn't believe in myself, was difficult'.¹²⁴*

- 15.72 An additional difficulty that arose was that sometimes a person who originated from one HSCT was resettled into the area of another HSCT, and an argument would result over their use of services:

¹²² John McCart Transcript – 16/11/23 – Pages 36-37

¹²³ Eilish Steele Statement – 21/05/24 – Page 38

¹²⁴ Eilish Steele Transcript – 04/06/24 – Pages 85-88

'... providers were discouraged from building schemes or developing schemes because it would have meant an influx of patients into that area. But sometimes the Trust would have said well, we don't want any of your patients using this, we are going to reserve all these beds for ourselves, even if it had have been maybe an appropriate placement [for someone from another Trust]'.¹²⁵

15.73 Esther Rafferty told the Inquiry that these discussions could become intense but would be resolved by directors of each of the relevant Trusts.¹²⁶

15.74 Despite the fact that most people with learning disabilities and their families felt that better services had resulted with resettlement, at least in the early days of resettlement,¹²⁷ there were some families who were very concerned that their relative's placement had failed, so that they ended up back in MAH. When closing a hospital for people with learning disabilities, it is a common finding that residents with more straightforward needs are resettled first, so those who remain tend to have more complex needs and behaviours that challenge services. This was certainly true in MAH and a number of families told the Inquiry about their relative's failed placements:

'I was led to believe that this place would suit my son, that the proper care would be given. But when I seen the place that he went into, it was more for independent living, which would never suit him. And how they even thought that that was a place for him to go? I think there was a push to get people out and that was another number off their ... But it was, as I say, independent living, with carers being there 24-hours, but to assist him in his needs. But he needs help with everything. As I said in my statement, they don't have cleaners, it was left up to the staff to clean, who said they had too much to cope with him that they didn't have time to clean ... Yes, he had staff 24, yeah ... But there were staff that weren't trained. As I said before, when he went in that weekend, I wasn't aware that they were in crisis and that their management had walked out that week and there was a new manager put in, and the staff that actually went up to see my son for nearly a year had left. So these were totally new people to him. And they still went ahead. That was Muckamore and Cedar saying "We're ready for him", when they weren't. So we got off to a terrible start ... No, I was the only one at any of these meetings saying "No, it's not fine", because his place wasn't getting cleaned, and they were sorry about that; he wasn't getting out. He wasn't getting anything. He wasn't getting any day care in it'.¹²⁸

¹²⁵ Esther Rafferty Transcript – 15/10/24 – Page 50 – Line 6

¹²⁶ Esther Rafferty Transcript – 15/10/24 – Page 51 – Line 26

¹²⁷ Beecham et al. (1997) The cost-effectiveness of community care for adults with learning disabilities leaving long-stay hospital in Northern Ireland; Roy McClelland Statement (Evidence Modules) – 03/03/23 – Page 1881 (Exhibit T04.05) – Moving on from MAH (December 2000)

¹²⁸ P16's Mother Transcript – 20/09/22 – Pages 64-72

*'The resettlement did proceed in March 2019 and it went really well initially for the first month ... In June 2019 I received a call from the manager at ... [the facility] ... asking me to come and collect P77. He told me P77 was in the car all day and flipped out when he tried to put him to bed. Belfast Trust had failed P77 as they were not checking his care under this resettlement. I advised the manager that I was not coming to get P77. Again, on the 27th of June 2019, I received another call from the manager ... they had phoned a taxi to collect P77 to take him on his own to Muckamore where he would be left outside Muckamore in the middle of the grass area. Thankfully this did not happen. However, a social worker ... called out to the ... house to see what the situation was. She phoned me to say staff ... locked P77 into his bedroom and were setting food plates on the floor without cutlery and then relocking the door. She thought this was acceptable but it sounded to me they were treating P77 like a dog'.*¹²⁹

- 15.75 By 2019-2020 MAH resettlement placements were for very complex individuals and the failure rate became very high. The BHSCT found there was a failure rate of 25% of resettlements from MAH in that year and they began to review unsuccessful placements in serious adverse event (SAE) meetings, to try to deduce some learning for the future.¹³⁰ It was concluded that the main areas for improvement were assessments and care planning, since these were sometimes not sufficiently detailed, especially for residents with complex needs. It was noted that the widely recommended person-centred planning tool 'Essential Lifestyle Planning' was not being used and, secondly, that communication between hospital, community, carers and providers was often poor; in particular, communication with family carers was 'insufficient or non-existent'.¹³¹ Moreover, in Belfast, intensive support teams still did not exist in the community, so that no support was available in a crisis on a 24/7 basis, especially as the ordinary community learning disability team members tended to be very stretched and already had very large caseloads (of 40-60 clients).¹³² Finally, a common problem was a lack of appropriate training for community-based staff in the new facility. A proposal for a dedicated Belfast resettlement team/transition team, able to reverse some of these difficulties, was made to Muckamore Departmental Assurance Group (MDAG) in February 2020, following consultation with a visiting team from

¹²⁹ P77's Mother Transcript – 20/06/23 – Pages 63-64

¹³⁰ Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 40

¹³¹ M. Smull, H. Sanderson and B. Allen (2001) Essential Lifestyle Planning: A Handbook for Facilitators. North West Training & Development Team; Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 40

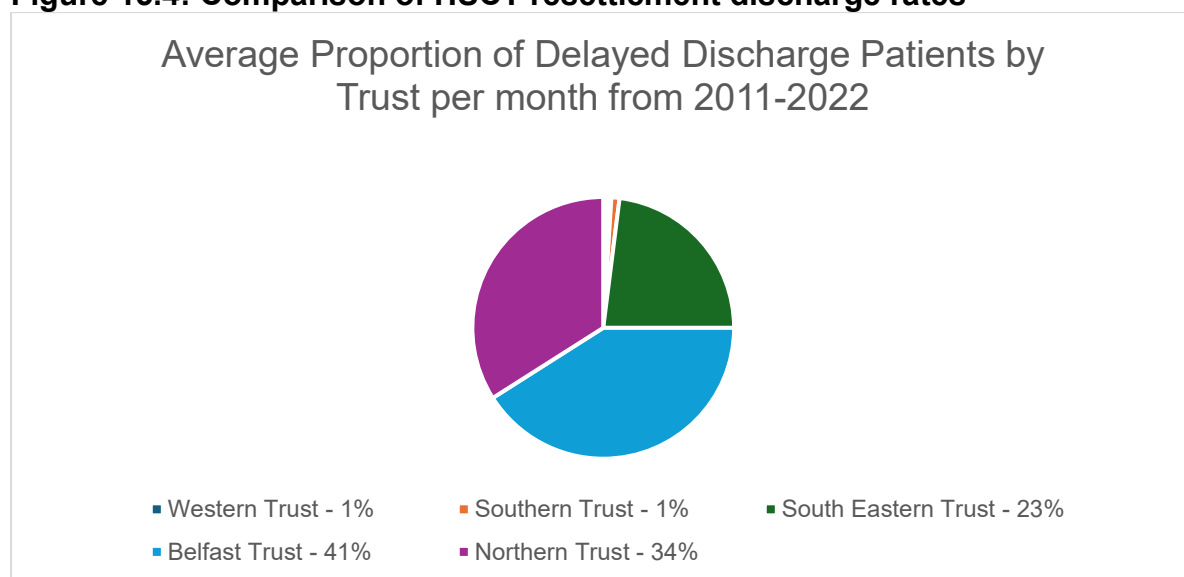
¹³² Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 37

East London learning disability services.¹³³ A community-based intensive support team and an additional forensic learning disability team were also proposed.¹³⁴ At that time MAH still had 51 patients to resettle, the majority from BHST and NHST, with some from South Eastern HST (SEHST), one from Southern HST (SHST) and none from Western HST (WHST).¹³⁵

15.76 BHST was consistently worse at resettlement, and had less well developed plans for those who were ready for discharge, than the other HSTs, particularly from 2017 onwards (see Figure 15.4).¹³⁶ However, as Roy McClelland told the Inquiry:

*'It must also be important for the Inquiry to reflect on a desperately regrettable perfect storm of factors may have contributed at Muckamore Abbey Hospital. This must include the fact that a single health Trust, albeit one of significant size and standing, was left to run a regional facility, including a facility with forensic responsibility, whilst at the same time trying to empty it of its patients, but without the whole system resources (not limited to funding) envisioned by the Bamford Review and agreed to by government'.*¹³⁷

Figure 15.4: Comparison of HST resettlement discharge rates



15.77 The main reason for the difficulty from 2017 was that MAH was in crisis following the discovery of widespread abuse on CCTV (see Chapter 10 (CCTV, 2017 Revelations and the Response)). There were large numbers of MAH staff

¹³³ Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 34

¹³⁴ Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 95

¹³⁵ Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 96

¹³⁶ Internal Analysis of Material provided by BHST

¹³⁷ Roy McClelland Transcript – 29/03/23 – Page 99 – Line 16

suspended, replaced often by agency staff with little appropriate training, and there were numerous changes of senior manager and of types of meeting, such that both staff and family members must have felt very bewildered.¹³⁸ Moreover, the leadership team at MAH was described as 'dysfunctional' by the Review of Leadership and Governance at MAH in 2020.¹³⁹

The 2021-2022 resettlement review

- 15.78 In 2021, the DoH and the HSCB (later SPPG) commissioned an independent report on the progress of resettlement for people with learning disability in Northern Ireland, in order to 'strengthen the oversight of resettlement'.¹⁴⁰ The Inquiry heard from Bria Mongan (former Executive Director of Social Work and Director of Children's Services at SEHSCT) and Ian Sutherland (former Director of Children's Services and Executive Director of Social Work at SEHSCT), who led the review. Both were qualified social workers with extensive professional and leadership experience in health and social care.¹⁴¹ The review team met with social care leaders and trust mental health and learning disability directors, the NIHE, the RQIA, the Northern Ireland Social Care Council (NISCC), the PCC and various other professional bodies, as well as patients themselves and their families. Their report found that: HSCB was monitoring performance of the five HSCTs, but not managing it; the five HSCTs were poorly coordinated in their approaches, with no overarching regional plan and an over-reliance on new-build schemes; and the HSCTs had variable success rates in resettlement, with BHSCT struggling most. The families felt that they had been insufficiently engaged in the resettlement process.
- 15.79 At the start of the review, in June 2021, MAH had reduced to 46 patients, many of whom had been in MAH for a long time. Of these 46, 10 patients had been on the PTL and were still in MAH, meaning that they had been in MAH for between 16 to

¹³⁸ Marie Heaney Statement (Organisational Modules) – 02/07/24 – Pages 20-27

¹³⁹ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital. DoH, Belfast – <https://www.health-ni.gov.uk/publications/review-leadership-governance-muckamore-abbey-hospital>

¹⁴⁰ B. Mongon and I. Sutherland (2022) Independent Review of the Learning Disability Resettlement Programme In Northern – <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-ind-review-ld-resttlement-july-2022.PDF>

¹⁴¹ Bria Mongan and Ian Sutherland Transcript – 25/06/24 – Page 7 – Line 15

45 years. All of them had had at least one previous trial resettlement.¹⁴² By July 2022, at the end of the review, the number of patients had reduced to 36, of whom 15 were from BHSCT, 14 from NHSCT, 6 from SEHSCT, 1 from SHSCT and none from WHSCT. The discharge plans were generally well-advanced for most HSCTs but only 2 of the 15 BHSCT patients had plans the review team considered definite (with a named scheme and estimated discharge date). Moreover, there were three vacant posts in the BHSCT resettlement team, perhaps explaining the lack of progress by BHSCT.¹⁴³

15.80 Overall, the review reported:

'Leadership and governance with regard to the resettlement programme in Northern Ireland has been less than adequate. Progress and momentum to deliver homes outside of hospital for the remaining cohort has been slow ... The BHSCT, which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis management of MAH. The Trust Board were reassured by the executives that there were plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust'.¹⁴⁴

15.81 The review also found some committees seemed to duplicate each other (such as the Regional Learning Disability Operational Group and Community Integration Project or CIP),¹⁴⁵ the Trust Board was not sufficiently robust in its challenges of senior leaders over the resettlement plans for remaining patients, and the review noted that there was no 'supply map' of care and specialist housing in Northern Ireland and no co-produced strategic vision for learning disability services in Northern Ireland. The review team recommended an overarching learning disability service model be considered as an urgent action (as the previous review 'A Way to Go' also recommended). The draft version of the 'We Matter' learning

¹⁴² Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (Mongon and Sutherland, 2022) – Page 66

¹⁴³ Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (Mongon and Sutherland, 2022) – Page 73

¹⁴⁴ Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (Mongon and Sutherland, 2022) – Pages 3-4

¹⁴⁵ Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (Mongon and Sutherland, 2022) – Page 30

disability service model was eventually launched for consultation in the summer of 2025.

- 15.82 Bria Mongan and Ian Sutherland told the Inquiry that there was some improvement in the regional commissioning function when the SPPG replaced the functions of the HSCB in 2022. There was a greater focus on performance management and better interaction and engagement with the trusts concerned.¹⁴⁶

The Inquiry resettlement meetings (June 2025)

- 15.83 After the evidence to the Inquiry had formally closed in March 2025, the Panel was urged by some families to hear further evidence of how resettlement was working currently. It was agreed that the Panel would take further information by way of informal information sessions to ensure that any recommendations we made about resettlement would be current and relevant. The available dates for these sessions were widely circulated not only among Core Participants but also advertised on the Inquiry website as well as in local press and media. Information was invited from all those who had recent experience of resettlement out of MAH since the end of our ToR in 2021.
- 15.84 The Inquiry conducted a series of information sessions on the topic of resettlement from Tuesday 03 June to Friday 06 June 2025. There were 11 oral sessions in total, in which the Panel heard from 15 participants, including one with personal experience as a patient. There was also a written contribution from another participant. The sessions took place in the relatively informal setting of Hearing Room B at the Inquiry Centre with just the Panel, the information provider, their solicitor (if they wanted one present) or a supporter of their choosing, a stenographer and the Secretary to the Inquiry. Questions were asked by the Panel, but each session was led by the attendee, often facilitated by their supporter.
- 15.85 The sessions were not held in public and were subject to a Restriction Order (No. 100). Participants in the sessions were invited to discuss issues they had

¹⁴⁶ Bria Mongan and Ian Sutherland Transcript – 25/06/24 – Page 20 – Line 7

experienced with resettlement since June 2021 (positive and negative) and also to indicate what recommendations they themselves would like to see being made in this area.

15.86 The Panel heard about both successful and unsuccessful resettlements. The difference between these two experiences related primarily to three factors. Successful placements involved:

- good communication with families, carers and, where appropriate patients, with a deep understanding of the individual's needs and the full involvement of families in the needs assessments
- the recruitment and training of care workers with sufficient skills to meet those individual needs
- the provision of social environments where individuals can meet others and leave their homes for activities.

15.87 Information providers to these sessions raised a number of issues that seemed to hinder appropriate and successful resettlements, suggesting that the earlier difficulties with the process of resettlement had not really been resolved:

- Participants suggested that there is a lack of communication between the HSCTs and resettlement service providers on one hand, and families and patients on the other.
- There was no consistent approach to involving families in resettlement. Some families had attended regular meetings to discuss potential placements while others were simply told that a decision had been made.
- Patients and families were often unaware of the different types of accommodation available and the differences between them.
- As patients are not given a choice of resettled accommodation, the HSCTs designates accommodation. However, patients were sometimes placed in accommodation that was unsuitable for their needs. For example, patients assessed as requiring nursing staff with training in learning disability have been placed in residential accommodation with care staff who lack learning disability training. This is not only unsatisfactory but likely to lead to problems and a failure of the resettlement.

- Participants raised concerns about the overuse of medication and errors in the administration of medication within resettlement placements, which they attributed to the fact that staff did not have the necessary training and experience.
- One participant raised concerns that care staff in a residential placement failed to follow the patient's positive behaviour support (PBS) plan and care plan.
- Participants also raised concerns over the lack of communication about the financing of the placement.
- Overall, the lack of communication between the HSCTs and service providers on the one hand, and families and patients on the other, has led participants to feelings of mistrust and of being misled.
- Delays in the resettlement process are not explained by the HSCTs and have resulted in patients waiting many years to be resettled without their relatives knowing what progress is being made.
- More recently, as MAH is due to close, participants advise there is a rush to resettle patients but with very little information communicated to families and patients. This accelerated process results in patients finding it difficult to process the transition.
- There was concern around the funding of GP services to enable visits to learning disability patients with severe disabilities and a wish expressed that specialised learning disability nurses with prescribing rights should be funded.
- A participant raised concerns that resettlement service providers can refuse to continue with the placement if they view the patient, or their family members, as making complaints about the care provided.
- The equipment required for patients was hard to come by once they had been resettled and, as the staff lacked experience, patients were not taken on outings.
- Participants also raised concerns that there is a high turnover of staff who are insufficiently trained to work with learning disability patients. This poses difficulties to patients who must transition to different staff within a short period of time.

- Access to day-care facilities depends on the type of accommodation the patient is moved to. Those patients in supported living accommodation may be able to access day-care centres, while those patients in residential homes find they are unable to access day care and as a result spend all their time in their accommodation.
- There was concern that some resettlement plans have not taken social needs into consideration and that some people only see their care assistants and do not have the opportunity to leave their new home for social activities. The Panel heard several participants expressing concerns that day-care services are not available for their loved ones.
- Patients can be more isolated and suffer a decline in social skills in resettlement placements, particularly where patients are accommodated in residential homes as opposed to supported living.
- There appears to be a greater focus on commissioning residential homes rather than supported living facilities. Families are concerned that this will mean their relative will lose their independent living skills.
- There was lack of consistency over the availability and use of carer and patient advocates, who were generally regarded as a useful tool when negotiating with HSCTs.

15.88 A summary of the participants' recommendations appears on the Inquiry's website.¹⁴⁷

15.89 The Panel was (and is) very grateful to all those who took part in these sessions, which helped to ensure the Panel had information that was as contemporaneous as possible prior to the publication of this report.

¹⁴⁷ Inquiry Resettlement Information Sessions w/c 02 June 2025: Summary of Key Points – <https://www.mahinquiry.org.uk/files/mahinquiry/documents/2025-07/25.07.10%20-%20Resettlement%20Information%20Sessions%20Summary%20.pdf>

RQIA 2026 report commissioning community learning disability placements

15.90 The RQIA published a further report (final version dated March 2026) in relation to the commissioning of learning disability community placements in two Trusts – SEHSCT and BHSCT.¹⁴⁸ This was triggered by concerns having been raised by inspectors in relation to a care home. The report was commissioned by the DoH in March 2024.

15.91 Its ToR were:

*‘(1) To examine the arrangements in place within the South Eastern and the Belfast HSC Trusts, with a view to assessing: a) The effectiveness of the planning processes for the delivery of services and sustaining capacity within services, to meet the needs of those with learning disability. b) The effectiveness of the systems in place to monitor and improve the safety and quality of care provided to individuals resident in residential learning disability services. c) The effectiveness of the current safeguarding systems in place as they relate to these environments. d) To seek views of service users and relatives in relation to planning, quality monitoring and safeguarding processes. (2) To produce a report of the findings of the investigation and where required, make recommendations for improvement’.*¹⁴⁹

15.92 The RQIA methodology included the use of questionnaires, focus groups with staff and managers in the HSCTs, and meetings with the service users and families in two residential care homes (it was not clear how these were chosen).

15.93 At the time, in 2024, there were 79 residential care homes in the five HSCTs (including 1,335 individual places), the vast majority of the homes (61) being independently run with only a few (18) being run by statutory agencies. Not all of the places were taken by people with a learning disability. In addition to these, there were nursing home places (of similar numbers) and supported living places (of rather larger numbers). It was calculated that there was a shortfall of over 200 places for supported living (and this was expected to increase in the future to over 450). Families reported a particular shortage of places for those with complex health and/or behavioural needs. Families were also concerned about the

¹⁴⁸ RQIA Investigation into Commissioning Arrangements for Residential Learning Disability Services in the South Eastern HSC Trust and the Belfast HSC Trust

¹⁴⁹ RQIA Investigation into Commissioning Arrangements for Residential Learning Disability Services in the South Eastern HSC Trust and the Belfast HSC Trust

financial disparity between residential homes and supported living, with those in the latter having more disposable income. The report went on to consider a series of issues, including those related to transitions for young people with learning disabilities, staff training, adverse events and safeguarding.

15.94 There were nine recommendations made in the RQIA report, which included: better provision of information to families (including about the differences between residential care and supported living); improved commissioning planning (looking forward more than one year ahead); better transition planning for young people; improved arrangements for the specialist training of staff when individuals have particularly complex needs; clarity for families about the ‘host’ trust when care home places are commissioned by more than one HSCT.

15.95 It was also recommended that: Trusts should improve their management, oversight, trend analysis and feedback in relation to adverse and serious adverse incidents (SAIs); the RQIA should modernise its methods for gaining feedback from service users and families; Trusts should evaluate and audit their processes for safeguarding to ensure proper involvement of service users and families; and Trusts should consider appointing family liaison officers to support families when there are complex issues to be negotiated (such as SAIs, safeguarding and transitions).

Conclusions

15.96 By 1995, the ambition of the DoH in Northern Ireland was to resettle all MAH long-stay patients by 2002.¹⁵⁰ This was not achieved. Neither were the revised ambitions of resettlement by 2011 or 2015 or 2019 achieved.¹⁵¹ This followed a similar pattern more recently in relation to the closure of MAH when repeated Ministerial announcements of target dates were not met.

¹⁵⁰ DHSS (NI) (1995) A regional strategy for the Northern Ireland Health and Personal Social Services, 1997-2002. Belfast, DHSS (NI)

¹⁵¹ Review of Mental Health and Learning Disability (Northern Ireland) (2005) Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland. Department of Health, Social Services and Public Safety, Belfast – Page 65 – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Equal%20Lives%20Report.pdf>; Fiona Rowan Transcript – 24/06/24 – Page 99 – Line 18

- 15.97 In 2005, the Equal Lives review noted a series of difficulties with resettlement in Northern Ireland that needed to be overcome, particularly the lack of bridging finance (compared with Great Britain) to enable people to be resettled from hospitals, and the lack of a commitment to the resettlement of all long-stay patients by a designated date.¹⁵² Equal Lives also pointed to the large size of many nursing homes and other resettlement schemes (bringing a risk of a new long-stay population), and barriers such as insufficient resources to build community infrastructure, lack of robust implementation strategies and underdeveloped involvement of people with learning disabilities and their carers.¹⁵³ Successive reviews had very similar criticisms. For example, the NIHE-commissioned review found that the delays were down to poor coordination between the DHSSPS (later DHSS) and DSD (now DfC), with a lack of an overall resettlement plan, insufficient funding, misalignment of health and housing funding streams, no system to monitor the progress against targets or to hold government departments and agencies to account, poor co-production with families and a number of other factors.¹⁵⁴ Professionals closely involved in resettlement also pointed to the inadequate assessment of some of the people to be resettled (causing placements to fail), the lack of staff training in the services to which they were being resettled, the absence of any emergency respite services and of intensive support teams, such that it was thought that 70% of admissions to hospital could have been avoided.¹⁵⁵
- 15.98 Nevertheless, all the resettlement reviews, especially in the early days of resettlement, showed that despite the relatively large size of some accommodation, the vast majority of people resettled were experiencing betterment in terms of choices in relation to their personal lives, property and privacy, trips into the community and contact with their families.¹⁵⁶

¹⁵² Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 63

¹⁵³ Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland (2005) – Page 17

¹⁵⁴ Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Page 28

¹⁵⁵ Fiona Rowan Statement (Organisational Modules) – 12/06/24 – Page 28 and Page 37; Esther Rafferty Transcript – 15/10/24 – Page 30

¹⁵⁶ Roy McClelland Statement (Evidence Modules) – 03/03/23 – Page 1881 (Exhibit T04.05) – Moving on from MAH (December 2000); Brendan Whittle Statement (Organisational Modules) – 07/06/24 – Page 1746 (Exhibit 24) – Quality of Life Questionnaires – Overview Report; Fiona Boyle Statement (Organisational Modules) – 27/04/23 – Page 65 (Exhibit 2) – The Hospital resettlement Programme in Northern Ireland after the Bamford Review; Fiona Boyle Transcript – 24/06/24 – Page 122 – Line 15

- 15.99 As time went on, the understanding of the need for bridging finance for MAH while people were being resettled increased, and there was: better coordination of resettlement plans, both regionally and between HSCTs and organisations like NIHE; a bigger variety of types of community housing and support for families; and provision of improved community learning disability services such as intensive support teams and community-based forensic teams, though these are still not available in all parts of Northern Ireland.
- 15.100 Although efforts were made to resettle many of the patients, no adequate consideration was given to the extent of harm caused by long periods in institutional care.
- 15.101 Successful resettlement requires a consistent focus on the individual patient's needs and an appropriate period for the patient to assimilate into the potential new surroundings and way of life.
- 15.102 There is still a lack of appropriate places for persons with learning disabilities and with challenging behaviours in the community.
- 15.103 There is a danger that with the managerial and political focus on closing MAH, that inappropriate placements will continue to be made in order to meet the expedient needs rather than resettling patients in settings appropriate for their needs and betterment.
- 15.104 Throughout MAH's history there have been too few allied health professionals, especially psychologists, speech therapists and occupational therapists, in both MAH and the community. Similarly, there seems to have been a paucity of well-trained social care staff in the community, capable of providing support for people with challenging behaviour. Both factors have led to breakdowns in community placements, meaning their residents were often readmitted to MAH.

Recommendations

R90	A regional standing committee of people with learning disabilities and autistic people and their relatives should be established, to be consulted by the DoH and other bodies on services for learning disabilities and autistic people. This should be funded by DoH and potentially facilitated by the PCC. The participants in this committee should be reimbursed for taking part.
R91	There needs to be a recognition that those service users in Northern Ireland yet to be resettled (if there are any by the time of publication of this report) will require a higher level of funding due to their needs and behaviour that challenges. A highly qualified team must be formed to progress their resettlement. An example of such a model might be the special development team in England.
R92	Families should be provided by the relevant Trust with a time frame for resettlement and relevant financial information. Families should also be afforded an appropriate amount of time to consider resettlement options.
R93	There needs to be a clear regional view of all services available in the community, especially given the variety of services and providers of services now available. The service map recommended in 2022 must be regularly updated to reflect available services and vacancies, searchable by both families and care managers.
R94	There will be a continuing need, which must be met, for new and ongoing community-based support for young people and adults with learning disabilities and autistic people whose families become unable to cope full time. This means there is a continuing need for a range of types of provision and well-coordinated support services in addition to the usual community learning disability team. These will include intensive support teams, community forensic teams, assessment and treatment services in the community, and emergency respite services. The availability of these must be monitored and published on the DoH website. These teams and services, some of which exist in parts of Northern Ireland but not all, need to have open referral systems, so that families can self-refer.
R95	HSCTs must develop registers of those at risk of requiring unplanned inpatient treatment, similar to the NHS England 'blue light protocol', in order to target community resources efficiently and prevent the person having to leave their home in the community.
R96	SPPG must ensure that people with learning disabilities and autistic people have access to mainstream (i.e. the same services that are available to those without a learning disability) mental health services, with appropriate adjustments for their disabilities.
R97	The SPPG must ensure that commissioning includes provision for people with learning disabilities and autistic people cared for in any facility to have fully funded access to primary care services. These may be provided by LD nurse practitioners/LD nurse consultants. Local commissioning groups (LCGs) should monitor this provision.

R98	The DoH must devise ways to recruit and retain more allied health professionals and social care staff in the community for autistic people and people with learning disabilities.
R99	Communication between the HSCTs and/or resettlement service providers and families and people with learning disabilities should be more open and transparent. Each service user/family should have appointed to them a key individual who is responsible for ensuring both the family and the service user are consulted and kept informed in relation to considerations of resettlement, including the staff training of the proposed resettlement. The key individual should also be in a position to assist with advice on direct payments. (See also Recommendation 5).
R100	Trusts, private and 3 rd sector care providers must ensure that person-centred day activities (including supported employment where appropriate) should be available and offered to all people with learning disabilities and autistic people. This should be monitored through Trust delivery plans.

(This page is intentionally left blank)

Do you see me?

When my son is in good form, he's smiley, he laughs very heartily. He loves eating. He has to have a magazine, he lives around his magazine deliveries. And he actually loves home life, as long as it's his dad and myself and the dog, he just loves being home with us. He's quite sociable when he's out - we try to get him out - you know, because he knows then people's not coming with us. He does have -- he's very anxious if people would come into our space, into our home, he's still a bit anxious. I'm not saying that every weekend's good, but the majority of the weekends is good at home, you know? It is hard work, but we just try and keep that time for him and we try to keep him up as long as possible and do things.'

'My daughter has two siblings... they were the best of friends growing up'

'She had a fantastic and loving relationship with her dad ... He typically cared for her on a one to one basis, taking her out every day in the car, which she loved.... We were proud and impressed by the way she was able to function in a world that she did not understand...she loved our caravan holidays in Castlerock, especially sea swims and picnics on the beach.'

Chapter 16

Planning and Funding of Learning Disability Services in Northern Ireland

Introduction

- 16.1 As has already become clear, providing health and social care for the population of Northern Ireland is complex. Services are designed through a network of teams and organisations, including a split between the commissioning and the provision of care (in order to reduce any conflict of interests between those setting standards and targets and those delivering them).
- 16.2 At the regional level, the Department of Health (DoH)¹ sets policy and priorities and decides high-level funding allocation. Until 2009, these priorities were passed on to the four regional health and social services boards (HSSBs), and then from 2009 to 2022 to the Health and Social Care Board (HSCB). That function is now the responsibility of the Strategic Planning and Performance Group (SPPG),² which is charged with translating the policy direction into commissioning plans within the budget available. The SPPG does this in conjunction with the Public Health Agency (PHA) and the five local commissioning groups (described in more in para 16.16). These plans are then discussed with health and social care trusts (HSCTs), which agree a trust delivery plan (TDP) and any associated budget. In practice, planning and commissioning care is achieved through a series of negotiations and a two-way information flow rather than a top-down process.
- 16.3 Before 2003, care quality in independent and third sector services contracted by HSSBs was assessed by in-house inspectors. NHS services, being directly managed, were not subject to inspection.³ Following the Health and Personal Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003, which introduced a statutory duty of quality for HSSBs (later to become the HSCB)

¹ Previously called the Department of Health, Social Services and Public Safety (DHSSPS)

² Prior to 2022, this function was performed by the Health and Social Care Board, which was an arm's length body separate from the DoH. The SPPG sits within the DoH

³ Briege Donaghy Transcript – 03/05/23 – Pages 16-17

and HSSTs (later to become HSCTs),⁴ the Regulation and Quality Improvement Authority (RQIA) has acted as the arm's length inspector for funded services.⁵ While the RQIA regulates independent and third sector providers and can stop them from providing services, it has no power to restrict HSCT services⁶ and must instead notify the DoH of any serious concerns through an Article 4 letter (under Article 4(2) of the 2003 Order).

16.4 The 2003 Order does not specify the frequency of reviews and the RQIA use risk-assessed intelligence⁷ and professional judgement to decide whether and when to inspect.⁸ The RQIA conducts both announced and unannounced visits.⁹ These have been discussed in more detail in Chapter 14 (External Agencies Inspection and Oversight).

16.5 In the following paragraphs, we discuss the different systems for planning and funding learning disability care over time.

Pre 1999 (and the legacy arrangements)

16.6 Muckamore Abbey Hospital (MAH) was originally managed by a Special Care Service Management Committee that covered the whole of Northern Ireland.¹⁰ In 1974 services were reorganised and learning disability services were moved from a regionwide specialist service to local HSSBs.¹¹ The aim of the reorganisation was to allow for local, integrated, planning of social and health care services but there were fears that a small service like MAH would be less visible in a multi-speciality organisation than it had been in the Special Care Service.¹² MAH now fell under South Belfast District, a subdivision of Eastern Health and Social

⁴ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 24

⁵ The DoH acts as the sponsor department for the RQIA, see <https://www.health-ni.gov.uk/topics/regulation-and-quality-improvement-authority>.

⁶ Briege Donaghy Transcript – 03/05/23 – Page 27 – Line 15

⁷ Briege Donaghy Transcript – 03/05/23 – Page 33 – Line 21

⁸ Briege Donaghy Transcript – 03/05/23 – Pages 52-56

⁹ Briege Donaghy Transcript – 03/05/23 – Page 23 – Line 16

¹⁰ I. Montgomery and J. Armstrong (2009) From Special Care to Specialist Treatment: A History of Muckamore Abbey Hospital. Ulster Historical Foundation, Belfast (ISBN:978-1-903688-41-0) – Page 26 – <https://ulsterhistoricalfoundation.com/library/from-special-care-to-specialist-treatment-a-history-of-muckamore-abbey-hospital>

¹¹ Health and Personal Social Services (Northern Ireland) Order 1972 – <https://www.legislation.gov.uk/nisi/1972/1265>

¹² From Special Care to Specialist Treatment (Montgomery and Armstrong, 2009) – Page 96

Services Board (EHSSB).¹³ Community and hospital services were managed separately in South Belfast District so while the aim of the 1974 change was to integrate care planning, it may have achieved the opposite for people with learning disabilities.

- 16.7 The Inquiry heard from representatives of the DoH that the 1974 reorganisation meant that, in contrast to the rest of the UK, Northern Ireland services work together within an integrated care system (ICS)¹⁴ but an integrated system would include wider public services, such as housing and independent and third sector providers, including residential and nursing homes and domiciliary social care providers. We saw little evidence that social care service planning was integrated with health, simply that both services were co-located within a single organisation, and no evidence of planning with independent and third sector providers.
- 16.8 Since 1999, the Northern Ireland Executive (NIE) has received a block grant from HM Treasury, and this is revised annually as part of the national (UK wide) spending reviews. The amount received is based on the Barnett Formula¹⁵ devised in 1979. Changes are largely determined through the principle of comparability rather than assessed need. HM Treasury adjusts the Northern Ireland block grant in line with comparable programmes in England.¹⁶ The NIE agrees a Programme for Government (PfG) framework¹⁷ and uses its discretion to decide how to allocate the discretionary part of the block grant to individual departments. Currently health and social care receive approximately 46% of the devolved expenditure.
- 16.9 Once funds have been allocated, the Minister of Health for Northern Ireland sets departmental priorities in line with the PfG.¹⁸ The DoH then use the priorities to develop a Commissioning Plan Direction, which includes performance indicators

¹³ From Special Care to Specialist Treatment (Montgomery and Armstrong, 2009) – Page 97

¹⁴ Health and Personal Social Services (Northern Ireland) Order 1972 – <https://www.legislation.gov.uk/nisi/1972/1265>; Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 6

¹⁵ S. Tudor (2023) The Barnett formula: How it operates and proposals for change. House of Lords Library — <https://lordslibrary.parliament.uk/the-barnett-formula-how-it-operates-and-proposals-for-change>

¹⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 10

¹⁷ June Champion Statement – 10/03/23 – Page 149

¹⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 10

(and targets) associated with the priorities.¹⁹ The SPPG (previously HSCB) uses this to negotiate local contracts with service providers (including HSCTs). If the funds allocated by the DoH are insufficient to meet core services, cost efficiency savings are required to achieve financial break-even across the health and social care system.²⁰ This was felt particularly from 2009 onwards. In 2010 the HSCTs were required collectively to find over £200 million cost savings,²¹ leading to staff recruitment freezes. The direct effect of these on recruitment of staff in MAH is explored in Chapter 12 (Staff and Ward Management). Similar pressures were seen in other departments, for example the Northern Ireland Housing Executive announced that it would have to limit the number of housing adaptations for people with a disability to 30 against a higher possible demand of around 200 (in 2009-2010).²²

16.10 Funding is accounted for via programmes of care (PoCs). These are categories derived from the Korner statistical information review in the 1980s²³ and were adopted in Northern Ireland in 1992.²⁴ The categories provide a consistent way of reporting data, and financial reporting still largely follows the PoC structure.²⁵ There are currently nine PoCs, one of which is learning disability.²⁶ Funding for learning disability services almost doubled from £240 million in 2010/11 to £412million in 2019/20 when it represented 8.6% of health and social care spend,²⁷ making it the third highest spend PoC, behind acute care services (40%) and services for older people (20%).²⁸ The Inquiry was also told that the financial model for resettlement included funding service development, and for the period from 2011/12 to 2021/22 a total of £86 million was invested to increase and enhance community infrastructure for the learning disabled population.²⁹

¹⁹ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 724

²⁰ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 25

²¹ Aidan Dawson 2nd Statement (Evidence Modules) – 26/05/23 – Page 524 (Exhibit) – Health and Social Care Board Public Health Agency Commissioning Plan 2010/2011

²² Northern Ireland Housing Executive (2009) News release – https://archive.niassembly.gov.uk/social/2007mandate/motions/pr_Housing_Exec.pdf

²³ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Page 8

²⁴ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Page 9

²⁵ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Page 8

²⁶ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Pages 3-4

²⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 14

²⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 14

²⁹ Brendan Whittle Transcript – 21/10/24 – Page 190 – Line 14

Nevertheless, the Inquiry heard from Sean Holland (Chief Social Work Officer from 2010 to 2022) that there were still current significant gaps in the provision of the out-of-hours service.³⁰

- 16.11 UK-wide changes from the late 1980s moved healthcare from the single direct management line created at the inception of the NHS to the creation of a quasi-market with a ‘purchaser/provider’ split. This was achieved in Northern Ireland with the Health and Personal Social Services (Northern Ireland) Order 1991, which created four HSSBs that commissioned services from 18 health and social services trusts (HSSTs). The HSSTs did not integrate community and hospital services – this was the role of the HSSBs.³¹ While the Department of Health and Social Services (DHSS) retained ultimate legal responsibility for services, it had a management executive as an operational arm’s length body³² to ensure the purchaser/provider split was working effectively.
- 16.12 From 1994, EHSSB commissioned services from North and West Belfast Health and Social Services Trust (NWBHSST) which now managed MAH.³³ However, MAH had patients from across Northern Ireland and therefore received funding from all four HSSBs. (Patients who were admitted before the 1994 organisational changes were later known as legacy patients.) EHSSB, as the lead commissioner, was responsible for assuring that the contract with NWBHSST was being delivered within budget and to the scale and standard commissioned.³⁴

Post-1999 organisational structures

- 16.13 Following the creation of the Northern Ireland Executive (NIE) in 2000, the previous arm’s length management executive set up by the 1991 Order was disestablished and its functions were absorbed into the DHSS, which had expanded its responsibilities and was renamed the Department of Health, Social Services and Personal Safety (DHSSPS).³⁵ The oversight previously undertaken

³⁰ Sean Holland Transcript – 21/10/24 – Page 133 – Line 26

³¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6; Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 10

³² Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Page 3

³³ The North and West Belfast Health and Social Services Trust (Establishment) Order (Northern Ireland) 1993 – <https://www.legislation.gov.uk/nisr/1993/352/contents/made>

³⁴ Andrew McCormick Statement (Organisational Modules) – 28/06/24 – Page 4

³⁵ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 7

by the management executive was now undertaken by the DHSSPS Service Delivery Unit until 2009, when another arm's length body (the HSCB) was created.³⁶

- 16.14 In 2005, the NIE Review of Public Administration led to further management changes. The 18 HSSTs were replaced with five new integrated HSCTs (integrating community, mental health, learning disability and acute care services). One of these was the Belfast Health and Social Care Trust (BHSCT).³⁷ EHSSB retained lead responsibility for commissioning services at MAH until 2009³⁸ when the Health and Social Care (Reform) Act (Northern Ireland) 2009 dissolved the four separate HSSBs, creating in their place the Public Health Agency (PHA) and the HSCB.³⁹ The HSCB was responsible for both commissioning and performance management of the HSCTs while the PHA focused on clinical standards and promoting good health. A Management Statement and Financial Memorandum defined the relationship between the Minister of Health for Northern Ireland, the DHSSPS (renamed the DoH in 2016)⁴⁰ and the HSCB.⁴¹
- 16.15 The HSCB Chair was directly appointed by the Minister of Health.⁴² The HSCB did not employ clinical directors, but the PHA Executive Director of Nursing and Allied Health Professions and the PHA Executive Director of Public Health attended HSCB senior management team and board meetings. The Executive Director of Social Work and Children's Services, who was employed by the HSCB, attended the senior management team and board meetings of the PHA.⁴³ The HSCB had a specific learning disability planning and commissioning team and received support from PHA nurse consultants for learning disability and mental health acting as 'essential members of this team'.⁴⁴

³⁶ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 27

³⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 2867 (Exhibit MMcG55) – HSSPS, A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery 2010-2015

³⁸ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 11

³⁹ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Pages 2-3

⁴⁰ The Health Department was renamed the Department of Health following the Departments Act (NI) 2016

⁴¹ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 12

⁴² Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Pages 14-15

⁴³ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 3

⁴⁴ Rodney Morton Transcript – 25/09/24 – Page 140 – Line 16

- 16.16 Five subcommittees of the HSCB (and its successor, the SPPG) are known as local commissioning groups (LCGs) that are co-terminus with the five geographical HSCTs. LCGs are multidisciplinary, multi-agency groups whose primary role is to ensure that local voices shape the commissioning plan and the decisions made by the HSCB board⁴⁵ and that the public has sight of and contributes to the commissioning plan.⁴⁶ LCGs prepare local commissioning plans in keeping with the priorities and objectives of the HSCB and these are incorporated within the regional HSCB commissioning plan.⁴⁷ Some specialist services (such as MAH) re commissioned collaboratively on a regional basis with input from all the LCGs.⁴⁸
- 16.17 HSCTs respond to the draft commissioning plan with individual trust delivery plans (TDPs) in which they described how they would deliver the plan (and raise any concerns about funding).⁴⁹ TDPs formed the basis for service and budget agreements (SBAs) between HSCTs and HSCB.⁵⁰ New or changed services are developed through a business case known as an investment proposal template (IPT).⁵¹ which includes a value for money assessment.⁵²
- 16.18 A mental health and learning disability commissioning team chaired by an Assistant Director of Social Work at HSCB, and with membership drawn from the HSCB and PHA,⁵³ scrutinised the TDPs.⁵⁴ However, the Inquiry heard that once a patient had been in MAH for six months, they were removed from their GP's register. While MAH had a contract for on-call emergency GP services, there was no primary care provision. The failure to include primary care within BHSCT's TDP was a glaring omission that meant that routine screening was not provided,⁵⁵

⁴⁵ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 22

⁴⁶ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 21

⁴⁷ Mark McGuicken 1st Statement (Evidence Modules) – Pages 1179-1180 (Exhibit MMCG31) – Department of Health, Social Services and Public Safety, Framework Document, Version September 2011; Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 3045 (Exhibit BW/16) – HSCB Standing Orders for the HSCB 2021

⁴⁸ Mark McGuicken 1st Statement (Evidence Modules) – Page 1179 (Exhibit MMCG31) – Department of Health, Social Services and Public Safety, Framework Document

⁴⁹ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 23

⁵⁰ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Pages 7-8

⁵¹ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Pages 7-8

⁵² Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 25

⁵³ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Pages 22-23

⁵⁴ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 4

⁵⁵ Damien Hughes Transcript – 24/09/24 – Pages 42-43; referred to in Mary Hinds Transcript – 25/09/24 – Page 22 – Line 2

leaving patients at a significant disadvantage compared to the general population of Northern Ireland. While the PHA was not directly responsible for the commissioning, as the lead agency for public health it might have been expected to comment on this

- 16.19 The final commission plan (including the TDPs and the SBAs) was signed by the chairs and chief executives of both HSCB and PHA⁵⁶ and sent for final approval by the Minister. In the event that the HSCB and PHA could not agree the commissioning plan, the matter would be referred to the DoH for resolution.⁵⁷
- 16.20 While the HSCB led the process for commissioning services with HSCTs and monitored their performance, it is the DoH that formally holds HSCTs to account for delivery through meetings between the Chair and Chief Executives and the Permanent Secretary.⁵⁸
- 16.21 Further consideration of the commissioning structure was presented in late 2014 in 'The Right Time, The Right Place' review of health and social care governance in Northern Ireland (known as the Donaldson Report). It concluded that the commissioning process was unnecessarily complex and not agile enough to respond quickly to changing needs.⁵⁹ The resulting Health and Social Care Act (Northern Ireland) 2022 dissolved the HSCB and transferred its functions back to the DoH, where the newly formed SPPG has become directly accountable to the Minister of Health for planning, improving and overseeing the delivery of health and social care services.⁶⁰ Under the Act, the five LCGs remained and an Integrated Care System for Northern Ireland (ICS NI)⁶¹ has since laid out the emerging new model.

⁵⁶ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 22

⁵⁷ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Page 18 and Page 54

⁵⁸ June Champion Statement (Evidence Modules) – 10/03/23 – Page 16

⁵⁹ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Page 167 (Exhibit MMcG-182) – The Right Time, The Right Place, An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland December 2014

⁶⁰ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 4

⁶¹ The Integrated Care System for Northern Ireland (ICS NI) May 2024 – <https://online.hscni.net/our-work/integrated-care-system-ni/ics-ni-publications/>

16.22 A range of management structures have been tried in Northern Ireland, from regional specialist services for people with learning disabilities to including all services in a local commissioning structure. Provider units have been of varying sizes. Each model has been perceived to have its own drawbacks. In 2016, an expert panel, chaired by Professor Rafael Bangoa, was tasked by the Health Minister with producing proposals to remodel the Health and Social Care (HSC) system in order to deliver safe, high-quality and sustainable services for the population of Northern Ireland. The panel's report published the same year, 'Systems, not Structures – Changing Health and Social Care', concluded that the problem was not organisational structures but accountability arrangements and proposed 'Accountable Care Systems (ACS) to integrate, by agreement rather than by creating new organisations'. Under an ACS, all providers would collectively be held accountable for achieving a single set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk-sharing arrangements and incentives.⁶² The Inquiry did not hear whether, or when, the DoH intends to introduce ACS as proposed 10 years ago.

Policy changes for people with learning disabilities

16.23 Attitudes to the care of people with learning disabilities began to change during the 1980s, and the DHSS 1987-1992 regional strategy for the Northern Ireland health and personal social services gave a commitment that rather than live in long-stay institutions like MAH, people with 'mental handicap' should be enabled to live in the community. The strategy set a target to reduce the number of people in long-stay hospitals by at least 20%.⁶³ All subsequent DHSSPS and DoH strategies reaffirmed this vision of life in the community⁶⁴ and the nature of the service at MAH began to change from long-term care to therapy; for example, the hospital's 'light industry workshops' were reframed as day care and became activities rather than work.⁶⁵ People who had been in MAH for years, even

⁶² Expert panel (2016) Systems, not Structures – Changing Health and Social Care: Executive summary – Page 9 – <https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-report-executive-summary.pdf>

⁶³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 116 (Exhibit MMcG-3) – DHSS People First Community Care in Northern Ireland for the 1990s

⁶⁴ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 6

⁶⁵ H471 Statement – 12/03/24 – Pages 3-4

decades, began to be resettled, and this is discussed in more detail in Chapter 15 (Resettlement).

- 16.24 In 1995 the EHSSB reviewed the future of learning disability services it wanted to commission and one of the options was the closure of MAH, to be replaced by smaller units throughout the area.⁶⁶ Following a campaign by staff, unions and families, this option was shelved. However, the DHSS committed in 1995 to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland.⁶⁷ This disconnect between DoH policy and the public discourse was a recurring theme over the time frame of the Inquiry's Terms of Reference (ToR) but was never acknowledged by the DoH.
- 16.25 In 1996 EHSSB published 'A Model of Community Based Services for People with Learning Disability'⁶⁸ stating that it would only purchase inpatient care for people with learning disabilities when it could be demonstrated that community or outpatient-based treatment was either not available or not appropriate. But 20 years later, people were still being admitted to hospital because there was a lack of support in the community. This demonstrates that commissioning for change requires more than fine words and good intent, it needs meticulous planning and good project management, both of which appear to have been absent around learning disability services.
- 16.26 The newly established DHSSPS published its 'Priorities for Action 2001-2002', which set a goal to 'agree a business case for the redevelopment of MAH to become a 115 bed unit'.⁶⁹ A business case was submitted in 2002, but it acknowledged that the reduction in beds would not be immediately achieved and proposed a target date of 2008-2009.

⁶⁶ From Special Care to Specialist Treatment (Montgomery and Armstrong, 2009) – Page 129

⁶⁷ Northern Ireland Audit Office (2009) Resettlement of long-stay patients from learning disability hospitals. NIAO, Belfast – www.niauditoffice.gov.uk/files/niauditoffice/media-files/resettlement_of_long-stay_patients_from_learning_disability_hospitals.pdf

⁶⁸ From Special Care to Specialist Treatment (Montgomery and Armstrong, 2009) – Page 144

⁶⁹ From Special Care to Specialist Treatment (Montgomery and Armstrong, 2009) – Page 149

16.27 In 2002, the DHSSPS commissioned an independent review of mental health and learning disability, chaired by David Bamford. By March 2003 it was clear that the work consisted of several interlinked reviews under one overarching title and all-encompassing policy, services and legislation. The review's second report, published in 2005, was 'Equal Lives' and covered learning disability. It concluded that:

'... progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else'.⁷⁰

16.28 A Bamford Recommendations Monitoring Group (which included service users and carers) was set up in 2009. Rather than challenging the DoH specifically, its role was seen as one of bringing challenge to the system generally and inputting public voice.⁷¹ The Bamford monitoring group was stood down in December 2016⁷² after an unpublished evaluation report:

'... the report recognises the important role played by the ministerial group, the interdepartmental senior officials group and the Bamford monitoring group, but recommends that the time has come to stand these structures down and mainstream the continued development of Mental Health and Learning Disability Services'.⁷³

16.29 The Bamford recommendations had been superseded by a learning disability service framework, introduced in 2012.⁷⁴ The framework provided an overarching structure describing how a service should be delivered and accountability structures for that service. The DoH Service Framework Programme Board decided in 2018 not to renew the learning disability framework,⁷⁵ meaning that no learning disability strategic framework has been in place from 2018 to the present

⁷⁰ Review of Mental Health and Learning Disability (Northern Ireland) (2005) Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland. Department of Health, Social Services and Public Safety, Belfast – Page ii – <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Equal%20Lives%20Report.pdf>

⁷¹ Mark McGuicken Transcript – 03/04/23 – Pages 67-68

⁷² Mark McGuicken Transcript – 03/04/23 – Pages 69-70

⁷³ Mark McGuicken Transcript – 03/04/23 – Page 70 – Line 4

⁷⁴ Mark McGuicken 2nd Statement (Evidence Modules) – 06/06/23 – Page 17

⁷⁵ Mark McGuicken Transcript – 03/04/23 – Page 78

day, although the Inquiry heard that the DoH is consulting stakeholders on a new learning disability service model.⁷⁶

Workforce planning

- 16.30 The Inquiry frequently heard of staff shortages across all the professions and in relation to support staff (this is discussed in more detail in Chapter 12). While the HSCB commissioned services, it was not responsible for workforce supply to the service providers (HSCTs and independent and third sector providers). As in the rest of the UK, the DoH in Northern Ireland is not directly responsible for ensuring safe staffing levels within individual hospitals.⁷⁷
- 16.31 Responsibility for strategic pre-registration workforce planning lies with the DoH and its Human Resources directorate determines how many pre-registration education places to commission from universities. This directorate is responsible for post-registration medical education but not the other professions. Unlike the rest of the UK, Northern Ireland lacks a comprehensive, centralised workforce intelligence function.⁷⁸
- 16.32 The DoH allocates annual budgets to the Chief Professional Officers (other than the Chief Medical Officer(CMO) for post-registration education for their respective staff groups.⁷⁹ Budgets are based on historic spend rather than current need and are supplemented by non-recurrent funding.⁸⁰ Education is commissioned on an annual cycle, which in turn limits long-term workforce planning.⁸¹
- 16.33 Nursing accounts for approximately two-thirds of the overall staff body at any given time.⁸² The DoH funds pre-registration professional nursing education from Northern Ireland universities⁸³ and the Chief Nursing Officer (CNO) oversees a

⁷⁶ Department of Health (2005) Public consultation on the draft learning disability service model – We Matter – <https://www.health-ni.gov.uk/news/public-consultation-draft-learning-disability-service-model-we-matter>

⁷⁷ Mark McGuicken Transcript – 03/04/23 – Page 38 – Line 1

⁷⁸ E. Maxwell (2022) Review of the current business model for commissioning and delivery of post-registration education for Nurses, Midwives, and Allied Health Professionals in Northern Ireland

⁷⁹ Some professionals, such as paramedics, fall outside this structure and lack access to dedicated funding.

⁸⁰ Review of the current business model for commissioning and delivery of post-registration education (Maxwell, 2022)

⁸¹ Review of the current business model for commissioning and delivery of post-registration education (Maxwell, 2022)

⁸² BHSC Closing Submission – 21/02/25 – Pages 25-26

⁸³ Mary Hinds Statement (Organisational Modules) – 17/04/24 – Page 18

postgraduate education budget of just over £11 million (2020/21) for nursing and midwifery and seven of the allied health professions.⁸⁴ There is no budget for social care support workers or healthcare assistants. Their education and development are funded by the employers' revenue.

16.34 We did not hear of an 'invest to save' approach to workforce strategy at the DoH. Following the Bamford Review, Deloitte management consultants were commissioned in 2009 to review the workforce plans for mental health and learning disabilities.⁸⁵ They concluded, unrealistically in our view, that services in the community could be expanded by moving funding out of MAH by reducing staff posts. The failure by Deloitte to consider the need to create community posts before funds could be taken out of MAH led to a 'chicken and egg' situation where staff could not be released until patients had been resettled, but patients could not be resettled because community services were not available. The Deloitte report was published in June 2009, but in October 2009 the Northern Ireland Audit Office (NIAO) reported that delays in resettlement were primarily due to a lack of funding for care and support services in the community. The DoH failed to recognise the shortcomings of the Deloitte review or to address the lack of community workforce to support its resettlement ambitions, which remained the case up until the end of the Inquiry hearings.⁸⁶

16.35 In addition, Equal Lives had proposed a new 'health facilitator' role and Deloitte recommended that this could be undertaken by registered nurses - learning disability (RNLDs) or social workers who would be released by the bed closures at MAH.⁸⁷ However, Deloitte made no recommendations about the education required to upskill existing staff for the proposed new roles.

⁸⁴ The seven professions were dietetics, occupational therapy, orthoptics, physiotherapy, podiatry, radiography, and speech and language therapy.

⁸⁵ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 7119 (Exhibit McMG-172) Workforce Planning in Mental Health and Learning Disability: Implementation of Bamford Review Recommendations

⁸⁶ Families who gave post-hearing evidence on resettlement in 2024 reported continued problems with both the support and skills of staff to support community living.

⁸⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 7159 (Exhibit McMG-172) Workforce Planning in Mental Health and Learning Disability: Implementation of Bamford Review Recommendations

- 16.36 As a result, changes in care models for people with learning disabilities were not supported by a corresponding education programme for the existing workforce. This almost certainly contributed to delays in resettlement and increased risks in inpatient settings such as MAH. It is likely that the failure properly to plan for the implementation of change led to higher costs than if a comprehensive education programme had been initiated in 2009.
- 16.37 ‘The New Decade, New Approach Deal’ (published in 2020) acknowledged that contracts with universities in Northern Ireland had failed to meet workforce demand, resulting in shortages across all clinical professions.⁸⁸ The BHSCCT’s closing statement to the Inquiry suggested that while there was an 8.8% increase in the registered nursing workforce between 2012 and 2019, changing demand required a 23% increase just to maintain services.⁸⁹ Staffing difficulties at MAH were exacerbated after the 2017 CCTV revelations and, according to the BHSCCT’s Chief Executive, were ‘leading to a workforce largely composed of agency staff’.⁹⁰ We describe elsewhere in this report the significant disbenefits to which that led.

Monitoring quality and safety

- 16.38 One of the responses to the 2001 report of the Public Inquiry into children’s heart surgery at Bristol Royal Infirmary was the requirement for clinical governance systems across the UK.⁹¹ Clinical governance is:
- ‘... a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’.*⁹²
- 16.39 The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 sets out a requirement that each HSCT (and

⁸⁸ The New Decade, New Approach Deal (2020) – https://assets.publishing.service.gov.uk/media/5e178b56ed915d3b06f2b795/2020-01-08_a_new_decade_a_new_approach.pdf.

⁸⁹ Brona Shaw Statement (Evidence Modules) – 17/04/24 – Page 4256 (Exhibit T02.65) NIAO Workforce planning for nurses and midwives, 31/07/20; BHSCCT Closing Submission – 21/02/25 – Page 26

⁹⁰ Cathy Jack Statement (Organisational Modules) – 14/06/24 – Page 38

⁹¹ UK Department of Health (2002) Learning from Bristol: The Department of Health’s Response to the Report of the Public Inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995 – <https://assets.publishing.service.gov.uk/media/5a7c743540f0b62aff6c1c71/5363.pdf>

⁹² G. Scally and L.J. Donaldson (1998) Clinical governance and the drive for quality improvement in the new NHS in England, BMJ, 317(7150), pp. 61-65 – <https://doi.org/10.1136/bmj.317.7150.61>

previously each HSST) puts arrangements in place to monitor and improve the quality of the health and social care that it provides and the environment in which it provides this. This means all trust board members are accountable for quality, and it should feature high on the board's agenda as a standing item.⁹³ In 2003, the DHSSPS issued a circular requiring HSSTs to have a designated clinical governance committee chaired by a non-executive director of the board⁹⁴ and to complete a baseline assessment and action plan for their organisation. HSSTs were also required to produce annual quality reports.⁹⁵ Had the BHSCT established effective clinical and social governance systems (see Chapter 13 (Senior Management and Trust Board Governance)), it would have been aware of the mounting data from incident reporting and safeguarding referrals showing that MAH was not an environment in which excellence in care would flourish.

- 16.40 In 2006, the DHSSPS issued guidance on establishing an assurance framework to strengthen board-level control and assurance (see Chapter 13) for further details).⁹⁶ Accountability was further strengthened in 2010 with the introduction of 'early alerts' to ensure timely reporting of significant events to the DHSSPS.⁹⁷
- 16.41 Reporting of serious adverse incidents (SAIs) to the DHSSPS had been introduced in 2004.⁹⁸ DHSSPS delegated the operational responsibility for the implementation of the SAI policy to the HSCB in 2010,⁹⁹ and HSCB reduced its oversight of SAI Level 1 audit reviews in 2016¹⁰⁰ as accountability for managing quality now lay with the HSCTs, with only the most significant exceptions reported upwards.
- 16.42 The responsibility for oversight of quality and safety was shared between the HSCB and PHA. When an SAI was reported, a designated review officer (DRO)

⁹³ June Champion Statement (Evidence Modules) – 10/03/23 – Page 234 (Exhibit T03.01) – HSC Board Member Handbook

⁹⁴ June Champion Statement (Evidence Modules) – 10/03/23 – Pages 27-28

⁹⁵ June Champion Statement (Evidence Modules) – 10/03/23 – Page 30

⁹⁶ June Champion Statement (Evidence Modules) – 10/03/23 – Page 38

⁹⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 61

⁹⁸ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Pages 43-44

⁹⁹ Mary Hinds statement – 17/05/2024 – Page 5

¹⁰⁰ Brendan Whittle 1st Statement (Evidence Modules) – 10/02/23 – Pages 45-46

was appointed (most often a professional officer of the HSCB or PHA). The DRO agreed the level of review being undertaken and the terms of reference for Level 2 and 3 SAIs. The DRO also reviewed the completed reports for the robustness.¹⁰¹ For a Level 3 SAI, the DRO would liaise on any immediate action to be taken and the membership of the review team, with particular attention paid to the independence of the panel. The DRO might feel the entire panel should be independent. The DRO would then agree the terms of reference and timescales for the reporting of the review with the reporting organisation. Once a Level 3 SAI review was completed, the DRO informed the trust whether and when the SAI review could be closed. Any additional information that became available, for example coroner reports, must be communicated to the DRO. In addition, a DRO might request that the reporting organisation provide an additional assurance mechanism by advising, within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring would be followed up via the HSCB governance team.¹⁰²

16.43 The HSCB and PHA boards did not receive individual incident data but did receive thematic reviews.¹⁰³ At all times, though, there was a lost opportunity to learn from trends and consider systemic factors. The Inquiry has seen significant amounts of data from incident reporting and safeguarding referrals to show that there were problems from at least 2010 – however, each was examined in isolation and so neither BHSCT, HSCB nor the DoH could see the wood for the trees. The failure to consider trend analysis was a significant factor in the lack of visibility of the deteriorating situation at MAH.

16.44 The former Executive Director of Nursing, Midwifery and Allied Health Professions (AHPs) in the Public Health Agency identified the need for a dashboard safety surveillance system at the PHA and HSCB, tracking adverse incidents.¹⁰⁴ This would focus on *‘proactively analysing the data in a way that would give people like me and others better information about the safety and quality of services in*

¹⁰¹ Mary Hinds Statement – 17/05/24 – Pages 7-8

¹⁰² Mary Hinds Statement – 17/05/24 – Page 8

¹⁰³ Rodney Morton Transcript – 25/09/24 – Page 117 – Line 12

¹⁰⁴ Rodney Morton Transcript – 25/09/24 – Pages 113-114

Northern Ireland'.¹⁰⁵ If workforce data was also integrated, it would provide a means of quickly identifying emerging safety or quality issues.¹⁰⁶ However, this was not implemented due to funding constraints.¹⁰⁷

Conclusions

- 16.45 The model of care for people with learning disabilities has been slow to change in Northern Ireland. Despite a policy direction to eliminate long-stay hospitals from at least 1986, there has been a failure to deliver this ambition in practice.
- 16.46 Various organisational structures have been in place at different times, none of which has delivered the required change in service provision. We are inclined to agree with Professor Bengoa that the solution is systems, not structures and that a greater focus should be placed on accountability arrangements than the division of management responsibilities.¹⁰⁸
- 16.47 Attempts to create change have been stifled by lack of funding from 2010 onwards and the requirement for the health and social care to break even in-year. Transformational change requires a multi-year investment and funding cannot simply be moved from one sector to another in-year. An invest-to-save approach is needed.
- 16.48 Commissioning of services at MAH failed to consider the primary care and health promotion needs of people with learning disabilities. Once a patient had been resident in MAH for six months, they were removed from their home GP's register. Despite the commissioning of an out-of-hours on-call GP service, no alternative provision for health checks or screening programmes was provided.¹⁰⁹ Since 2019 MAH has employed a salaried GP for a number of hours per week, but it is unclear whether this provides the full range of primary care services.¹¹⁰

¹⁰⁵ Rodney Morton Transcript – 25/09/24 – Page 111 – Line 20

¹⁰⁶ Rodney Morton Transcript – 25/09/24 – Page 113 – Line 21

¹⁰⁷ Rodney Morton Transcript – 25/09/24 – Pages 113-114

¹⁰⁸ Expert panel (2016) Systems, not Structures – Changing Health and Social Care: Full report – <https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf>

¹⁰⁹ Damien Hughes Transcript – 24/09/24 – Page 43 – Line 2

¹¹⁰ H223 Statement – 22/05/24 – Page 5

- 16.49 No evidence was provided to the Inquiry that the impact of service reductions at MAH, including overall staffing and day-care provision, was evaluated. Nor was there consideration of how the lack of community crisis intervention services contributed to costly inpatient admissions, a feature of the system that we heard about frequently from patient relatives and staff.
- 16.50 Monitoring of services at MAH was fragmented. While large amounts of data were collected, there was almost no attempts to synthesise it and explore patterns and trends. Nor was there any attempt to integrate performance data with quality and safety data to provide a holistic view.
- 16.51 Any commissioning plan is entirely dependent on the workforce that delivers services, but there was no regard for creating a workforce with the right skills to meet patient needs. The approach was focused on the number of bodies needed rather than the knowledge and competencies required.

Recommendations

R101	Planning and commissioning services for people with learning disabilities and autistic people should be done as a single process across the whole system (including primary care, housing, benefits and independent and third sector providers of services). There must be a risk assessment that assesses how the impact of change in one part of the system impacts on another part (e.g. how failure to invest in community early intervention services impacts resettlement). The risk assessment should be multi-agency and include housing, private and third sector providers as well as health and social care.
R102	DoH should establish a comprehensive, centralised workforce intelligence function, similar to those in the rest of the UK, within 12 months of the publication of this report. The learning disability service model must include a fully funded, comprehensive workforce model, together with a transition plan to enable the current workforce to deliver the new model.
R103	A live dashboard of performance, quality and safety indicators within learning disabilities must be developed and made publicly available within 12 months of the publication of this report.

Patients are people first

'My son played a full role in family life as he was growing up. He loved parties and he got on well with extended family'

'He adored singing and would sing with his sister and loved music'

'I taught my son how to read at the age of five and he is still a great reader.'

'His room would have been meticulous with his books and music, and carefully organised. He had a degree of independence in his teenage years. He had his own front door key and could have come home and settled himself until his sister or I came home.'

'He loved music, storytelling and videos and regularly watched movies with me like The Lion King.'

Chapter 17

Managing the Delivery of Service for People with Learning Disabilities and Autistic People

Introduction

- 17.1 Chapter 16 (Planning and Funding of Learning Disability Services in Northern Ireland) considered the way policy decisions influenced the funding and commissioning of services for people with learning disabilities and autistic people. In this chapter we consider the way service delivery was organised and managed, how problems at Muckamore should have been identified, and potential flaws in the way the system operated.
- 17.2 We described how the Department of Health (DoH) (through the Strategic Planning and Performance Group ((SPPG)) and its predecessors) commissions services from health and social care trusts (HSCTs). These contracts include standards to be met, and the funding provided to do so. Performance against these contracts is monitored through accountability meetings between the HSCT chief executive officer (CEO) and the Permanent Secretary at the DoH.
- 17.3 HSCTs also have a statutory duty to manage services in such a way that care is of high quality, and this is inspected by Regulation and Quality Improvement Authority (RQIA). Failures in quality must be reported on an individual basis by the HSCTs via serious adverse incident (SAI) referrals and 'early alerts' to the SPPG (and previously the Health and Social Care Board (HSCB)) and Public Health Agency (PHA). However, HSCTs have a responsibility to run their own internal quality assurance systems to ensure safe, effective and compassionate care.

Types of service provided

- 17.4 The majority of people with learning disabilities and/or autism have never been admitted to a specialist learning disability inpatient facility, but most will have received some services from the HSCTs' community and social care services. This may include the purchase by HSCTs of social or nursing care services from independent (private) or third sector (not for profit or charity) providers. People

resettled out of MAH usually receive services from independent or third sector organisations¹ and the HSCTs remain accountable for the care they have purchased. In June 2018 the South Eastern Health and Social Care Trust (SEHSCT) was criticised by the Commissioner for Older People for Northern Ireland for failing to use the mechanisms within its contract with Dunmurry Manor Care Home to 'bring about change and improvements required in the home'.²

- 17.5 People with learning disabilities and/or autism (other than those who have been resident in a long-stay hospital for more than six months) are registered with a GP practice and receive both primary care and urgent care. They will also be registered with a dental practice. These services are commissioned directly by the DoH and are not the responsibility of HSCTs.
- 17.6 The BHSCT provides inpatient learning disability services for people within its catchment area and also those in the Northern Health and Social Care Trust (NHSCT) and SEHSCT catchment areas. The Western Health and Social Care Trust (WHSCT) and Southern Health and Social Care Trust (SHSCT) provide their own inpatient facilities.

Provider responsibilities for social care

- 17.7 Following the split between commissioners and providers in the 1990s (discussed in Chapter 16), the responsibility for providing care services fell to semi-autonomous health and social services trusts (HSSTs). Initially there were 18 trusts (including North and West Belfast Health and Social Services Trust ((NWBHSST)), which managed MAH) and this was reduced to five in 2007 (including Belfast Health and Social Care Trust ((BHSCT)) which took over the management of MAH).
- 17.8 The Health and Personal Social Services (Northern Ireland) Order 1972 that integrated health and social care services (discussed in Chapter 16) had created

¹ Marie Heaney Transcript – 06/06/23 – Page 48 – Line 20; June Champion Statement (Evidence Modules) – 10/03/23 – Page 69. Resettlement is discussed in detail in Chapter 15.

² Commissioner for Older People for Northern Ireland (2018) Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home: Summary report. COPNI, Dundonald – https://setrust.hscni.net/wpfd_file/set3918-commissioner-for-older-people-northern-ireland-copni-report-home-truths-a-report-on-the-commissioners-investigation-into-dunmurry-manor-care-home/

a statutory responsibility for health and social service boards (HSSBs) to provide named social care functions through their directly managed providers. The 1991 split between commissioners and providers meant that the DoH no longer had direct management of care delivery and Article 3 of the Health and Personal Social Services (Northern Ireland) Order 1994 delegated this duty to the HSSTs (and later HSCTs).³ These duties became known as delegated statutory functions (DSFs), which are discussed in more detail in Chapter 13 (Senior Management and Trust Board Governance). Trusts must provide an annual report to the Chief Social Work Officer (CSWO) on their discharge of these functions⁴ to ensure an unbroken line of professional oversight of DSFs. The intention is to have clarity on who is responsible (and liable) for which function, ensuring the delivery of care and services is provided as required by legislation. Reports are also intended to provide detail on any risks to the effective delivery of service, including alerting the CSWO to any SAIs.⁵

- 17.9 The 1972 Order did not specify adult safeguarding as a statutory duty, although it did specify child protection, but it has become practice to include it in DSF reports. The DoH 2020 review of leadership and governance at MAH was very critical of the reporting process, and we discuss the limitations of the governance of adult safeguarding in Chapter 11 (Safeguarding).

Impact of resettlement agenda on the operation of MAH

- 17.10 Resettlement is discussed in detail in Chapter 15 (Resettlement); however, while it was a DoH priority, there was little consideration given to how to continue to provide high-quality services at MAH until resettlement was complete. The co-director responsible for MAH highlighted the dual burden placed on BHSCT⁶ – to deliver both inpatient services and enhanced community services while simultaneously closing wards to release funding.⁷ Failure to develop sufficient community service across the region led to continued requests for admissions,⁸

³ Mark McGuicken Statement (Evidence Module) – 13/02/23 – Page 69

⁴ Mark McGuicken Statement (Evidence Module) – 13/02/23 – Page 70

⁵ Department of Health, Social Services and Public Safety (2015) Circular (OSS) 4/2015: Roles and Responsibilities of the DHSSPSNI, the HSCB and the HSC Trusts for the Professional Oversight of the Discharge of Delegated Statutory Functions – <https://www.health-ni.gov.uk/sites/default/files/publications/health/CIRCULAR%28OSS%29-4-2015.pdf>

⁶ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 4

⁷ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 4

⁸ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 6

placed further strain on MAH's capacity and complicated efforts to progress resettlement.⁹

Management structures within NWBHSST and BHSCT

- 17.11 The NWBHSST managed community services and mental health and learning disability inpatient services, whereas its successor, the BHSCT, is much larger and manages acute hospital services as well. The Inquiry heard from some witnesses that BHSCT is too large to effectively manage all its services. Part one of the Review of Public Administration, published in 2005, recommended that having 18 trusts was inefficient and this led to the integration on 01 April 2007 of community, mental health, learning disability and acute care services within a smaller number of HSCTs.¹⁰ The 2016 report, 'Systems, not structures – Changing Health and Social Care', concluded that the problem was not organisational structures but accountability arrangements.¹¹ It is therefore important to review the accountability arrangements before making any judgement about whether it was indeed possible (or not) for BHSCT to detect or prevent abuse at MAH.

Accountability for quality and safety

- 17.12 Following the 2001 Public Inquiry into paediatric cardiac surgery at Bristol Royal Infirmary, clinical governance systems were introduced across the UK to strengthen accountability and improve care standards.¹² Clinical governance is defined as:

'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.¹³

⁹ John Veitch Statement (Organisational Modules) – 31/05/24 – Page 17

¹⁰ Mark McGuicken Statement (Evidence Module) – 13/02/23 – Page 7

¹¹ Expert panel (2016) Systems, not Structures- Changing Health and Social Care: Executive summary – Page 9
<https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-report-executive-summary.pdf>

¹² UK Department of Health (2002) Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at Bristol Royal Infirmary –
<https://assets.publishing.service.gov.uk/media/5a7c743540f0b62aff6c1c71/5363.pdf>

¹³ G. Scally and L.J. Donaldson (1998) Clinical governance and the drive for quality improvement in the new NHS in England, BMJ, 317(7150), pp. 61-65 – <https://doi.org/10.1136/bmj.317.7150.61>

Clinical governance includes the monitoring of quality through a number of processes, including clinical audit, which is defined by the National Institute for Health and Care Excellence (NICE):

*‘Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery’.*¹⁴

Audits can be time-limited to evaluate the impact of a change, or continuous in order to monitor services over time. A significant example of the latter is the Sentinel Stroke National Audit,¹⁵ a prospective, longitudinal audit that measures the quality of care that stroke patients receive throughout the whole care pathway up to six months post admission in England, Wales and Northern Ireland. It has been collecting a standardised dataset from hospitals across the UK since 1998 to monitor standards for stroke care developed by the Royal College of Physicians. Individual NHS trusts can compare their performance against other similar organisations.

The Royal College of Psychiatrists has developed a similar approach with its Quality Network for Learning Disability Services (QNLD) Standards for Acute Inpatient Learning Disability Services,¹⁶ now in its fifth edition.

- 17.13 In Northern Ireland, clinical governance was formally mandated through a 2003 Department of Health, Social Services and Public Safety (DHSSPS) circular, requiring HSSTs to: establish clinical governance committees chaired by non-executive directors (NEDs); complete baseline assessments together with actions; and produce annual quality reports.¹⁷ Thus NEDs should have oversight of the

¹⁴ NICE (2002) Principles for Best Practice in Clinical Audit – <https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf>

¹⁵ Sentinel Stroke National Audit Programme – <https://www.strokeaudit.org>

¹⁶ Royal College of Psychiatrists (2025) Quality Network for Learning Disability Services (QNLD): Standards for Acute Inpatient Learning Disability Services https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnlld/qnlld-inpatient-standards---5th-edition.pdf?sfvrsn=6851348e_12

¹⁷ June Champion Statement (Evidence Modules) – 10/03/23 – Pages 28 and 30

clinical governance structures and decisions about the data the trust Board receives.

- 17.14 Clinical governance requires more than simply monitoring data. It requires detailed analysis of trends by unit, thematic clusters, improvement actions and evaluation of whether the actions have improved outcomes for patients. It goes beyond evaluation of the care of individual patients to look at the quality of the service across patients. It is distinct from performance management, which focuses on achieving operational delivery targets, in that it considers whether the service is adding value.
- 17.15 Since 2003, HSCTs have also been under a statutory duty to have organisational arrangements in place to monitor and improve the quality of health and social services provided and the environment in which they provide them.¹⁸ This requires adequate organisational structures, clinical governance and risk management arrangements.¹⁹
- 17.16 Trusts must complete an annual and a mid-year assurance statement, signed by the chief executive and submitted to the DoH, providing evidence of the continuing robustness of their organisation's system of internal control.²⁰

Distributed management

- 17.17 HSCT boards (and previously those of HSSTs) discharge their operational delivery and quality and safety duties through a distributed management system. Within NWBHSST, MAH was managed by the Director of Hospital and Community Learning Disability Services, who reported to the NWBHSST chief executive.²¹ When BHSCT was established, it created a directorate structure, with each directorate's director attending the Trust Board as a non-voting member. The NWBHSST Director of Hospital and Community Learning Disability Services

¹⁸ Health and Personal Social Services (Quality, Improvement and Regulation (Northern Ireland) Order 2003 – <https://www.legislation.gov.uk/nisi/2003/431/contents/made>

¹⁹ Martin Dillon 3rd Statement (Organisational Modules) – 30/05/24 – Pages 2-3; Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 6

²⁰ June Champion Statement (Evidence Modules) – 10/03/23 – Page 127 (Exhibit JC1 T02.01) Department of Health, Social Services and Public Safety Framework Document (September 2011) and Page 1637 (Exhibit JC1 T16.01) BHSCT Integrated Governance and Assurance Framework (2022-2023)

²¹ Miriam Somerville Statement (Organisational Modules) – 24/04/24 – Page 1

became Co-Director of Learning Disability Services within the Directorate of Social Work, Children's Community Services and Adult and Primary Care Services. Co-directors are deputies to the director of the directorate, with responsibility for a specific part of the directorate.

- 17.18 Management arrangements for learning disability services within BHSC evolved over time.²² From September 2012, MAH sat within the Directorate of Adult, Social and Primary Care Services.²³ In June 2016, the co-director for learning disability post was given up as a cash-releasing exercise together with a Band 8a when both postholders retired,²⁴ significantly reducing the management presence in MAH.
- 17.19 Directorates are subdivided into divisions and further divided into care delivery units (CDUs).²⁵ Intellectual Disabilities is currently a division²⁶ and is managed independently of mental health and other disabilities.²⁷ MAH is a care delivery unit of the Intellectual Disabilities division. Each division has a collective leadership team of a co-director (manager), a chair of division (medical) and divisional leads (often by profession, and who also meet their professional executive director regularly). Dividing directorate services into divisions means there can be more management attention for each CDU than a flatter structure would allow.
- 17.20 Currently the Intellectual Disabilities division has five CDUs: MAH; the Iveagh Centre; day opportunities; residential care in supported living; and community treatment and support, which is a multidisciplinary unit and includes safeguarding and intensive support.²⁸
- 17.21 CDUs are managed by service managers or lead nurses. In the past, MAH had three assistant service managers with responsibility for the wards divided between

²² June Champion Statement (Evidence Modules) – 10/03/23 – Page 2982 (Exhibit JC1 T29.01) Membership Tables of Trust Boards 2007-2021

²³ Catherine McNicholl Statement (Organisational Modules) – 28/06/24 – Page 4

²⁴ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital. DoH, Belfast – Page 84 – <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mah-review.pdf>

²⁵ June Champion Statement (Evidence Modules) – 10/03/23 – Page 40

²⁶ June Champion Statement (Evidence Modules) – 10/03/23 – Page 44

²⁷ June Champion Statement (Evidence Modules) – 10/03/23 – Pages 6-7

²⁸ Marie Heaney's Transcript – 06/06/23 – Talking to June Champions Statement (Evidence Modules) – 10/03/23 – Pages 67-72

them.²⁹ Each ward also has a ward sister/manager and a deputy manager. Esther Rafferty (former service manager at MAH and Associate Director of Nursing – Learning Disability Services from 2012 to 2018) explained her roles to the Inquiry. The Associate Director of Nursing role was to be professional lead for learning disabilities nursing across BHSCT. The service manager role was managerially responsible for the nursing and social work/social care staff on site and to provide management and leadership to the inpatient services.³⁰

- 17.22 MAH was therefore two levels removed from the BHSCT Board (division, then Director of Adult, Social and Primary Care Services, who attends Board meetings) and one level removed from the NWBHSST Board (Director of Hospital and Community Learning Disability Services, then Chief Executive, who attended the Board meetings). Personal oversight by every member of the Board is simply not possible and accountability relies on the robust flow of data to allow HSCT boards to be assured of quality and safety. The Director of Adult, Social and Primary Care Services was responsible for ensuring information relating to risks at MAH were brought to the attention of the full BHSCT Board, either through the risk register or through direct reporting.
- 17.23 In addition to the service delivery directorates, there are corporate directorates (Human Resources, Finance, Planning, IT, Information and Performance Management, Redevelopment and Estates, Risk and Governance, Corporate Nursing and Medicine) that provide data independently of the service directorates to support the governance of the organisation.³¹

Assurance mechanisms

- 17.24 Assurance at BHSCT is primarily through the Board Assurance Framework (BAF).³² This is the principal register of risks and controls of those risks. The Board is responsible for ensuring that risks are managed and escalating any potential lack of control to the SPPG. The draft BAF is developed by the Assurance Committee, whose role is:

²⁹ June Champion Statement (Evidence Modules) – 10/03/23 – Page 46

³⁰ Esther Rafferty Statement (Organisational Modules) – 27/06/24 – Page 2

³¹ June Champion Statement (Evidence Modules) – 10/03/23 – Page 43

³² Martin Dillon 3rd Statement (Organisational Modules) – 30/05/24 – Page 3

'To assist the Board of Directors in ensuring that an effective assurance framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors'.³³

17.25 The Assurance Committee operates through six steering groups, each overseeing the implementation of assurance processes across different areas of the Trust's operations.³⁴

17.26 The BAF only includes the highest-level risks (either by potential impact or because they have not been adequately controlled at directorate level).³⁵ The BAF is fed by three levels of risk register; service unit (or CDU), directorate and corporate. Reporting to the Board is proportionate to the risk to BHSCT objectives. If a risk can be mitigated it will not be escalated.³⁶ Thus a risk identified by a CDU such as MAH will be assessed by the directorate. If the directorate believes it is well managed, it will not be included in the directorate risk register. Similarly, risks on the directorate risk register will be assessed at corporate level, and if they are considered to be controlled, they will not be included in the BAF.

17.27 Peter McNaney (former BHSCT Chair 2014-2023) described the Board meeting oversight:

'... given the level of risk carried, and the extent of services provided by the Belfast Trust, what can be brought to the Board of an organisation of the size and nature of the Belfast Trust may be considerably different to what could come to a Board of a much smaller organisation carrying much less risk'.³⁷

'The nature of the serious issues that did come to the Trust Board, which are reflected in the minutes of the Trust Board meetings, illustrate this. Most of the Trust Board's time is spent considering and seeking assurance about some very serious problems occurring within the Trust and that are ongoing at any one time'.³⁸

³³ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 78 (Exhibit T03.01) Board Assurance Framework (2016/17)

³⁴ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 8

³⁵ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 23

³⁶ June Champion Statement (Evidence Modules) – 10/03/23 – Pages 49-50

³⁷ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 5

³⁸ Peter McNaney Statement (Organisational Modules) – 03/07/24 – Page 5

- 17.28 The Trust Board must therefore be confident that the assessment of risks and their controls below Board level are robust. This is the responsibility of the directors to monitor. Each service and corporate directorate's director attends the Executive Team meetings and can (and should) challenge their colleagues, particularly if they have data from their own directorate that is contrary to that of their colleagues. This would be true whatever the size of the organisation. While there are many examples of large-scale abuse in much smaller organisations, including Ralphps Close,³⁹ Winterbourne View⁴⁰ and Whorlton Hall,⁴¹ even taking a larger organisation such as BHSCT, the Board had sufficient data and systems to be aware of risk, regardless of its size.
- 17.29 In fact, the Inquiry heard that MAH frequently did identify risks relating to staffing from 2012 onwards, which were included in the Learning Disabilities service area risk register⁴² (a subdivision of the Adult, Social and Primary Care Services Directorate), and which were at times included in the directorate risk register,⁴³ but the shortages of staff on the wards and the serious consequences for patients did not appear on the corporate risk register at any time. The decision to escalate a directorate risk to the corporate risk register is made by members of the Executive Team and suggests that there was visibility of the staffing risks, but they were not given priority at this very senior level. The only risks specific to MAH that appeared on the corporate risk register prior to 2019 related to the risk of peer-on-peer abuse (November 2014) and risks relating to delivering safeguarding protection plans (February 2015). The mitigations for these risks were adherence with policies, appropriate training and incident reporting and management.⁴⁴ Adherence to policy included close observation by staff, but there appears to have been no consideration of whether that could be delivered with the existing staffing. Despite

³⁹ Northern Ireland Assembly (2014) Written Ministerial Statement: Department of Health, Social Services and Public Safety – Ralphps Close Residential Care Home – <https://www.niassembly.gov.uk/assembly-business/official-report/written-ministerial-statements-2011-2016/departments-of-health-social-services-and-public-safety--ralphs-close-residential-care-home/#:~:text=The%20report%20has%20concluded%20that,to%20account%20for%20their%20actions>

⁴⁰ UK Department of Health (2012) Transforming care: A national response to Winterbourne View Hospital – <https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response>

⁴¹ Social Care Institute for Excellence and Durham Safeguarding Adult Partnerships (2023) Safeguarding Adults Review on Whorlton Hall – www.anncrafttrust.org/wp-content/uploads/2022/12/WhorltonHallSafeguardingAdultsReviewExecutiveSummaryDecember2022.pdf

⁴² Esther Rafferty Statement (Evidence Modules) – 13/04/24 – Page 6

⁴³ John Veitch Transcript – 18/06/24 – Page 54

⁴⁴ Cathy Jack Statement (Organisational Module) – 14/06/24 – Page 48

the increasing evidence of risk apparent from viewing of CCTV from September 2017 onwards, it was not until January 2019 that the risk of abuse in general was added to the corporate risk register.⁴⁵

17.30 In addition to the risk register, Datix software was introduced by NWBHSST from 2002 to capture adverse event reporting.⁴⁶ In 2007, the new BHSCT continued using Datix, and by 2012, all wards in MAH were directly entering incident data on the web based Datix system.⁴⁷ Datix allows easy generation of trend data by local as well as senior managers, but this function does not appear to have been used.

17.31 As discussed, retrospective analysis of incident data showed an alarming increase in violence at MAH. Trends from available data should have been used from 2002 onwards to assess risk as part of the assurance process.

17.32 On her appointment, Dr Cathy Jack (current BHSCT Chief Executive since 2010) appeared to concede this and told the Board that:

'In the past there had been too much reliance on trust ... there is now a new focus on culture, openness, and transparency, which is data driven'.⁴⁸

⁴⁵ Cathy Jack Statement (Organisational Module) – 14/06/24 – Page 49

⁴⁶ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 172

⁴⁷ Brona Shaw Statement (Evidence Modules) – 06/04/23 – Page 173

⁴⁸ MAHI – Additional Materials Referenced – Page 130 (Trust Board confidential minutes 21/09/20)

Conclusions

- 17.33 The complexity of BHSCT services meant that it needed excellent data and governance to maintain effective operational oversight of the quality of care provided at MAH, and could not rely on individuals' anecdotal observations. The Trust was simultaneously managing acute care targets, resettlement planning and the development of community services, all within a context of constrained resources and rising demand.
- 17.34 These pressures were compounded by ineffective governance structures. Collectively, these factors contributed to a Trust environment in which the care of vulnerable individuals at MAH was not adequately safeguarded. This is not a result of the size of BHSCT but the result of a failure to grasp the key principles of assurance as opposed to reassurance.

(This page is intentionally left blank)

Do you see me?

'My son also liked to watch Teletubbies and DVDs of nature and the countryside. He liked to go visit the family farm and would help feed the animals.'

'It is about rebuilding the quality of my son's life again after MAH and making him feel safe, loved, wanted and cared for in our family home.'

'My daughter has a great personality. In her younger years she refused to talk but enjoyed slapstick humour. She is a huge fan of Mr. Bean and loved to be involved in practical jokes on others. She saw the funny side of things and enjoys life'

Chapter 18

Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty

Introduction

- 18.1 This chapter examines the legislative framework governing learning disability, mental health and deprivation of liberty (DoL) in Northern Ireland. It is referable directly to paragraph 18(a) of our Terms of Reference (ToR), which invites the Inquiry to examine the relevant primary and secondary legislation. It also addresses paragraph 19, which requires an evaluation of the adequacy of this legal and regulatory framework, alongside other relevant documentation, in providing ‘a framework to prevent abuse of patients with mental health conditions or learning disability in Muckamore Abbey Hospital (MAH) and other such settings in Northern Ireland’.
- 18.2 The analysis centres on two key statutes that underpin the admission and detention of patients at MAH: the Mental Health (Northern Ireland) Order 1986 (MHO) and the Mental Capacity Act (Northern Ireland) 2016 (MCA 2016). It is not intended to attempt a comprehensive review of this legislation in this chapter. This is because both Acts have broad application beyond the scope of this report. Instead, this chapter focuses on provisions that are most relevant to the experiences of patients at MAH, particularly those that intersect with issues of capacity, consent and liberty. It considers the legislative context surrounding the enactment of these Acts, examines their key statutory provisions and concludes with a comparative perspective across selected jurisdictions to highlight areas of strength and concern.

The Bamford Review

- 18.3 Understanding the legislative framework governing mental health and learning disability in Northern Ireland requires a consideration of these statutes within their broader legal and policy context. Central to this is the Bamford Review of Mental Health and Learning Disability in Northern Ireland (the Bamford Review). Commissioned in 2002 by the (then) Department of Health, Social Services and Public Safety (DHSSPS), the Bamford Review undertook a comprehensive

evaluation of mental health and learning disability law, policy and service provision. This included a review of the MHO.¹

- 18.4 The Bamford Review produced a series of influential reports that shaped subsequent reform efforts. Most notably, the genesis of the MCA 2016 lies in the Bamford Review. More than two decades later, the Bamford Review remains a foundational reference point for understanding the legal landscape surrounding learning disability and mental health in Northern Ireland. Two of the Bamford Review reports are particularly relevant to this Inquiry.

The Equal Lives report

- 18.5 Initiated in 2002 and published in September 2005, the ‘Equal Lives’ report was the second output from the Bamford Review. To avoid duplication, this report is discussed in detail in Chapter 15 (Resettlement), to which topic it is particularly relevant.

A Comprehensive Legislative Framework

- 18.6 One of the final reports from the Bamford Review was ‘A Comprehensive Legislative Framework’, which was an in-depth review of mental health and learning disability legislation. It was produced by the Legal Issues Working Committee in August 2007.²
- 18.7 The committee identified the need for changes to existing mental health legislation in Northern Ireland. This was based on a review of existing provisions under the MHO, alongside developments in human rights and mental health law.³ At the time of the Bamford Review, capacity legislation had been introduced elsewhere in the UK. In the landmark Bournemouth case (2004), the European Court of Human Rights (ECHR) held that Article 5(1) of the European Convention on Human Rights (the right to liberty and security of the person) requires procedural

¹ Roy McClelland Statement – 03/03/23 – Page 315 (Exhibit T02.02) – Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

² Roy McClelland Statement – 03/03/23 – Page 1301 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

³ Roy McClelland Statement – 03/03/23 – Page 1311 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

safeguards for the admission, treatment and detention of individuals lacking capacity.⁴

18.8 One of the key recommendations of the report was that:

*‘There should be a single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland. This should be through the introduction of provisions for all persons who require substitute decision making’.*⁵

18.9 It was proposed that new legislation would fuse together mental health law and mental capacity law.⁶ This fused model would apply to all individuals requiring substitute decision-making, including their mental health, physical health, welfare and financial needs.⁷

18.10 The report outlined 18 recommendations to guide development of a new legal framework. Important among these were: that the legislation should be principles-based, with those principles explicitly stating that it should provide for compulsory admission to an approved facility for assessment and for compulsory treatment in hospital; that any interference with a person’s autonomy should be based on impaired decision-making capacity; and that some of the key definitions and provisions from the Mental Capacity Act 2005 in England and Wales should be adopted, including the requirement that any decision taken on behalf of a person lacking capacity must be in their best interests.⁸

18.11 This principles and rights-based approach signalled a shift away from prioritising public protection only. It placed greater emphasis on safeguarding the rights and dignity of people with a mental health disorder, while at the same time ensuring access to appropriate care and treatment.⁹

⁴ HL v UK 45508/99 [2004] ECHR 471 – [https://www.mentalhealthlaw.co.uk/HL_v_UK_45508/99_\(2004\)_ECHR_471](https://www.mentalhealthlaw.co.uk/HL_v_UK_45508/99_(2004)_ECHR_471)

⁵ Roy McClelland Statement – 03/03/23 – Page 1394 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

⁶ Roy McClelland Statement – 03/03/23 – Page 1363 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

⁷ Roy McClelland Statement – 03/03/23 – Page 1394 (Exhibit T 02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

⁸ Roy McClelland Statement – 03/03/23 – Page 1396 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

⁹ Roy McClelland Statement – 03/03/23 – Page 1335 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

18.12 The Bamford Review concluded that legislative reform should be a government priority.¹⁰ It emphasised that successful implementation of new legislation would depend on adopting recommendations across all the Bamford Review reports. It also proposed a phased introduction of some legislation, which should be aligned with service development.¹¹ As discussed later in this chapter, the unified legislation proposed by the Bamford Review in 2007 was not introduced until nine years later.

Post-Bamford developments

18.13 Following publication of the Equal Lives report in 2005, frustration grew over lack of tangible progress. This delay was partly attributable to direct rule from Westminster, which limited local policy and legislative decision-making.¹² Additionally, a decision appears to have been made to delay action until all reports from the Bamford Review had been received so that a global view of what was needed could be taken.¹³

18.14 By 2007-2008, with the restoration of the Northern Ireland Executive (NIE), discussions around legislative reform resumed. However, the Bamford Review team operated in an advisory capacity only to the Department of Health (DoH). Responsibility for advancing the proposed reforms lay with an interdepartmental committee established by the DoH.¹⁴ The NIE accepted the broad thrust of the Bamford recommendations.¹⁵ Nevertheless, progress remained slow. A series of departmental consultations, action plans and focus groups followed, reflecting an incremental approach to reform.¹⁶ Professor Roy McConkey (Emeritus Professor of Developmental Disabilities at Ulster University) told the Inquiry:

‘Although, I do remember the Permanent Secretary or the Head of the Civil Service in Northern Ireland, who I happened to know personally because he had trained at Queen's with me when I was doing psychology there, saying,

¹⁰ Roy McClelland Statement – 03/03/23 – Page 1393 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

¹¹ Roy McClelland Statement – 03/03/23 – Page 1393 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

¹² Roy McConkey Transcript – 21/03/23 – Page 53 – Line 1

¹³ Roy McConkey Transcript – 21/03/23 – Page 52 – Line 11; Roy McClelland Transcript – 29/03/23 – Page 14 – Line 8

¹⁴ Roy McConkey Transcript – 21/03/23 – Page 53 – Line 23

¹⁵ Roy McClelland Statement 03/03/23 – Page 3105 (Exhibit T07.01) – Delivering the Bamford Vision – The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability – Action Plan 2012-2015

¹⁶ Roy McClelland Statement – 03/03/23 – Pages 18-28

you know, it's the kiss of death if you set up an interdepartmental committee, and I hadn't appreciated what he meant by that until, as you'll hear, this is how it unfolded. So the Government then did produce an action plan, which was to cover the years 2009 to 2012. That action plan was a fairly substantial document. I've given you a link to it. There was 43 pages devoted to learning disability and all the different actions that the various departments were going to take in relation to implementing. It was hard sometimes to track where the Bamford recommendations sat with relation to this action plan that had been produced by the cross-departmental steering group and the teams that were involved in it. Nonetheless, it certainly seemed a good action plan and in terms of an intent to make a start on the whole implementation of the Bamford recommendations'.¹⁷

- 18.15 By 2012, a further action plan proposed only a 25% reduction in long-stay patients. This was far short of the Equal Lives report, which had recommended a goal of complete resettlement of all patients by 2011.¹⁸

Mental Health (Northern Ireland) Order 1986

- 18.16 At the time of the Bamford Review, and throughout most of the period examined by this Inquiry, the principal statutory framework for mental health treatment in Northern Ireland was the MHO.
- 18.17 The MHO provides the legal basis for the detention of individuals with a mental health disorder in a mental health hospital for the purposes of assessment, and then treatment, where there is a risk of serious physical harm to themselves or to others.¹⁹ It also makes provision for:
- forensic patients within the criminal justice system²⁰
 - patients who are subject to guardianship²¹
 - the management of a patient's property and affairs²²
 - the management of money and valuables.²³
- 18.18 Importantly, detention under the MHO is not based on a patient's capacity to make decisions in their own best interests. Instead, it depends on whether the patient is

¹⁷ Roy McConkey Transcript – 21/03/23 – Page 54 – Line 1

¹⁸ Roy McConkey Transcript – 21/03/23 – Page 54 – Line 26

¹⁹ Mental Health (Northern Ireland) Order 1986, Article 4; Mental Health (Northern Ireland) Order 1986, Article 12

²⁰ Mental Health (Northern Ireland) Order 1986, Part III

²¹ Mental Health (Northern Ireland) Order 1986, Article 18 – 26

²² Mental Health (Northern Ireland) Order 1986, Part VIII

²³ Mental Health (Northern Ireland) Order 1986, Article 116

suffering from a mental disorder, defined to include mental illness, mental handicap and any other disorder or disability of the mind.²⁴ It also requires assessment as to whether there is a risk of serious physical harm to the patient or to others if they are not detained.²⁵

18.19 A patient may be admitted to hospital for assessment on the application of their nearest relative or by an approved social worker.²⁶ The nearest relative must ordinarily be consulted when an approved social worker makes an application.²⁷ There is scope within the MHO for a nearest relative to object.²⁸ An application must be based on a medical recommendation by a doctor (it should not generally be given by a doctor on the staff of the hospital to which the patient would be admitted) who has examined the patient within the previous two days.²⁹ This should preferably be the patient's own medical practitioner. Immediately after their admission, the patient must be examined by a different doctor (usually a consultant psychiatrist).³⁰ If the second doctor is not a psychiatrist, the detention period is 48 hours. If the second doctor is a psychiatrist, the initial assessment maximum period is seven days. Thereafter the patient may be detained for a further period of assessment for seven days.³¹

18.20 As discussed in Chapter 7 (Restrictive Practices), the MHO authorises patients to be admitted to a hospital and detained upon the application of a medical practitioner for assessment for up to 14 days (under Article 4) or for treatment for up to 6 months initially (Article 12). Article 7 deals with the position where a patient is already in hospital for a mental disorder and a doctor is not immediately available. In those circumstances a nurse can sign a form that a patient requires a mental health assessment, and they can then be detained for that purpose for up to six hours.

²⁴ Mental Health (Northern Ireland) Order 1986, Article 3 (1)

²⁵ Mental Health (Northern Ireland) Order 1986, Article 4 (2)

²⁶ Mental Health (Northern Ireland) Order 1986, Article 5 (1)

²⁷ Mental Health (Northern Ireland) Order 1986, Article 5 (3)

²⁸ Mental Health (Northern Ireland) Order 1986, Article 5 (4)

²⁹ Mental Health (Northern Ireland) Order 1986, Article 6

³⁰ Mental Health (Northern Ireland) Order 1986, Article 9 (1)

³¹ Mental Health (Northern Ireland) Order 1986, Article 9 (7) and (8)

- 18.21 Following admission for assessment, a patient may be admitted on a longer-term basis for compulsory medical treatment. This includes cases where a patient lacks capacity and cannot consent, as well as cases where a patient has capacity but does not consent.³² For individuals with a learning disability, the threshold for longer-term detention is higher.³³ A patient can be admitted for treatment if they are suffering from a mental illness, or a 'severe mental impairment' that is associated with abnormally aggressive or seriously irresponsible conduct.³⁴
- 18.22 A patient may be detained for treatment for up to six months from the date of admission, based on a report from a consultant psychiatrist. They must have examined the patient, confirming that, in their opinion:
- the patient is suffering from a mental illness or severe mental impairment of a nature or degree which warrants detention in hospital for medical treatment;
 - failure to detain the patient would create a substantial likelihood of serious physical harm to the patient or to others;
 - and where other methods of dealing with the patient are available, they are not appropriate.
- 18.23 Detention can be renewed for a further period of six months, and annually thereafter.³⁵
- 18.24 Since the commencement of the MCA 2016, a best interests test must also be applied in respect of decisions about the treatment and care of persons under the age of 16 years.³⁶
- 18.25 The Review Tribunal provides a mechanism for independent judicial oversight of a detention.³⁷ There are various routes by which a detention can be reviewed by the Review Tribunal.³⁸ A patient may apply to the Review Tribunal for discharge from an order during the first six months of their detention, and after any renewal

³² Mental Health (Northern Ireland) Order 1986, Article 64 (3)(b)

³³ Alex Ruck Keene Transcript – 20/03/23 – Pages 45-46

³⁴ Mental Health (Northern Ireland) Order 1986, Article 3 (1)

³⁵ Mental Health (Northern Ireland) Order 1986, Article 12 (1)

³⁶ Mental Health (Northern Ireland) Order 1986, Article 3A – 3B

³⁷ Alex Ruck Keene Transcript – 20/03/23 – Page 63 – Line 1

³⁸ Mental Health (Northern Ireland) Order 1986, Part V

of their detention thereafter.³⁹ An application may also be made by a nearest relative.⁴⁰ The Attorney General, the DoH, and the Master (Care and Protection) have a power of referral.⁴¹ A Health and Social Care Trust (HSCT) also has a duty to refer in certain circumstances.⁴² A patient may be discharged at the direction of a Review Tribunal, by a responsible medical officer or by their nearest relative, subject to certain conditions.⁴³

18.26 The MHO imposed upon the Regulation and Quality Improvement Authority (RQIA), and its predecessor the Mental Health Commission (MHC), a duty to keep the care and treatment of patients under review, including the exercise of the powers under the MHO. It required the RQIA to make inquiry into any case where there appeared to be ill treatment, deficiency in care or treatment, or improper detention in hospital of any patient by reason of their mental disorder. It required the RQIA to visit and interview patients liable to be detained in hospital under this Order, and to alert the DoH (and others) of any case where it was desirable for the department to exercise its function to secure the welfare of any patient by preventing any ill treatment or remedying any deficiency in their care or terminating any improper detention.⁴⁴ This role in so far as it was exercised by the RQIA is explored in more detail in Chapter 14 (External Agencies Inspection and Oversight).

18.27 The MHO is supplemented by a Code of Practice issued in 1992. This sets out a number of principles intended to guide the treatment and care of individuals with a mental disorder. These include respect for dignity, individuality and personal background. It also emphasises using the least restrictive degree of control and segregation necessary for their safety and the safety of others, immediately removing constraints or control where they are no longer required. The Code

³⁹ Mental Health (Northern Ireland) Order 1986, Article 71 (4) and (5); Mental Health (Northern Ireland) Order 1986, Article 77

⁴⁰ Mental Health (Northern Ireland) Order 1986, Article 71 (4) and (5); Mental Health (Northern Ireland) Order 1986, Article 77

⁴¹ Mental Health (Northern Ireland) Order 1986, Article 72

⁴² Mental Health (Northern Ireland) Order 1986, Article 73 (1)

⁴³ Mental Health (Northern Ireland) Order 1986, Article 77; Mental Health (Northern Ireland) Order 1986, Article 14 (1), (4) (6), (7)

⁴⁴ Mental Health (Northern Ireland) Order 1986 Article 86

promotes self-determination and personal responsibility to the greatest degree possible, in line with the person's needs, wishes and abilities.⁴⁵

- 18.28 The Inquiry heard from Alex Ruck Keene KC (expert barrister in mental capacity, mental health and healthcare law) that, since the MHO was enacted, there have been significant developments in the international and domestic human rights landscape. Key developments include ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) by the UK and landmark UK Supreme Court judgments on the deprivation of liberty (DoL) and mental capacity.⁴⁶ It was within the context of this changing legal landscape, and following the recommendations of the Bamford Review, that the MCA 2016 was introduced.

Mental Capacity Act (Northern Ireland) 2016

- 18.29 The MCA 2016 was partially commenced in 2019.⁴⁷ It introduced a statutory framework for decisions about DoL based on an individual's mental capacity and their best interests. Prior to this, Northern Ireland had no dedicated mental capacity legislation. The MCA 2016 therefore represented a major reform of mental capacity law in Northern Ireland.⁴⁸ Before the enactment of statutory provisions, decisions were governed by the High Court exercising its inherent jurisdiction. Legal principles were also developed through common law jurisprudence, with case law establishing precedents that lower courts are bound to follow.
- 18.30 Following the recommendations of the Bamford Review, the MCA 2016 was intended to fuse together mental health law and mental capacity law. The aim was to provide an overarching framework for all care and treatment decisions, based almost entirely on mental capacity. This would replace the MHO for all individuals aged 16 and over. However, implementation of the MCA 2016 has been phased.

⁴⁵ Department of Health (2025) Draft Revised Code of Practice for the Mental Health (Northern Ireland) Order 1986 – <https://www.health-ni.gov.uk/consultations/draft-revised-code-practice-mental-health-northern-ireland-order-1986>

⁴⁶ Alex Ruck Keene Transcript – 20/03/23 – Page 24, Page 53, Page 55, Page 94 and Page 129

⁴⁷ The Mental Capacity (2016 Act) (Commencement No. 1) Order (Northern Ireland) 2019 – <https://www.legislation.gov.uk/nisr/2019/163/made>

⁴⁸ Alex Ruck Keene Transcript – 20/03/23 – Pages 25-26

As part of the initial phases of commencement, only provisions in relation to research, money, valuables and DoL are in force.⁴⁹

- 18.31 Alex Ruck Keene noted that this phased approach has created a situation where medical professionals and relatives have had to grapple with an unintended and unresolved interface between the MHO and the MCA 2016.⁵⁰ However, we note that the Bamford report on legislation had stated that consideration had to be given to a phased introduction of aspects of the legislation, which should be aligned with service development.⁵¹
- 18.32 The MCA 2016 is predicated on a set of statutory principles. The first set of principles relate to the presumption of a person's mental capacity.⁵² For the purposes of the MCA 2016, a person 'lacks capacity' if they are unable to make their own decision in relation to a matter because of an impairment or disturbance in the functioning of their mind or brain.⁵³ This is a decision-specific and functional capacity test.
- 18.33 For a finding of incapacity to be made there must be a causal link between a person's mental impairment and their inability to make a decision. This requires treating medical staff to ask three questions. First, is the person unable to make their own decision in relation to a matter? Secondly, is there an impairment or disturbance of the functioning of the person's brain? Thirdly, is the person's inability to make the decision because of the identified impairment or disturbance? Under the MCA 2016, the test of whether someone is able to make a decision is much as it had been under the common law.⁵⁴ It asks whether a person is able to understand, retain and appreciate the relevance of, and use and weigh the relevant information, and communicate their decision.⁵⁵

⁴⁹ The Mental Capacity (2016 Act) (Commencement No. 1) Order (Northern Ireland) 2019 – <https://www.legislation.gov.uk/nisr/2019/163/made>

⁵⁰ Alex Ruck Keene Transcript – 20/03/23 – Page 82, Page 144 and Page 145

⁵¹ Roy McClelland Statement – 03/03/23 (Exhibit T02.10) – Page 1311 – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

⁵² Mental Capacity Act (Northern Ireland) 2016, section 1

⁵³ Mental Capacity Act (Northern Ireland) 2016, section 3 (1)

⁵⁴ Re C (adult: refusal of medical treatment) [1994] 1 All ER 819 (QBD) – <https://cascaidr.org.uk/2017/03/22/re-c-adult-refusal-of-medical-treatment-1994-1-all-er-819-qbd/>

⁵⁵ Mental Capacity Act (Northern Ireland) 2016, section 4

- 18.34 The second principle underpinning the MCA 2016 is that any acts or decisions must be made in the person's 'best interests'.⁵⁶ This requires 'special regard' to the person's past and present wishes and feelings, their beliefs and values, and other factors they would be likely to consider if they were able to do so.⁵⁷ Three years before the MCA 2016, the UK Supreme Court clarified that the purpose of the best interests test is to consider matters from the patient's point of view.⁵⁸
- 18.35 The MCA 2016 provides a framework to authorise a DoL where an individual lacks capacity.⁵⁹ A DoL occurs when a person is under continuous supervision and control and is not free to leave.⁶⁰
- 18.36 Currently, only the MCA 2016 provisions relating to DoL on the basis of incapacity have been commenced. The MHO therefore continues to govern detention for mental health purposes and has statutory precedence over the DoL framework in the MCA 2016. This means that where a person would normally be detained under the MHO, that framework must be applied.⁶¹ Pending full commencement of the MCA 2016, acts of care and treatment continue to be governed by the common law doctrine of necessity, which permits a doctor to provide treatment without consent if necessary, and by 'declaratory orders' granted under the inherent jurisdiction of the High Court. The latter authorise a lawful act of care or treatment in relation to a specific patient on application to the High Court by the relevant HSCT.⁶² Furthermore, the MCA 2016 only applies to individuals aged 16 and over.⁶³ This means that the MHO remains the sole statutory framework for those under the age of 16.

⁵⁶ Mental Capacity Act (Northern Ireland) 2016, section 2

⁵⁷ Mental Capacity Act (Northern Ireland) 2016, section 7 (6)

⁵⁸ In a case called *Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant)* [2013] UKSC 67 – <https://www.supremecourt.uk/cases/uksc-2013-0134>

⁵⁹ Mental Capacity Act (Northern Ireland) 2016, section 24; Mental Capacity Act (Northern Ireland) 2016, section 25

⁶⁰ Department of Health (2019) *Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards Code of Practice – Chapter 2, para 2.7* – <https://www.health-ni.gov.uk/sites/default/files/publications/health/mca-dols-cop-november-2019.pdf>

⁶¹ Alex Ruck Keene Transcript – 20/03/23 – Page 110 – Line 1; The Mental Capacity (2016 Act) (Commencement No.1) Order (Northern Ireland) 2019, Article 3; *Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards Code of Practice (DoH, 2019)*, paras 7.1-7.2

⁶² Alex Ruck Keene Transcript – 20/03/23 – Page 104, Page 116 and Page 118

⁶³ The Mental Capacity Act (Northern Ireland) 2016, Introductory Text

- 18.37 Unlike the hospital-based MHO, the MCA 2016 is not location-specific.⁶⁴ It permits DoL authorisations in any setting where appropriate care and treatment can be provided, including private homes or a supported living facility.⁶⁵
- 18.38 The MCA 2016 contains a range of statutory safeguards, all of which must be met in order to provide protection for someone who would otherwise have been liable for depriving a person of their liberty.⁶⁶ A short-term DoL in a hospital for examination or examination, followed by treatment or care, can be authorised based on a report from an appropriate healthcare professional.⁶⁷ The professional must have seen the patient within the previous two days.⁶⁸ They must be an approved social worker or prescribed healthcare professional with specific training, at least two years' experience working with people who lack capacity, and be designated by the hospital's managing authority to make such reports.⁶⁹
- 18.39 The short-term DoL application must be in a prescribed form and be grounded in supporting documents, notably a medical report from a doctor trained to make such reports.⁷⁰ This doctor must also have examined the patient within the previous two days.⁷¹ A short-term DoL authorisation has a maximum duration of 28 days and cannot be extended beyond this.⁷²
- 18.40 A longer-term DoL may be authorised by a trust panel authorisation.⁷³ This can only be granted if a short-term detention authorisation cannot be made.⁷⁴ A longer-term detention can be authorised for any setting where appropriate care and treatment is available, including a hospital, nursing home, other health and social care setting or in a private home.⁷⁵

⁶⁴ Alex Ruck Keene Transcript – 20/03/23 – Page 60 – Line 3

⁶⁵ Alex Ruck Keene Transcript – 20/03/23 – Page 153 – Line 4

⁶⁶ Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards Code of Practice (DoH, 2019), para 7.3

⁶⁷ Mental Capacity Act (Northern Ireland) 2016, Schedule 2, paragraph 2 and 3

⁶⁸ Mental Capacity Act (Northern Ireland) 2016, Schedule 2, paragraph 5

⁶⁹ Mental Capacity Act (Deprivation of Liberty) (No.2) Regulations (Northern Ireland) 2019, section 17

⁷⁰ Mental Capacity Act (Northern Ireland) 2016, section 300; Mental Capacity Act (Deprivation of Liberty) (No.2) Regulations (Northern Ireland) 2019, section 40

⁷¹ Mental Capacity Act (Northern Ireland) 2016, Schedule 2, paragraph 4

⁷² Mental Capacity Act (Northern Ireland) 2016, Schedule 2, paragraph 15

⁷³ Mental Capacity Act (Northern Ireland) 2016, Schedule 1, section 297

⁷⁴ Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards Code of Practice (DoH, 2019), para 11.5

⁷⁵ Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards Code of Practice (DoH, 2019), para 7.21

- 18.41 An application for an authorisation can be made by anyone involved in the patient's care or treatment who can make a formal assessment of capacity (for example a social worker, doctor, or nurse).⁷⁶ The application must follow a prescribed format and include: a statement of incapacity; a best interests determination statement; and a report by a doctor, who has completed specific training in relation to making such reports.⁷⁷ They must have examined the patient within the previous two days.⁷⁸ A detention may initially be authorised for six months.⁷⁹ It can then be renewable for a further six months, then annually thereafter.⁸⁰
- 18.42 Under the MCA 2016, a person with capacity may choose a 'nominated person' to act on their behalf.⁸¹ If they lack capacity, one may be appointed.⁸² The nominated person must be consulted on an application for a DoL authorisation.⁸³ They can also apply to the Review Tribunal to review an authorisation.⁸⁴
- 18.43 There are a number of ways of challenging the appropriateness of a DoL authorisation before an expanded Review Tribunal, which has the power to revoke it.⁸⁵ The person subject to the DoL can apply to the Review Tribunal or a nominated person may apply on their behalf. Where the individual has capacity, the nominated person may do so only with the individual's consent.⁸⁶ Additionally, referrals can be made to the Review Tribunal by the Attorney General, the DoH, the Master (Care and Protection) on the direction of the court.⁸⁷ The relevant HSCT has a duty to refer in specified circumstances.⁸⁸
- 18.44 In addition to the safeguards around the use of DoL, when the rest of the Act is commenced there will be graduated safeguards governing acts of care and

⁷⁶ Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards Code of Practice (DoH, 2019), para 11.7

⁷⁷ Mental Capacity Act (Northern Ireland) 2016, section 300; Mental Capacity Act (Deprivation of Liberty) (No.2) Regulations (Northern Ireland) 2019, section 40

⁷⁸ Mental Capacity Act (Northern Ireland) 2016, Schedule 1 (6), (7)

⁷⁹ Mental Capacity Act (Northern Ireland) 2016, Schedule 1, section 15 (6)

⁸⁰ Mental Capacity Act (Northern Ireland) 2016, section 37; Mental Capacity Act (Northern Ireland) 2016, section 38

⁸¹ Mental Capacity Act (Northern Ireland) 2016, section 70

⁸² Mental Capacity Act (Northern Ireland) 2016, section 73

⁸³ Mental Capacity Act (Northern Ireland) 2016, section 9 (3) and (4)

⁸⁴ Mental Capacity Act (Northern Ireland) 2016, section 45

⁸⁵ Mental Capacity Act (Northern Ireland) 2016, section 45; Mental Capacity Act (Northern Ireland) 2016, section 52

⁸⁶ Mental Capacity Act (Northern Ireland) 2016, section 45

⁸⁷ Mental Capacity Act (Northern Ireland) 2016, section 47

⁸⁸ Mental Capacity Act (Northern Ireland) 2016, section 48

treatment. The DoH has not published a time frame for the commencement of the remaining parts of the MCA 2016. The reasons for delay remain unclear.

Legislative comparisons across jurisdictions

- 18.45 A comprehensive comparative study of other jurisdictions is beyond the scope of this report. However, there are several key distinctions between Northern Ireland, the rest of the UK and the Republic of Ireland that merit attention. Each jurisdiction has separate mental health and mental capacity legislation.
- 18.46 In England and Wales, mental health legislation permits detention for immediate treatment.⁸⁹ This is unlike Northern Ireland, where assessment must precede treatment. Community treatment orders exist in England and Wales but not in Northern Ireland.⁹⁰ Draft legislation before the UK Parliament places a greater emphasis on capacity and excludes learning disability and autism from longer-detention provisions.⁹¹ Mental capacity legislation was introduced in England and Wales in the form of the MCA 2005, predating Northern Ireland's MCA 2016 by 11 years. The Bamford Review recommended that provisions of the MCA 2005 were adopted in Northern Ireland.⁹² While there are many similarities between the legislation, only the MCA 2005 applies to persons who are detained in hospital or care home settings.⁹³ By contrast, the MCA 2016 is not place-specific. Alex Ruck Keene told the Inquiry that in practice the framework for authorising a DoL in England and Wales is 'unfeasibly complicated' and 'widely recognised not to be working'.⁹⁴ We were told that there are plans to introduce Liberty Protection Safeguards as part of future reform.⁹⁵
- 18.47 Relevant legislative provisions in Scotland differ more significantly from Northern Ireland. A major distinction is that a tribunal is involved from the outset of a decision to detain for treatment, rather than at the stage when a detention is being

⁸⁹ Mental Health Act 1983, section 3

⁹⁰ Mental Health Act 1983, section 17A

⁹¹ Alex Ruck Keene UK and ROI Mental Health and Capacity Frameworks Presentation – 20/03/23 – Page 4

⁹² Roy McClelland Statement 03/03/23 – Page 1396 (Exhibit T02.10) – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) – A Comprehensive Legislative Framework 2007

⁹³ Alex Ruck Keene Transcript – 20/03/23 – Page 153 – Line 17

⁹⁴ Alex Ruck Keene Transcript – 20/03/23 – Page 151 – Line 17; Alex Ruck Keene Transcript – 20/03/23 – Page 152 – Line 22

⁹⁵ Alex Ruck Keene Transcript – 20/03/23 – Pages 152-153

challenged.⁹⁶ Other notable differences are that this legislation has a capacity element based on significantly impaired decision-making that has been caused by a mental disorder.⁹⁷ There is Scottish provision for compulsory treatment orders in hospital or in the community, whereas the Northern Ireland MHO only makes provision for treatment in hospital.⁹⁸ Scotland's capacity legislation dates from 2000.⁹⁹ It provides a structure for decision-making where a person lacks capacity but does not make provision for DoL on the basis of incapacity.¹⁰⁰ This legislation focuses on benefit to the person rather than on best interests.¹⁰¹ Separate legislation provides a framework for intervention where an adult is vulnerable and at risk, regardless of whether they have capacity.¹⁰² The Inquiry heard that Scotland is considering radical proposals for legislative reform, influenced by the UNCRPD.¹⁰³ This would replace capacity with autonomous decision-making, aligning mental health and mental capacity law in Scotland.¹⁰⁴ This is a different approach from the fusion model adopted in Northern Ireland.¹⁰⁵

18.48 In the Republic of Ireland, the Mental Health Act 2001 makes provision for detention for treatment of a mental disorder, severe dementia or significant intellectual disability.¹⁰⁶ This is broader than Northern Ireland's mental disorder-only scope. Though not capacity-based, the law requires that mental disorder must impair the person's judgement.¹⁰⁷ It also provides for early review by a tribunal via automatic referral.¹⁰⁸ The Inquiry heard that reform of the Republic of Ireland's mental health legislation is under consideration.¹⁰⁹ Capacity legislation was not in force when the Inquiry heard evidence about this topic and was

⁹⁶ Alex Ruck Keene Transcript – 20/03/23 – Page 154 – Line 14; Mental Health (Care and Treatment) (Scotland) Act 2003, section 57

⁹⁷ Mental Health (Care and Treatment) (Scotland) Act 2003, section 36 (4); Mental Health (Care and Treatment) (Scotland) Act 2003, section 44; Alex Ruck Keene – 20/03/23 – Page 154 – Line 27

⁹⁸ Mental Health (Care and Treatment) (Scotland) Act 2003, Part 7, sections 64 and 66

⁹⁹ Adults with Incapacity (Scotland) Act 2000 – <https://www.legislation.gov.uk/asp/2000/4/contents>

¹⁰⁰ Alex Ruck Keene UK and ROI Mental Health and Capacity Frameworks Presentation – 20/03/23 – Page 2

¹⁰¹ Adults with Incapacity (Scotland) Act 2000, section 1 (2)

¹⁰² Adult Support and Protection Act 2007 – <https://www.legislation.gov.uk/asp/2007/10/contents>; Alex Ruck Keene Transcript – 20/03/23 – Page 156 – Line 7

¹⁰³ Alex Ruck Keene Transcript – 20/03/23 – Page 158 – Line 15

¹⁰⁴ Alex Ruck Keene Transcript – 20/03/23 – Page 158 – Line 1

¹⁰⁵ Alex Ruck Keene Transcript – 20/03/23 – Page 89 – Line 2

¹⁰⁶ Mental Health Act 2001, section 3; Mental Health Act 2001, section 14; Mental Health Act 2001, section 15

¹⁰⁷ Alex Ruck Keene UK and ROI Mental Health and Capacity Frameworks Presentation – 20/03/23 – Page 4; Mental Health Act 2001, section 3

¹⁰⁸ Alex Ruck Keene Transcript – 20/03/23 – Page 159 – Line 2; Mental Health Act 2001, section 17

¹⁰⁹ Alex Ruck Keene Transcript – 20/03/23 – Page 159 – Line 6

subsequently introduced in 2023.¹¹⁰ While this legislation has a functional capacity test similar to Northern Ireland's MCA 2016, there is no requirement for a required link between a person's inability to make a decision and a mental impairment.¹¹¹ Notably, legislation in the Republic of Ireland does not currently contain provisions authorising DoL based on incapacity. Currently the only route for doing so is under the High Court's inherent jurisdiction.¹¹²

Relatives' understanding of patient detention

- 18.49 The Inquiry heard from a number of patients' relatives who frequently expressed their concern at their lack of knowledge of the system of detention of patients and patients' rights. They often complained of a lack of information about the effects of detention and how to challenge it. Frequently expressed was a sense of powerlessness. This has been looked at in more detail elsewhere in this report and particularly in Chapter 2 (Admission of Patients to MAH).
- 18.50 Both the MHO and the MCA 2016 provide mechanisms for independent judicial oversight of a detention or DoL by the Review Tribunal. 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.¹¹³
- 18.51 The Inquiry also heard evidence from the father of a former patient whose son was originally a voluntary patient. Later, his son was detained without him being informed of the detention or of the fact that he could apply to the Mental Health Review Tribunal (as it was then) on his son's behalf.¹¹⁴ Several other witnesses told the Inquiry of ignorance or confusion as to their rights as a family when a relative patient was detained.

¹¹⁰ Assisted Decision-Making (Capacity) Act 2015 – <https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>

¹¹¹ Alex Ruck Keene UK and ROI Mental Health and Capacity Frameworks Presentation – 20/03/23 – Page 4

¹¹² Alex Ruck Keene UK and ROI Mental Health and Capacity Frameworks Presentation – 20/03/23 – Page 4; Assisted Decision-Making (Capacity) Act 2015, section 106

¹¹³ P121's Sister Statement – 03/10/23 – Page 5 (restricted)

¹¹⁴ P115's Father Transcript – 27/09/23 – Page 80 – Line 23; P115's Father Statement – 05/09/23 – Page 12

18.52 The Inquiry also received evidence from the Chair of the Review Tribunal, who had previously been a legal member of the Review Tribunal from 2008. She said that she did not recall any allegations of abuse at MAH being raised by anyone, with the Review Tribunal, or of any member of the Review Tribunal raising any suspicions of abuse.¹¹⁵ This is despite evidence received by the Inquiry alleging abuse towards patients during this time frame. We note that the Review Tribunal's role is limited to reviewing a detention or DoL.¹¹⁶

The Adult Protection Bill

18.53 In June 2025 the Health Minister Mike Nesbitt introduced the draft Adult Protection Bill to the Northern Ireland Assembly. The aim of the Bill is said to be to strengthen and underpin the adult protection process. The failings at Dunmurry Manor Care Home and at MAH were specifically referenced in the introduction to the Bill.¹¹⁷

18.54 The Bill introduces seven principles: prevention; autonomy; empowerment; dignity; proportionality; partnership; and accountability.¹¹⁸

18.55 The Bill provides additional protections for adults at risk of harm and defines the principles that a social worker or an HSCT must apply when performing the function of removing an adult from their home. In short, they must be satisfied that it is in the best interests of the adult and the intervention is the least restrictive option. The individual's feelings and wishes must be taken into account.¹¹⁹

18.56 An adult at risk is an adult who is unable to protect their own wellbeing or property; another person is likely to cause the adult harm or the adult's personal circumstances increase their exposure to harm.¹²⁰

18.57 The Bill imposes a duty on HSCTs to make inquiries about an adult's wellbeing or property if it reasonably suspects that an adult is at risk and that an intervention

¹¹⁵ Attracta Wilson Statement (Organisational Modules) – 16/05/24 – Page 8

¹¹⁶ Mental Capacity Act (Northern Ireland) 2016, section 52; Mental Health (Northern Ireland) Order 1986, article 77

¹¹⁷ Department of Health (18 June 2025) Health Minister introduces Adult Protection Bill to Assembly – <https://www.health-ni.gov.uk/news/health-minister-introduces-adult-protection-bill-assembly>

¹¹⁸ Adult Protection Bill Section 1

¹¹⁹ Adult Protection Bill Section 1

¹²⁰ Adult Protection Bill Section 2

may be necessary to protect the adult from harm. If the Trust determines that it needs to intervene, it must consider the provision of an independent advocate to the adult. A social worker may enter the property to consider whether intervention is necessary. If necessary, they may apply to a magistrates' court to carry out an assessment by way of a medical examination by a health professional.¹²¹

18.58 A social worker can also apply to the magistrates' court to ban an individual from premises if an adult is at risk of being seriously harmed.¹²²

18.59 The Bill would require that the Trust must appoint a sufficient number of adult protection social workers to carry out the functions of Part 1 of the Bill, and that the appointed social workers must have appropriate competence in dealing with adults at risk. The Trust must, as far as is reasonably practicable and appropriate, establish and have regard to the views of relatives, carers and other interested persons and keep them informed on any trust actions regarding the adult at risk.¹²³

18.60 An Adult Protection Board will be created under the Bill, which will include representatives from the Public Health Agency, Northern Ireland Social Care Council, the Patient Care Council, HSCTs and the Chief Constable of the Police Service of Northern Ireland (PSNI). The Board must: develop and publish a strategic plan for the protection of adults at risk; develop practices and procedures for protecting adults at risk; promote an awareness of the need to protect adults at risk; monitor, review and hold to account the people and bodies represented on the Board; keep the people and bodies represented on the Board under review to encourage best practice and the standardisation of procedures and cooperation; make arrangements for training and advice for members of the Board; and undertake serious case reviews. The Board may also compile and analyse information regarding protection of adults at risk.¹²⁴

¹²¹ Adult Protection Bill Section 3

¹²² Adult Protection Bill Section 10

¹²³ Adult Protection Bill Sections 27 and 28

¹²⁴ Adult Protection Bill Section 32

- 18.61 The Bill creates new offences of wilful neglect or ill treatment of an adult by a care worker. A care worker will include both paid workers and any individual who, as a volunteer, provides health or social care to an adult. However, a 'volunteer' is confined to someone who volunteers for a body whose activities are not carried out for profit. The offence carries five years' imprisonment.¹²⁵
- 18.62 It also establishes an offence by care providers and sets out the offence of ill treatment or neglect of an adult by a care provider. A care provider commits an offence if: (1) an individual who has the care of an adult via the care provider's arrangements ill-treats or neglects the adult; (2) the care provider's activities are managed in a way that amounts to gross breach of a duty of care owed by the care provider to the adult; (3) in absence of a breach, the ill treatment or neglect would not have occurred or been less likely to occur. The offence carries a fine.¹²⁶
- 18.63 This appears, with respect to the drafters of the Bill, to be quite a convoluted way of approaching the issue and one that creates an offence that would be hard to prove in practice. Proving a gross breach is always regarded as an extremely high bar. An alternative approach would be to adopt the health and safety model of applying a reverse burden to the offence. This would require any organisation such as an HSCT, in order to avoid conviction and penalty, to prove that, where deliberate harm had been caused to a patient by any individual employed by that organisation, it had taken all reasonable and practicable steps to prevent such deliberate harm to patients, or alternatively, that it was not practicable or not reasonably practicable to do more than was in fact done to satisfy the duty or requirement.¹²⁷ This would in our view place a significant burden upon HSCTs to demonstrate not merely that policies were in place but that the outcomes of the policy were measured and as effective as possible in practice.

¹²⁵ Adult Protection Bill Part 3

¹²⁶ Adult Protection Bill Part 3

¹²⁷ See Health and Safety at Work (Northern Ireland) Order 1978, Article 37; Health and Safety at Work etc. Act 1974, section 40; and *R v Chagot Ltd (t/a Contract Services)* [2008] UKHL 73 – the approach adopted in the 1974 Act was proportionate and compatible with the presumption of innocence in Article 6(2) of the European Convention on Human Rights

- 18.64 Section 43 of the Bill makes provision for regulations to be made in relation to the installation and use of CCTV for the purpose of safeguarding adults at risk in certain premises – day-care settings, nursing homes, residential care homes and mental health units. Enforcement and compliance with such regulations would fall to the RQIA.¹²⁸
- 18.65 The Panel has already indicated its intention to recommend the installation of CCTV in the public areas of care settings for the purpose of safeguarding adults, subject to careful consultation, and this provision, to allow subsidiary regulations to be made, will hopefully make such a process easier to facilitate. The power to monitor and enforce compliance with such regulations is provided to the RQIA.
- 18.66 The Bill does not appear to address or make any provision regarding assistance or guidance in relation to the situation faced by BHSCT and PSNI in the investigation of multiple incidents of harm to vulnerable adults.
- 18.67 Further, the Bill does not appear to impose a duty of reporting (or indeed a duty of candour) upon any healthcare provider or healthcare worker in circumstances where they are aware of harm, or the risk of harm, being caused to a vulnerable adult. However, the Panel is aware that this topic is already under review by the Northern Ireland Assembly. We would respectfully endorse the recommendation made by the 2018 Inquiry into Hyponatraemia-related Deaths to introduce a statutory duty of candour.
- 18.68 The Inquiry heard that adult safeguarding is not a delegated statutory function (DSF), and accordingly there is no requirement that adult safeguarding be included in the DSF reports required of HSCTs.¹²⁹ Currently there is no mention of this deficit in the current Bill.

¹²⁸ Adult Protection Bill Section 46

¹²⁹ Sean Holland Transcript – 21/10/24 – Page 18 – Line 2

Conclusions

- 18.69 The MHO, the MCA 2016 and their Codes of Practice contain safeguards for detention and DoL. They also articulate clear principles to guide how people with mental illnesses and learning disabilities should be cared for and treated. However, the Inquiry received evidence from patients and their relatives, and from staff members, alleging serious failings. These include neglect and abuse of patients, improper use of seclusion, restraint and PRN ('pro re nata', as needed) sedation medication, damage to patient clothing and property, and misuse of patient finances. Some staff at MAH appear to have lost sight of these basic principles in their treatment of the patients under their care during the period examined by the Inquiry, and the legislation examined was ineffective in safeguarding these vulnerable patients.
- 18.70 The MCA 2016 was only partially brought into effect (commenced) in 2019, near the end of the time frame being considered by the Inquiry.¹³⁰ Much of the evidence received therefore relates to events at MAH prior to this. The MCA 2016 is based on the principle of respecting the best interests of the patient and it requires special regard to be given to the patient's wishes and feelings. It introduces safeguards that must be met to provide protection for someone who might otherwise be liable for depriving a person of their liberty. Once fully commenced there will be a graduated series of safeguards in relation to care and treatment. This means that the more serious the type of intervention, the more rigorous the set of safeguards needed.¹³¹
- 18.71 The Adult Protection Bill introduces welcome duties on HSCTs to make investigations where there is concern about an adult at risk. Further, there is a requirement to ensure there are sufficient adult protection social workers to carry out the necessary functions and that they have the appropriate competency to do so.¹³²

¹³⁰ The Mental Capacity (2016 Act) (Commencement No. 1) Order (Northern Ireland) 2019

¹³¹ Alex Ruck Keene Transcript – 20/03/23 – Page 102 and Page 150

¹³² Adult Protection Bill Article 27

- 18.72 The Bill will also introduce new individual offences and a gross breach of duty offence for providers who so mismanage their activities as to amount to a gross breach of duty of care to an individual who is ill-treated or neglected as a result of that mismanagement. However, in the Panel's view, this would be hard to establish, and the existence of such an offence as currently drafted is unlikely to have any significant effect upon patient safety.
- 18.73 It would be of benefit, and require a specific focus by HSCTs, if adult safeguarding was a delegated statutory function and a requirement that trusts should include adult safeguarding in their DSF reports.

Recommendations

R104	A statutory duty of candour should now be enacted in Northern Ireland so that: (i) Every healthcare organisation and everyone working for them must be open and honest in all their dealings with service users and the public. (ii) Where harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances. (iii) Full and honest answers must be given to any question reasonably asked about treatment by a service user (or duly authorised representative). (iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission. (v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission. (vi) Healthcare organisations that believe or suspect that treatment or care provided by them has caused harm to a service user must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances. (vii) Registered clinicians and other registered healthcare professionals who believe or suspect that treatment or care provided to a service user by, or on behalf of, any healthcare organisation by which they are employed has caused harm to the service user must report their belief or suspicion to their employer as soon as is reasonably practicable.
R105	Consideration should be given to a different approach to the prosecution of organisations for failing to prevent deliberate harm being caused by their employees, such as by applying a reverse burden to the offence. This would require any organisation, such as an HSCT, to prove that, where deliberate harm had been caused to a service user by any individual employed by that organisation, that it had taken all reasonable and practicable steps to prevent such deliberate harm to service users, or alternatively, that that it was not practicable or not reasonably practicable to do more than was in fact done.

(This page is intentionally left blank)

PUBLIC INQUIRY MUCKAMORE ABBEY HOSPITAL

TERMS OF REFERENCE

Core objectives

1. The core objectives of the Inquiry are to:
 - a. examine the issue of abuse of patients at Muckamore Abbey Hospital (MAH);
 - b. determine why the abuse happened and the range of circumstances that allowed it to happen;
 - c. ensure that such abuse does not occur again at MAH or any other institution providing similar services in Northern Ireland.

Timeframe

2. The Inquiry will report and make findings on events that occurred between 2nd December 1999 and 14th June 2021.
3. The Inquiry will be able to receive and take account of evidence outside of that period where such evidence will assist the Inquiry in examining, understanding and reporting on matters within these terms of reference.

What occurred?

4. The Inquiry will examine the nature and extent of abuse of patients at MAH.
5. The term “abuse” may include (but is not restricted to) the following:
 - a. physical abuse;
 - b. sexual abuse;
 - c. psychological abuse;
 - d. mental or emotional abuse;
 - e. patient neglect;
 - f. inappropriate or negligent care;
 - g. appropriation of or improper interference with patients’ finances or belongings;
 - h. other misbehaviour towards patients.
6. The Inquiry will examine the role of frontline staff, those with responsibility for clinical and professional oversight, those with leadership and/ or management

responsibilities within the relevant Health Trusts (and any other relevant persons or bodies)¹ in respect of such abuse.

7. The Inquiry will also consider, to the extent necessary to enable the Inquiry to examine the nature and extent of abuse of patients, the adherence by staff and management, the Trusts, the Board and the Department of Health to relevant statutory obligations, the regulatory framework, protocols, policies and guidance in respect of all aspects of service delivery.
8. The Inquiry will examine the primary and secondary causes of such abuse and will address the question of whether the abuse resulted from systemic failings within MAH or the wider health care system in Northern Ireland.

Recruitment, retention, training and support

9. The Inquiry will examine the policies and practices relating to recruitment, retention, training and support of staff and management at all levels within MAH (and, where necessary, within other facilities offering comparable services).

Identifying and responding to concerns

10. The Inquiry will examine the adequacy of methods available to communicate concerns (including allegations of abuse) by staff, patients, relatives and others about the treatment of patients at MAH.
11. The Inquiry will examine the response to such concerns by frontline staff, those with responsibility for clinical and professional oversight and those with leadership and/ or management responsibilities within the relevant Health Trusts, the Health and Social Care Board, the Public Health Agency and the Department of Health.
12. The Inquiry will examine the operation of all relevant commissioning, supervisory and regulatory agencies (including but not limited to those agencies specified in paragraph 11) to determine whether and if so why there were failures in the early identification, investigation and resolution of issues raised about the treatment of patients.
13. The Inquiry will also examine the response of other relevant agencies, including the Police Service for Northern Ireland (PSNI), the Patient and Client Council (PCC), the Health and Safety Executive (HSE) and the Regulation and Quality Improvement Authority (RQIA), when allegations of abuse of patients at MAH were reported to them.

¹ Note that all references in this document to the Health Trusts and other bodies with roles and responsibilities in respect of health and social care shall include any precursors of such bodies that existed within the timeframe of these terms of reference.

CCTV

14. The Inquiry will examine the effects of instalment, operation and use of CCTV at MAH.

Safeguards, mechanisms and policies regarding other patients

15. The Inquiry will examine the safeguards, mechanisms and policies in place to ensure that patients were not subject to abuse or other disturbing behaviour by other residents/patients and whether those controls and policies were sufficient.

Resettlement

16. The Inquiry will examine the adequacy and workings of the policy and process of discharge and resettlement of patients of MAH.

Resources

17. The Inquiry will consider the adequacy of financial resources to ensure:
 - a. appropriate numbers, skills, quality and training of staff;
 - b. appropriate care, treatment and accommodation for patients with mental health conditions and/or learning disabilities treated or cared for at MAH.

Legal and regulatory framework

18. The Inquiry will examine the following:
 - a. the relevant primary and secondary legislation;
 - b. the regulatory framework;
 - c. any relevant Codes, policies, guidelines, reports and other documentation relating to management, administration and working practice at MAH (and, where necessary, of other comparable facilities).
19. The Inquiry will consider the adequacy of the above to provide a framework to prevent abuse of patients with mental health conditions or learning disability in MAH and other such settings in Northern Ireland.

Matters of practice and procedure

20. The Inquiry Chair will determine how the Inquiry is conducted, including the procedure, the nature of evidence and calling of witnesses to the Inquiry.
21. Aspects of practice and procedure may be governed by protocols to be established at the outset of the Inquiry.
22. Appropriate witness services will be made available in the course of the Inquiry.

Report and recommendations

23. The Inquiry will submit its report to the Minister of Health. The Inquiry may make findings on matters within the terms of reference as outlined above, including the issue of abuse and whether such abuse resulted from systemic failings.
24. Having regard to (and dependent on) those findings, the Inquiry will make recommendations in respect of the following:
 - a. the core objective of ensuring that any such abuse and any such failings do not recur at MAH or at any other facility providing similar services in Northern Ireland;
 - b. improvement of the training of staff and management at MAH and comparable facilities;
 - c. improvement of management, policies, systems and processes within MAH, including those relating to whistleblowing and corporate governance;
 - d. improvement of competence, quality and internal governance of the Board of such hospitals;
 - e. to the extent that it is necessary and appropriate, the role of wider adult social care services and the relevant health and social care bodies (including but not limited to the Health and Social Care Trusts, the Health and Social Care Board, the Public Health Agency and the Department) in ensuring the safety of patients and best practice in service delivery at MAH and comparable facilities;
 - f. the legal and regulatory framework and related matters;
 - g. the requirement or desirability of the provision of redress to meet the particular needs of victims of abuse within MAH.
25. The Inquiry Chair may, if necessary and appropriate, issue an interim report or reports with recommendations.

Definitions of abuse

*Glynis H Murphy, Prof of Clinical Psychology & Disability, Tizard Centre,
University of Kent, UK*

1. In the UK, reports of abuse of people with learning disabilities, both children and adults, have repeatedly appeared over the years. One of the earliest inquiries into such abuse related to the care of adults with learning disabilities in Ely Hospital in Wales (1969), which led to a government White Paper 'Better Services for the Mentally Handicapped' (1971),¹ and which signalled the start of a closure programme for hospitals for people with learning disabilities and the transfer of services to the community. Nevertheless, cases of abuse continued to occur in congregate settings, for example, that of Longcare in Buckinghamshire (1998), Winterbourne View in Gloucestershire (2011), Whorlton Hall in Durham (2019) and others. See Appendix 3.
2. The UK Government recognised the need for better protection for vulnerable individuals needing care and support, and in 2000 the Department of Health published 'No Secrets', which was intended to be guidance on the development and implementation of multi-agency policies and procedures to protect vulnerable adults from abuse.² 'No Secrets' defined abuse as the 'violation of an individual's human or civil rights by any other person or persons'³ and maintained that abuse could be a single or repeated act. Different forms of abuse were identified: physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect and acts of omission, and discriminatory abuse.
3. More recently the UK Department of Health and Social Care issued 'Care and support statutory guidance',⁴ extending this list of types of abuse to include institutional abuse and providing a series of examples of each type of abuse. See

¹ Department of Health and Social Security Welsh Office (1971) Better Services for the Mentally Handicapped – <https://archive.org/details/b32230473/mode/2up>

² Department of Health (2000) No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse – <https://assets.publishing.service.gov.uk/media/5a7af2a640f0b66a2fc03f4d/>

³ No secrets (Department of Health, 2000) – Page 9

⁴ Department of Health and Social Care (updated 2025) Care and support statutory guidance – <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

also the Social Care Institute for Excellence (SCIE) for types and indicators of abuse.⁵

Safeguarding policies in Northern Ireland

4. The Department of Health (DoH) in Northern Ireland has had a series of policies regarding the safeguarding of vulnerable adults in its care. The definitions of abuse given in these policies have developed over time. The policies and the definitions of abuse are listed chronologically below.

2003

5. In 2003, the 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults',⁶ developed collaboratively by the Police Service of Northern Ireland (PSNI), Department of Health, Social Services and Public Safety (DHSSPS), Health and Social Services Boards and Trusts in Northern Ireland, said that abuse was: the violation of an individual's human and civil rights by any other person (as in 'No Secrets'), and included a more elaborate definition from the original Department of Health and Social Services (DHSS) guidance, produced in 1996:

'The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependent, whether they be informal or formal carers, staff or family members or others. It can occur outside such a relationship'.

6. The joint protocol went on to describe the procedures for investigating suspected abuse, including specifying how the PSNI and Health and Social Care Boards would collaborate. A referral form, the AJP1,⁷ was included in the appendix, together with AJP2 (strategy for the investigation) and AJP3 (clarification discussion).

⁵ Social Care Institute for Excellence (2015) Types and indicators of abuse: Safeguarding adults – <https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse/#organisational>

⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3466 (Exhibit MMcG/68) – Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults December 2003

⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 3500-3505 (Exhibit MMcG/68) – Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults December 2003

2006

7. The Northern Ireland DHSSPS had supported the establishment of a Regional Adult Protection Forum in 2002,⁸ to improve arrangements for the protection of vulnerable adults. In their view, there was a need for a coordinated regional policy and so, in September 2006, a further policy document was issued: 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance'.⁹ The DHSSPS noted that different Trusts and Boards in Northern Ireland used different definitions of a 'vulnerable adult' and therefore proposed the following (from the Law Commission for England and Wales 1995 definition of a 'vulnerable adult'¹⁰) to define a vulnerable adult as:
- 'a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'.*
8. The definition of abuse that they adopted was identical to that in the joint protocol (see above). It listed forms of abuse as: physical abuse (including inappropriate restraint or use of medication); sexual abuse; psychological abuse; financial or material abuse; neglect and acts of omission; institutional abuse; and discriminatory abuse.¹¹
9. The DHSSPS adopted the Law Commission's 1995 report concept of 'significant harm' as an important threshold when considering the nature of intervention,¹² and listed the rights of vulnerable adults as guiding principles, including the right to: privacy; be treated with respect and dignity; lead an independent life and be enabled to do so; be able to choose how to lead their lives; the protection of the law; have their rights upheld regardless of ethnic origin, gender, sexuality, impairment or disability, age and religious or cultural background; and have the opportunity to fulfil personal aspirations and realise potential in all aspects of daily

⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 34

⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3506 (Exhibit MMcG/69) – Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance September 2006

¹⁰ Law Commission for England and Wales (1995) Mental Incapacity, Report No. 231. London: HMSO – <https://assets.publishing.service.gov.uk/media/5a7c31d6ed915d76e2ebbb4c/0189.pdf>

¹¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3516 (Exhibit MMcG/69) – Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance September 2006

¹² Mental Incapacity, Report No. 231 (Law Commission, 1995)

life. The DHSSPS asserted that this included human rights considerations under the European Convention on Human Rights (ECHR), particularly in relation to Article 2: Right to life,¹³ Article 3: Freedom from torture¹⁴ (including humiliating and degrading treatment), and Article 8: Right to respect for private and family life¹⁵ (one that sustains the individual).

10. They also asserted that any person 'who has knowledge or a reasonable suspicion that a vulnerable adult has been, or is at risk of, being abused'¹⁶ should raise the alert and inform a nominated manager within the agency.
11. The remainder of the policy document dealt with the procedures that should be followed (including where joint investigations included the PSNI).

2009

12. In July 2009, there followed the 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults',¹⁷ developed by a partnership involving the PSNI, DHSSPS, Regulation and Quality Improvement Authority (RQIA), the Health and Social Care Trusts (HSCTs) and the former Health and Social Services Boards in Northern Ireland. It asserted that Trust and PSNI staff should read the protocol in conjunction with the September 2006 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance' (see above).

¹³ Equality and Human Rights Commission (2021) Article 2 of the ECHR – Right to life – <https://www.equalityhumanrights.com/human-rights/human-rights-act/article-2-right-life>

¹⁴ Equality and Human Rights Commission (2021) Article 3 of the ECHR – Freedom from torture and inhuman or degrading treatment – <https://www.equalityhumanrights.com/human-rights/human-rights-act/article-3-freedom-torture-and-inhuman-or-degrading-treatment>

¹⁵ Equality and Human Rights Commission (2021) Article 8 of the ECHR – Respect for your private and family life – <https://www.equalityhumanrights.com/human-rights/human-rights-act/article-8-respect-your-private-and-family-life>

¹⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3526 (Exhibit MMcG/69) – Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance September 2006

¹⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3566 (Exhibit MMcG/70) – Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults July 2009

Vulnerable adults were defined as those of 18 years old and above who:

*'are, or may be, in need of community care services OR are resident in a continuing care facility by reason of mental or other disability, age or illness OR who are, or may be, unable to take care of themselves, OR unable to protect themselves against significant harm or exploitation'.*¹⁸

13. The definitions of abuse were as given previously in the 2003 joint protocol and in the September 2006 Safeguarding Vulnerable Adults policy (see above). The remainder of the 2009 document dealt with the procedure to be adopted, including the grounds for joint investigations and the three forms AJP1, AJP2 and AJP3 were again attached.

2010

14. In 2010, the Adult Safeguarding in Northern Ireland Regional and Local Partnership Arrangements were issued, setting up the NIASP (the Northern Ireland Adult Safeguarding Partnership) and LASP (Local Adult Safeguarding Partnership).¹⁹ The aim was 'to improve safeguarding and protection outcomes for adults in Northern Ireland who are vulnerable'. The development of the policy framework was undertaken jointly by the DHSSPS and the Northern Ireland Office (NIO) with the support of other government departments. The definition of a vulnerable adult was unchanged from the 2006 Safeguarding Vulnerable Adults policy. The definition of abuse was also presumably unchanged (it was not mentioned). The document set out the roles and responsibilities of the two new bodies, the NIASP and LASPs in great detail. In summary:

*'The NIASP will determine the strategy for safeguarding vulnerable adults, develop and disseminate guidance and operational policies and procedures, monitor trends and outcomes and monitor and evaluate the effectiveness of partnership arrangements. In broad terms the LASPs will facilitate practice, including engagement with service users, families and carers and the wider public, at a local level'.*²⁰

¹⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3573 (Exhibit MMcG/70) – Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults July 2009

¹⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3620 (Exhibit MMcG/71) – Adult Safeguarding in Northern Ireland Regional and Local Partnership Arrangements March 2010

²⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3623 (Exhibit MMcG/71) – Adult Safeguarding in Northern Ireland Regional and Local Partnership Arrangements March 2010

2015

15. In 2015, 'Adult Safeguarding: Prevention and Protection in Partnership'²¹ appeared. Its function was to replace Part 1 of 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance' (September 2006). In the foreword, the Minister for Health, Social Services and Public Safety said:
'As far as possible, the aim of the policy is to prevent harm from occurring in the first place, to offer effective protection to those who are harmed and to provide them access to justice'.²²
16. The policy emphasised that 'safeguarding is everyone's business'. It moved away from the phrase 'vulnerable adult' to the idea of 'adults at risk of harm and in need of protection'. The policy was firmly embedded in a collaborative, person-centred, empowering, human rights approach. Harm and serious harm are defined,²³ and abuse is defined using a 1993 definition for 'elder abuse':
'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'.²⁴
17. For the first time, seven forms of abuse were listed and defined: physical abuse, sexual violence and abuse, psychological/emotional abuse, financial abuse, institutional abuse, neglect and exploitation²⁵ (in addition domestic violence, human trafficking and hate crime were also described as related issues). The remainder of the policy documents the roles of NIASP and LASPs and the procedures for safeguarding adults.

²¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3653 (Exhibit MMcG/72) – Adult Safeguarding Prevention and Protection in Partnership July 2015

²² Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3655 (Exhibit MMcG/72) – Adult Safeguarding Prevention and Protection in Partnership July 2015

²³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 3664-3665 (Exhibit MMcG/72) – Adult Safeguarding Prevention and Protection in Partnership July 2015

²⁴ Action on Elder Abuse: definition of abuse 1993 <http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html>. This was later adopted by the World Health Organization – <https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people>

²⁵ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 3666-3667 (Exhibit MMcG/72) – Adult Safeguarding Prevention and Protection in Partnership July 2015

2016

18. In August 2016, the updated 'Protocol for Joint Investigation of Adult Safeguarding Cases' was produced.²⁶ It ran to over 100 pages, referred to some of the previous policy documents (described above) and asserted that it would:
- 'provide clarity in respect of the roles and responsibilities of adult protection services where the nature of the harm to the adult in need of protection constitutes a potential criminal offence'.²⁷*
19. The definition of 'adults at risk of harm and in need of protection' was unchanged from the 2015 'Adult Safeguarding document (see above). The roles of the various organisations were detailed (HSCTs, PSNI, Public Prosecution Service, RQIA), and most of the document explained the procedures to be followed during a safeguarding incident.
20. Abuse is defined as:
- 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'. Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse'.²⁸*
21. Further definitions of types of abuse were given in the appendix to the protocol (along with the relevant flow charts and forms AJP 1, 2, 3, 4 and 5).²⁹ The protocol also listed the types of incident that may constitute a relevant reportable offence, and which must be referred to the PSNI: physical assault, sexual offences, domestic abuse, financial abuse, human trafficking and modern slavery, institutional abuse, historical abuse and poor practice that may constitute ill treatment or wilful neglect.³⁰

²⁶ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3716 (Exhibit MMcG/73) – Protocol for joint Investigation of Adult Safeguarding Cases August 2016

²⁷ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3720 (Exhibit MMcG/73) – Protocol for joint Investigation of Adult Safeguarding Cases August 2016

²⁸ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3767 (Exhibit MMcG/73) – Protocol for joint Investigation of Adult Safeguarding Cases August 2016

²⁹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Pages 3805-3819 (Exhibit MMcG/73) – Protocol for joint Investigation of Adult Safeguarding Cases August 2016

³⁰ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 3797 (Exhibit MMcG/73) – Protocol for joint Investigation of Adult Safeguarding Cases August 2016

(This page is intentionally left blank)

Safeguarding Reviews and Inquiries into Abuse in Care Settings for Adults with Intellectual and/or Developmental Disabilities in the UK

Josie Collins, Lecturer in Forensic Psychology, Department of Law & Criminology, Royal Holloway, University of London, Egham, UK
Glynis H Murphy, Prof of Clinical Psychology & Disability, Tizard Centre, University of Kent, UK

1. In the UK, following the tragic death of an 8 year old child, Victoria Climbié, the Children Act 2004 brought in a requirement for Local Authorities to hold a Serious Case Review (SCR) whenever a child died or suffered significant harm as a result of abuse or neglect (by no means all such children had special needs, such as Intellectual & Developmental Disabilities (IDD)). These reviews were later re-named Child Safeguarding Practice Reviews (CSPRs) and were required to be published.
2. According to Brandon et al in their triennial review of SCRs¹ there were approximately 100 such reviews in England each year. These kinds of reviews were later adopted for adults too, as a result of the Care Act 2014 (section 42-44) and were re-named Safeguarding Adult Reviews (SARs). They were to be undertaken where the adult was in need of care and support and was thought to be subject to abuse or neglect. As yet, there is no absolute requirement to publish SARs but a national library of such reviews has been established.
3. Broadly speaking all such reviews (SCRs, SARs & CSPRs) were intended to identify lessons to be learned across all organisations, to determine the causes, to identify good practice and draw out lessons that agencies can learn for the future. The reviews were not intended to be disciplinary investigations, that was the task of the agency running the care home/residential school/hospital. They were also not investigations into the immediate cause of death or serious injury, that was the task of the Coroner's Office and the police.

¹ Brandon, M., Sidebotham, P., Belderson, P., Cleaver, H., Dickens, J. Garstang, J., Harris, J., Sorensen P. & Wate, R. (2020). Complexity and challenge: a triennial analysis of SCRs 2014-2017. https://assets.publishing.service.gov.uk/media/5e5ce103e90e07110f9f6cab/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

In addition to these reviews, sometimes a serious case of suspected abuse has resulted in a call for a Public Inquiry, as in the Ely Hospital inquiry, chaired by Sir Geoffrey Howe (DHSS 1969), and the Muckamore Abbey Hospital Inquiry, chaired by Tom Kark, KC (due to report in June 2026).

A summary of 12 cases follows, where Serious Case Reviews/Safeguarding Adult Reviews or Inquiries took place in relation to abuse in care settings for adults with IDD. The findings are extensive and this extract therefore only aims to provide a brief summary. For full details on the findings and recommendations, please refer to the respective individual full reports.

Ely Hospital, Cardiff, Wales (1967)²

4. In 1967, a nurse who had worked for about a year at Ely Hospital (a long-stay NHS psychiatric institution housing approximately 600 service users with IDD) made allegations about the care in Ely hospital, and these were printed in the UK newspaper *News of the World*. The nurse claimed that four service users were being treated inhumanely and threatened by six members of staff. In addition, the nurse alleged that staff were generally mistreating service users, showing a lack of care, and that complaints were not being addressed.

The Public Inquiry that followed found evidence of ill-treatment toward specific individuals residing at Ely Hospital across four male wards, whereby patients had likely been assaulted and subject to prolonged periods of seclusion. Evidence was also found of staff having consumed and taken food from the hospital that was meant for the service users. It was concluded that outdated, rough and unsympathetic nursing methods, rather than malice had contributed towards such incidents having occurred, and that the concerns raised when allegations were made to the *News of the World* were valid.

² Department of Health and Social Security. (1969). Report of the Committee of Inquiry into Allegations of Ill – Treatment of Patients and other irregularities at the Ely Hospital, Cardiff. DHSS. Obtainable from: <https://sochealth.co.uk/national-health-service/democracy-involvement-and-accountability-in-health/complaints-regulation-and-enquiries/report-of-the-committee-of-inquiry-into-allegations-of-ill-treatment-of-patients-and-other-irregularities-at-the-ely-hospital-cardiff-1969/ely-hospital-report/>

The main findings of the Committee of Inquiry are summarised below:

- Specific incidents of ill-treatment, including physical assault had occurred at Ely Hospital.
- Staff had consumed significant amounts of food meant for service users.
- Nursing standards, as well as systems for reporting incidents and handing over nursing responsibilities on the male wards were found to be outdated.
- There was an inadequate structure of nursing administration and a lack of oversight of the quality of nursing care.
- Due to whistle-blowers being penalised after making well-intentioned complaints, poor leadership, inadequate complaints procedures and administrative structures that promoted isolation, a culture of fear had been established in which staff did not feel able to raise concerns.
- Senior members of nursing staff were found to be, in part, accountable for the culture of the hospital.
- Overcrowding and poor infrastructure fostered an environment in which the care and treatment of patients residing at Ely Hospital had fallen below public standards.
- Patients of different ages and conditions were accommodated together.
- Improvements to the co-ordination of services with local authorities were needed.

Stoke Place Mansion & Stoke Green House, Longcare Limited (1998)³

5. An independent inquiry by Buckinghamshire County Council was conducted following the reports of widespread abuse at two large residential homes for adults with IDD run by Longcare Limited between 1993 and 1994. The homes were known as Stoke Place Mansion and Stoke Green House. The first allegations of physical violence were made by a service user in 1991. By 1994 attempts were being made to implement a programme of improvements following the exposure of widespread abuse. Both physical and sexual abuse (including rape) were uncovered, and criminal convictions were brought against several individuals in positions of responsibility at the homes. Some of the service users were

³ Buckinghamshire County Council (1998). Independent Longcare inquiry. Buckingham: Buckinghamshire County Council.

considered to have capacity to give evidence in court (Gudjonsson, Murphy & Clare, 2000),⁴ but the owner, Gordon Rowe, committed suicide before his appearance in court. Other staff got minimal prison sentences of 18 months and 2.5 years. The inquiry concluded that the protection of vulnerable adults is reliant on openness by proprietors and managers, vigilance by all with responsibility and/or contact with service users, encouragement and support for whistle-blowers, and prompt and coordinated action on receipt of information indicating possible harm to the welfare of service users.

Cornwall Partnership NHS Trust (2006)⁵

6. This inquiry was a joint investigation between the Commission for Healthcare Audit and Inspection and The Commission for Social Care Inspection (which at the time were the health and social care inspection bodies in England), into services for people with IDD provided by Cornwall Partnership NHS Trust. It followed concerns raised by East Cornwall Mencap in October 2004 about the care and treatment of people living in the Trust's assessment and treatment centres, and supported living services. Five cases in which complaints spanned several years were outlined by East Cornwall Mencap to illustrate their concerns. During the investigation, the Healthcare Commission and the Commission for Social Care Inspection visited every site operated by the Trust, including 45 supported living services, three assessment and treatment centres, a special service for one person detained under the Mental Health Act (1983) and its services for children. Institutional abuse was widespread, and some individuals had suffered abuse including physical, emotional and environmental abuse. Moreover, the NHS Trust's services did not reflect the principles of rights, independence, choice and inclusion, set out in the Department of Health's *Valuing People* strategy.⁶

⁴ Gudjonsson, G. H., Murphy, G. H., & Clare, I. C. H. (2000) Assessing the capacity of people with intellectual disabilities to be witnesses in court. *Psychological Medicine*, 30 (2), 307-314 (doi:10.1017/S003329179900149X)

⁵ Flynn, M. (2006). Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust. *The Journal of Adult Protection*, 8(3), 28-32. <https://www.emerald.com/jap/article-pdf/8/3/28/1303411/14668203200600018.pdf>

⁶ Department of Health. (2001). *Valuing People* strategy. <https://assets.publishing.service.gov.uk/media/5a7b854740f0b62826a041b9/5086.pdf>

The main findings of the investigation are summarised below:

- Unacceptable restrictions on service users were common, for example the locking of doors to restrict internal movement, the removal of taps and lighting fixtures, and the mismanagement of residents' personal finances.
- Inadequate local procedures and a lack of appropriate action taken by the Trust to investigate potential abuse.
- The role of Cornwall County Council in coordinating inter-agency referrals was insufficient.
- Assessment and treatment centres and supported living services operated by the Trust did not meet best practice guidance as detailed in the Mansell Report (2007) and, in some instances, these services were being provided in unacceptable environments.
- Record keeping was poor.
- There was evidence of physical restraint being used illegally.
- There was evidence that pro re nata (PRN) medication was being used to control unacceptable and/or challenging behaviour.
- Treatment plans for service users were not always available, and treatment programmes were not consistently adhered to.
- Community care assessments were not being completed to determine service user need.
- Quality and frequency of staff training was poor.
- Evidence of policy review, development and implementation were lacking.
- There was poor oversight and governance from directors, managers, and senior leadership.
- A poor working relationship between Cornwall County Council and the Trust resulted in a lack of involvement from social services.
- Limited access to advocacy services for service users.
- Closed culture within IDD services with a lack of cross-agency working and collaboration with other services.
- Lack of staff understanding for what constitutes abuse, best practice and the principles of the *Valuing People* strategy (Department of Health, 2001).

Kent & Medway Serious Case Review – Care Worker: AB (2007)⁷

7. The purpose of this SCR was to establish how abuse concerns regarding a staff member (AB) were initially handled by the service and how agencies collaborated to safeguard vulnerable adults. Between 2002 and 2004, a care worker (AB) was accused of physically and psychologically abusing, and neglecting, five service users in a care home for adults with learning disabilities. Although AB was charged, the Crown Prosecution Service later dropped the case, citing public interest concerns, as senior staff who failed to address the abuse were not prosecuted.

Findings of the SCR are summarised below:

- There was evidence that the abuses of which AB was accused represented some broader failures in service management, policies and practice.
- There was evidence of inadequate staff training and supervision.
- Concerns regarding staff practices were not adequately reported.
- Poor management and a lack of staff training did not exonerate someone who used violence and/or disregarded a patient's rights to dignity and respect.
- Investigations into abuse needed to focus on management failures as well as individual accountability.

Winterbourne View, Castlebeck Care Limited, Gloucestershire (2011)⁸

8. Winterbourne View opened in December 2006, and was a small private hospital, owned by Castlebeck Care Limited. It was registered as providing assessment, treatment, and rehabilitation for up to 24 people with IDD across two wards, most of whom were detained under the Mental Health Act 1983. In 2010, Winterbourne View Hospital had a turnover of £3.7m. Following concerns by a whistle-blower, which were ignored by the organisation, an undercover reporter worked as a care worker at the hospital for a period of 5 weeks. He filmed serious physical and verbal abuse, and this was revealed in a BBC Panorama report on national television on 31 May 2011. As a result:

⁷ Kent and Medway Safeguarding Vulnerable Adults Committee Executive Summary Serious Case Review Case AB-2007

⁸ Flynn, M. (2012). Winterbourne View Hospital. A Serious Case Review. Gloucestershire, UK: South Gloucestershire Council. <https://minhalexander.com/wp-content/uploads/2016/09/south-glos-serious-case-review-winterbourne-view.pdf>

- Winterbourne View closed in June 2011 with remaining residents placed in other settings.
- A Serious Case Review was conducted by South Gloucestershire Safeguarding Adults Board, with an independent chair, leading to 43 recommendations to improve the care and treatment of people with IDD within services.
- A police investigation resulted in 11 criminal convictions against staff.
- The Care Quality Commission (CQC - the inspection body that replaced the Commission for Healthcare Audit and Inspection) inspected all hospitals and homes operated by Castlebeck Care and conducted a wider “health check” inspecting 159 IDD services across England.
- The Government conducted a review, led by the Department of Health, to investigate the failings surrounding Winterbourne View, to learn from what had happened, in order to prevent similar abuse from occurring, and to explore and recommend wider action to improve quality of care for vulnerable groups.
- A programme of work followed in the NHS in England, known as *Transforming Care*, with the original aim of closing all hospital beds for people with IDD (around 3000 beds remained from previous bed closure programmes) and improving community provision.

The main findings of the SCR for Winterbourne View, are summarised below:

- The service was supposed to provide short term assessment and treatment but the length of stay for service users was too long (average length of stay was 19 months).
- Service users were staying too far from their homes (almost 50% of service users were over 40 miles from their family or primary carer).
- There was a high rate of physical interventions and restraints (over 500 reported cases of restraint over 15 months).
- There were 150 separate incidents (including Accident and Emergency visits by service users, police attendance at the hospital, safeguarding concerns reported to the local council) suggesting multiple agencies failed to identify key warning signs of abuse.

- There was no Registered Manager in position, substandard recruitment processes and limited staff training.
- A 'closed and punitive' culture had developed, whereby visitors including family were not allowed access to top floor wards and service users' bedrooms.
- Wider concerns included inappropriate placements, in hospitals for assessment and treatment, as well as inappropriate care models that were not personalised.
- There were poor care standards including an over reliance on physical restraint.

Atlas Care Homes, Devon (2013)⁹

9. Atlas was commissioned to provide specialist care to adults with learning disabilities whose support needs were described as complex and challenging. They were based in Devon and registered under (i) the Care Standards Act (2000) as care homes and domiciliary care agencies, and (ii) the Health and Social Care Act (2008) as care homes without nursing, with one location providing a supported living service. Concerns about abuse came to light through a CQC inspector querying the use of prone restraint in 2010, followed by numerous reports of concerns and whistle-blowing alerts to CQC in the following two years (including alerts from the residents themselves).

Criminal court proceedings against Atlas Project Team Ltd founder, directors, managers and staff of seven Atlas care homes began in October 2011 and were concluded in June 2017. Investigations revealed service users were subjected to systemic neglect, seclusion in rooms without food, drinks, heating or access to toilets, physical assaults, and orders from staff to undertake housework and gardening tasks. Due to the criminal investigation, the Serious Case Review report presents findings from a review completed in 2013 (but published later because of the criminal proceedings).

⁹ Flynn, M. (2019). Devon Safeguarding Adults Partnership. Safeguarding Adults Review. Atlas Care Homes. [https://nationalnetwork.org.uk/2019/Atlas%20Safeguarding%20Adults%20Review%20-%20FINAL%20\(PUBLICATION%20VERSION\).pdf](https://nationalnetwork.org.uk/2019/Atlas%20Safeguarding%20Adults%20Review%20-%20FINAL%20(PUBLICATION%20VERSION).pdf)

The main findings of the review are summarised below:

- Despite the publication of the *Valuing People* Strategy (Department of Health, 2001), remote commissioning of isolated and out of area placements had continued.
- There was a lack of monitoring of individuals who were placed out of area.
- Questions and allegations from relatives were dismissed by Atlas directors, managers, staff and clinicians.
- The process of registering a service with the CQC and outlining its purpose, as well as making any amendments, required review.
- The CQC's approach to inspection of services was inconsistent and inspectors lacked specialist knowledge.
- The expertise of families and relatives of people with IDD were not valued.

Long Leys Court, Lincolnshire (2015)¹⁰

10. In June 2015, the Lincolnshire Safeguarding Adults Board received two notifications raising allegations of emotional and physical abuse of 12 adults with learning disabilities and mental health issues (seven men and five women, aged 20-69 years) residing at Long Leys Court, a 16-bedded assessment, treatment and rehabilitation centre run by Lincolnshire Partnership NHS Foundation Trust. The initial allegations of abuse were reported to have involved five patients and included neglect, misuse of restraint, and incidents of abusive behaviour by staff. Early reviews of information suggested that a further 43 adults at risk may have been subject to abuse whilst they were admitted to Long Leys Court between 2011 and 2015. There were concerns about chemical restraint, and about the use of seclusion. Long Leys Court was ordered to close and by October 2015 the 12 patients included in the review had been transferred. Lincolnshire Police led a criminal investigation into several incidents; however, the investigation did not result in any professionals being charged with criminal offences.

¹⁰ Lincolnshire Adults Safeguarding Board. (2020). Safeguarding Adults Review - Long Leys Court. <https://nationalnetwork.org.uk/2020/SAR%20Long%20Leys%20Court%20Overview%20Report.pdf>

Findings of the SAR are summarised below:

- The abuse at Long Leys Court occurred in the years immediately following the abuse uncovered at Winterbourne View and during a period when additional measures and new care arrangements were being implemented to improve the care and safeguarding of adults with IDD residing in assessment and treatment centres in England.
- A lack of tenacity and curiosity may have resulted in assurances of service user safety not being sought or tested.
- The multi-disciplinary team was inadequate due to a lack of shared practice between professionals. The NHS team at Long Leys Court were responsible for providing care and medical assessment and treatment to the adults admitted. The local authority social care professionals, despite being on the unit regularly, did not have any defined role, did not see themselves as part of the multi-disciplinary team and were not professionally curious.
- Evidence did not provide assurance that the guidelines to ensure the quality of physical health provision were being met, suggesting GP care arrangements should be reviewed.
- A complicated picture of governance in Lincolnshire and the assurances and checks in the NHS were ineffective in protecting the adults at Long Leys Court between 2011 and 2015.
- The external regulator, the Care Quality Commission, did not pick up any unusual alerts about Long Leys Court because of the combination of a culture there, which did not encourage reporting and the lack of curiosity at the CCG (Clinical Commissioning Group).
- The review highlighted that service users were deprived of their liberty without authorisation, not always assessed in line with the Mental Capacity Act (2005) when they should have been, restrained including chemical restraint, and not always referred for advocates as required under the Mental Health Act (2007) and the Mental Capacity Act (2005) during their admissions to Long Leys Court.
- Correspondence between organisations about safeguarding concerns was not being logged appropriately by the NHS CCG, Lincolnshire Partnership NHS Foundation Trust, and the local authority.

- Application of the Mental Capacity Act (2005), despite some good practice, was not embedded at Long Leys Court. The new process of Care and Treatment Reviews were not always carried out to the standard set in the relevant guidance.
- During the period under review – 2011 to 2015 – there was a confirmed culture of bullying and harassment at Long Leys Court, which suppressed effective whistleblowing and actions being taken.
- The culture inside Long Leys Court was not one that encouraged openness or reporting.
- The views and wishes of service users and families were not being valued in line with Quality Practice Standards between 2011 and 2015 at Long Leys Court. There was an absence of compliance regarding Duty of Candour and non-compliance to existing Trust Policies and Procedures.

Mendip House, Somerset Court, National Autistic Society (2016)¹¹

11. Mendip House was one of seven residences located at the National Autistic Society's campus known as Somerset Court and housed six autistic adults. Following allegations made by whistle-blowers, incidents at Mendip House were revealed to Somerset's Safeguarding personnel in May 2016. The scattered knowledge arising from previous incidents was collated and further failures and evidence of harmful practices became apparent. A SAR commissioned by Somerset's Safeguarding Adults Board in March 2017 revealed whole service concerns. Mendip House was closed on 31st October 2016.

Findings of the SAR are summarised below:

- An audit of case files requested by Somerset County Council during June 2016, found that Mendip House service users had been funding the meals of staff accompanying them during outings since 2014 (almost £10k was reimbursed to its six residents).

¹¹ Flynn, M. (2018). Somerset Safeguarding Adults Board. Safeguarding Adults Review. Mendip House.

- The service was characterised by a lack of goal setting for service users, planning, support, staff expertise, management and oversight from commissioners.
- Assumptions about a service's reputation and expertise did not constitute evidence of good quality care.
- Previous investigations conducted in isolation by the National Autistic Society into poor/abusive conduct of their staff had not been reported to Somerset County Council or the CQC. On occasions where investigations were reported, the outcomes involved the whistle-blower having resigned and the alleged perpetrator given a warning and retained/recycled within the service.
- There was a delay in dismissing National Autistic Society employees during the investigation.
- There was a lack of monitoring of service provision provided outside of the service user's localities of origin.

Beech Lodge Care Home, Sussex Health Care (2018)¹²

12. In April 2015 two males with profound learning difficulties and cerebral palsy resident at Beech Lodge Care home in West Sussex were taken to Accident and Emergency following fractures to their femurs. Following a safeguarding review by a local CLDT, it was concluded that their injuries were "probably caused as a result of single-handed manual handling" not in adherence with guidelines in place. There was insufficient evidence to reach a criminal threshold. As a result, an independent SAR was conducted.

Findings of this review are summarised below:

- The safeguarding review conducted in 2015 by West Sussex Adult Services Community Learning Disability Team was not well co-ordinated or evidenced, resulting in inconclusive conclusions that were based on assumptions. Such conclusions led families to believe agencies colluded to suppress the truth.

¹² Boxall, B. (2018). West Sussex Safeguarding Adults Board. Safeguarding Adults Review In Respect of Matthew Bates and Gary Lewis. BDB Consultancy Ltd. <https://www.westsussexsab.org.uk/media/o2amybpc/wssab-sar-mb-and-gl.pdf>

- Safeguarding alert forms were not completed to a good standard and contained false information that the police had been contacted.
- There were multiple opportunities where the police should have been contacted but were not by different agencies involved, including the service provider, the general hospital, and West Sussex Adult Safeguarding Duty Team.
- Prior to injuries being sustained, there were concerns raised about the governance of Sussex Health Care across their homes in West Sussex in April 2014, however these were not acted upon.

Whorlton Hall, Cygnet Healthcare, Durham (2019)¹³

13. Whorlton Hall was a small independent hospital, in the Durham area, originally registered with the CQC for 24 adult inpatients with IDD and additional mental or physical health needs, and/or behaviours that challenged.

In 2018/9, two whistle-blowers working in Whorlton Hall became concerned about abuse there and reported this to managers. They then contacted the BBC Panorama programme because managers in the service were not listening to their concerns. At the time there were 13 patients at Whorlton Hall, and CCGs from 10 different areas across the North-East, North-West, the Midlands and Northern Ireland, commissioned these placements. There were no placements commissioned by the local Durham CCG. In response to the whistle-blowers, the BBC sent in an undercover reporter who filmed evidence of physical and psychological abuse of the people with IDD residing at Whorlton Hall, and this was screened in a Panorama programme on national TV on 22nd May 2019. Following the Panorama programme a criminal investigation commenced. Cygnet made several staff suspensions, including interim suspensions of nursing staff. Whorlton Hall was then closed, and all the service users were moved to alternative residences.

¹³ Murphy, G. (2020). CQC inspections and regulation of Whorlton Hall: first independent report. Tizard Centre, University of Kent. https://www.cqc.org.uk/sites/default/files/20020218_glynis-murphy-review.pdf

Whorlton Hall had originally been owned and operated by Castlebeck Care (which had also owned Winterbourne View), but it later transferred to The Danshell Group in 2013. Danshell owned and operated Whorlton Hall until August 2018, when all their 25 different facilities (with 288 beds) in different parts of the country were acquired by Cygnet Health Care. The acquisition of Danshell services by Cygnet occurred on 1st August 2018, and a new senior operational team took over responsibility on 1st January 2019.

Following the TV Panorama programme in 2019, the first independent report on Whorlton Hall was commissioned by CQC, to examine the CQC inspections and regulation of Whorlton Hall. A second report published in December 2020 provided a reflection on progress made towards the recommendations in the first phase of the independent review.¹⁴

Taken together these reports highlighted several key findings including:

- The review highlighted frequent breaches to human rights, including restrictive practices without proper safeguards and poor-quality care plans that undermined individual care and well-being.
- Despite adherence to formal procedures, inspectors, and visiting professionals (GPs, CCGs, advocates) failed to detect ongoing abuse or a “toxic or closed culture” within Whorlton Hall.
- Indicators such as high staff turnover, frequent use of agency staff, low qualified nurse presence, restrictive practices (restraint, seclusion), and a punitive atmosphere were present but did not raise concerns amongst inspectors.
- A lack of unannounced inspections, insufficient evening/weekend visits, limited in-ward observations, and inadequate overt/covert monitoring aided concealment of abuse.

¹⁴ Murphy, G. (2020). CQC inspections and regulation of Whorlton Hall: second independent report. Tizard Centre, University of Kent. https://www.cqc.org.uk/sites/default/files/20201215_glynis-murphy-review_second-report.pdf

Later, a Safeguarding Adults Review of Whorlton Hall, commissioned by Durham Safeguarding Adults Partnership was completed,¹⁵ which highlighted several systemic weaknesses, which are summarised below:

- There was a lack of standards/expertise and requirements for provider-led safeguarding investigations of cultures.
- Centrality of a sustained relationship of trust with a professional to enable effective safeguarding responses for individuals in specialist hospital settings.
- An illusion of advocacy provision for people with IDD, and who are in-patients or at risk of being admitted to specialist hospital.
- Need for closer working between CQC and local authorities to improve outcomes from organisational safeguarding enquiries in specialist hospitals.
- Gaps in guidance and funding responsibilities for emergency specialist hospital closures after organisational abuse or deregulation.
- No evidence-base for what made a CCG effective at 'micro' commissioning and quality assurance of services for people with IDD, to inform Integrated Care Systems.

Cawston Park Hospital, Jeasal Group (2019)¹⁶

14. Following the death of two service users with IDD (Joanna and Jon) at Cawston Park Private Hospital, a SAR was commissioned by Norfolk's Safeguarding Adults Board in April 2019. In December 2020 the death of a third service user (Ben) was added to the review's remit. Cawston Park Hospital was registered with the CQC for the assessment and treatment for persons detained under the Mental Health Act (1983). Across six wards, two of which were locked wards (The Grange and the Lodge), Cawston Park Hospital had the capacity for 57 beds. Two of the deceased were placed at the Grange and the Lodge. All three adults were admitted to the hospital under sections of the Mental Health (1983) following personal and family crises.

¹⁵ Fish, S., Pearson, F., & Johnson, F. (2023). Safeguarding Adults Review Whorlton Hall. Commissioned by Durham Safeguarding Adults Partnership. <https://www.safeguardingdurhamadults.info/media/42270/Safeguarding-Adults-Review-Whorlton-Hall-May-2023/pdf/WhorltonHallReport-May2023.pdf?m=638205410398630000>

¹⁶ Norfolk Safeguarding Adults Board (2021, September). Safeguarding Adults Review: Joanna, Jon & Ben. [https://nationalnetwork.org.uk/2021/NSAB%20SAR%20Joanna%20Jon%20and%20Ben%20\(FINAL-PUBLICATION\)%2009092021.pdf](https://nationalnetwork.org.uk/2021/NSAB%20SAR%20Joanna%20Jon%20and%20Ben%20(FINAL-PUBLICATION)%2009092021.pdf)

Findings of the Safeguarding Adults Review are summarised below:

- Several harmful practices were described by relatives of service users at Cawston Park Hospital, including unsafe grouping of service users, the excessive use of restraint and seclusion by unqualified staff, overmedication, and inactivity.
- The complex causes of patients' behaviour, mental distress or physical health care were not understood by staff.
- There was a lack of information on service user care recorded.
- The hospital made undocumented assumptions on service users' mental capacity.
- Physical inactivity increased risk of obesity and of other physical health issues.
- There was a lack of knowledge and understanding of a person's life before admission to hospital.
- There was a lack of consequences for when CCGs responsible for placements were not represented at critical review meetings.
- There was a lack of corporate governance.
- The views of service users and their relatives were not sought by management.
- There was a lack of information sharing between staff/service users, and managers/directors.

Kent and Medway – Stephen (2024)¹⁷

15. Stephen was a 19-year-old male who had diagnoses of autism and complex post-traumatic stress disorder. He resided in supported living in Kent, and he died in February 2022 after he ran out of the supported living accommodation onto the railway tracks nearby and was hit by a train.

Kent County Council then established a SAR referral. It transpired that three days prior to Stephen's death he had been discharged from an NHS Hospital Trust, where he had been admitted after his supported living accommodation was not

¹⁷ Kent and Medway Safeguarding Adults Board. (2024). Safeguarding Adults Review: 'Stephen'. https://www.kmsab.org.uk/assets/1/safeguarding_adults_review_stephen.pdf

able to meet his needs. A Mental Health Act assessment while he was in hospital had concluded that Stephen was not detainable. The plan was to place him in a specialist autism bed, but this was proving difficult to find. There was an agreement for him to be placed as an informal patient in a mental health ward whilst the search for a specialist autism bed continued. However, this decision was retracted, and he was discharged back to the supported living placement that had previously failed him, with 3:1 support and with instructions to unlock the doors if he became violent, to prevent harm to staff. On one day in February 2022, Stephen became violent and so the staff, as instructed by the multi-agency network, unlocked the doors of the premises allowing Stephen to leave. Staff followed Stephen and the police were called. Stephen went onto a railway, where he died after having been hit by a train. Previous reports indicate that there had been previous incidents of Stephen having walked onto the railway tracks and as a result concerns had been raised regarding the proximity of the accommodation to the railway tracks.

Findings of the SAR are summarised below:

- Workers across health, social care and the police lacked understanding and knowledge of trauma informed practice.
- Providers lacked understanding of the legal frameworks that safeguard adults with IDD and who hold responsibility for these, such as the Deprivation of Liberty Safeguards.
- Staff should receive autism training to ensure they have the knowledge and skills needed to fulfil their professional role.
- Any changes to the Mental Health Act should ensure that there are provisions for autistic individuals to be detained when appropriate (i.e., during a mental health crisis) when their safety or the safety of others is at risk, and specialist autism beds should be available.
- The provision of support for autistic children transitioning into adult services should be monitored.
- The focus should be on the individual, rather than the agency pressures.

Conclusion

16. Research and ongoing investigations suggest the abuse of adults with IDD within services commissioned within the UK, especially those designed to provide assessment and treatment, continues to be uncovered. The investigations described remarkably similar issues each time and yet lessons do not seem to have been learned in similar services. Previous research has identified several risk factors for abuse in these settings that include victim, perpetrator, environmental and organisational characteristics that may contribute towards abusive practices being permitted to manifest within a service (Collins and Murphy, 2022).¹⁸ The extent to which the recommendations from each SAR and Inquiry have been implemented is as yet unclear.

¹⁸ Collins, J., & Murphy, G. H. (2022). Detection and prevention of abuse of adults with intellectual and other developmental disabilities in care services: A systematic review. *Journal of Applied Research in Intellectual Disabilities*, 35(2), 338-373. <https://doi.org/10.1111/jar.12954>

What Good Management and Governance Looks Like

Dr Elaine Maxwell, Panel Member

1. Effective running of a healthcare facility involves a number of different activities, each aligned and conducted in a timely manner. To achieve this, there must be effective governance and management. This includes clarification of the overall ambitions, strategic planning to ensure the capacity to achieve those ambitions, operational processes to enact the plans and effective systems to monitor that the activities are completed as designed, they are delivering the ambitions and there are no unintended consequences. These activities are distributed throughout leadership and management teams. Leadership teams focus on strategy and assurance that goals are being met, and management teams focus on the details of operational delivery, although both teams share collective accountability for the services.
2. The Northern Ireland Executive sets the broad direction for Health and Social Care within its Programme for Government and provides a budget within which to achieve it.¹ The Minister of Health sets high-level goals in an annual Commissioning Plan Direction.² This is passed to the commissioner of services (HSCB/SPPG), which translates it into measurable goals and enters into annual contracts with the providers (HSCTs) who hold contracts for service delivery. The HSCB/SPPG is accountable to the Minister for performance management of the Health and Social Care Trusts (HSCTs) against the contracts,³ and also for monitoring progress towards longer-term goals, including those for public health and major changes such as resettlement of patients outside of long-stay hospitals.
3. HSCT Boards set strategy for the long-term development of their organisation to ensure they are able to deliver the contracts agreed with the commissioners. This includes infrastructure such as estates and equipment, and recruiting, retaining

¹ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 10

² Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 11

³ Mark McGuicken 1st Statement (Evidence Modules) – 13/02/23 – Page 67

and developing the workforce. Boards are responsible for creating effective assurance systems that demonstrate that: services are provided within the agreed budget; the statutory duty for quality is met (including compliance with regulatory standards); and any risks are identified and mitigated. Boards have a duty to assure themselves robustly but also to alert the commissioner, which in turn alerts the Department of Health (DoH), and ultimately the Minister, of any problems. The Boards must therefore have systems for early identification of variation from their plans (whether financial, activity or quality) or harm to users of their services.

4. Large organisations such as HSCT Boards, with multiple areas of activity, cannot operate through a single line of authority due to the sheer volume of information and time required for each area. They must instead rely on a scheme of delegated authority, and most healthcare providers use a matrix management model. Matrix management is a model where staff report to more than one manager, meaning there is no single chain of command. This allows collaboration across a range of viewpoints. In healthcare this can mean a professional line to maintain professional standards and a general management line to ensure that the contracted activities are delivered. This allows complex services to be managed in a balanced manner with input from subject experts. Leaders in each line must work collaboratively to ensure staff do not receive mixed or contradictory messages. HSCT matrices are generally two-dimensional, with a general management axis (through the Clinical Directorate structure) and a functional axis (led through the executive directors). Each axis has an agreed level of delegated authority from the Board, which allows them to act promptly within certain parameters without waiting for issues to progress up a hierarchical chain of command.
5. To manage a matrix structure effectively, HSCT Boards must be explicit and transparent about the level of delegated authority, indicating how decisions are to be made and how accountability is demonstrated. They must be clear about the limits of the delegated authority and how matters outside these limits are to be escalated to the intermediate levels of the matrix and ultimately to the Board itself.

The Board

6. Ultimate responsibility for all the activities of the HSCT lies with the voting members of the HSCT Board. This is a responsibility that they share collectively, although the Chief Executive is legally the Accountable Officer.⁴ Unlike many private businesses, which break their company's governance into two distinct boards known as the supervisory board and the management board,⁵ HSCT Boards have a single combined board. While the Board has both executive directors (who in addition to their Board roles have delivery management responsibilities) and non-executive directors (NEDs), they should perform as a single unitary board. This means NEDs cannot rely on reassurances from others but must examine data and test assumptions to assure themselves, and executive directors must satisfy themselves about practice in each other's management responsibility areas (i.e. the Finance Director must be independently satisfied that information on patient safety provides sufficient assurance). Both executive and non-executive directors require a high level of knowledge and skill in health and social care governance for the delegated management structure to work effectively.
7. The Board maintains oversight of the risks through the Board Assurance Framework (BAF), which contains real time assessment of risks to organisational strategic objectives and the success of actions to mitigate the risks. The BAF is derived from the risks identified within the management units.⁶ Risks that are scored very high or are not effectively mitigated are escalated through the management structure and ultimately to the Board.
8. HSCT Board subcommittees synthesise and summarise information on behalf of the whole Board. These include an audit committee to review the internal controls (historically related to finance but include all internal controls, including risk management controls) and an assurance committee to review performance. These committees have delegated authority over certain matters; these should be

⁴ June Champion Statement (Evidence Modules) – 10/03/23 - Page 10

⁵ D. Byrne What is a two-tiered board structure? Corporate Government Institute – <https://www.thecorporategovernanceinstitute.com/insights/lexicon/what-is-a-two-tiered-board-structure>

⁶ HSC Board Members Handbook

explicit in the delegation schedule and they should guide which matters are escalated to the whole Board.

9. The Chair of the Board is always a NED with no additional delivery management responsibilities. Further objectivity can be provided through the appointment of a Senior Independent Director (SID) who can act as a focal point for any concerns that cannot be resolved by the Chief Executive or the Chair.⁷ The SID may also be available directly to staff who have concerns that cannot be resolved via the management structure.
10. HSCT Boards conduct most of their meetings in public but may hold some, or parts of some meetings, in private. There should be clear criteria for presenting and discussing issues in private.
11. In 1991 the UK established the Committee on the Financial Aspects of Corporate Governance, led by Sir Adrian Cadbury.⁸ His report led to the 2018 Corporate Governance Code. Among other matters, the Code requires an external evaluation of the suitability of Board governance arrangements at least every three years,⁹ although this is not yet common practice in Health and Social Care organisations. The Good Governance Institute has a self-assessment governance maturity matrix for healthcare organisations.¹⁰ This comprises six levels of performance against 10 dimensions: clarity of purpose; application of principles; leadership and strategic direction; effective external relationships; effective internal relationships; transparency and public reporting; systems and structures; challenge on delivery of agreed outcomes; risk and compliance; and organisational effectiveness.

⁷ Yorkshire Ambulance Trust (2024) Corporate Governance Guide: The Board of Directors – www.yas.nhs.uk/media/4916/gu-the-board-of-directors-v10.pdf

⁸ J. Johannesson, I. Palona, J.F. Salazar Guillen and M. Fock (2012) UK, Russia, Kazakhstan and Cyprus governance compared, *Corporate Governance*, 12(2) - Pages 226-242 – <https://doi.org/10.1108/14720701211214106>

⁹ Financial Reporting Council (2018) UK Corporate Governance Code – https://media.frc.org.uk/documents/UK_Corporate_Governance_Code_2018.pdf

¹⁰ Good Governance Institute (2015) Self-Assessment Maturity Matrix – www.hqip.org.uk/wp-content/uploads/2018/02/nh6rmx.pdf

Operational management structures

12. As the Board cannot micromanage the entire organisation, it delegates significant amounts of work to the functional and clinical management structures. The Board must pay particular attention to the boundaries between different areas of delegated authority where responsibilities may overlap or may fall between two stools.
13. Large and complex organisations often need to respond to unexpected events or unanticipated consequences of their actions in order to maintain reliable services.¹¹ Research across a range of industries into organisations where reliability is a higher priority than cost efficiency (often described as ‘high reliability organisations’) reveals five management principles to both detect and resolve any untoward events. These are: preoccupation with failure; reluctance to simplify; sensitivity to operations; commitment to resilience; and deference to expertise.¹²

Preoccupation with failure

14. High reliability organisations (HROs) constantly anticipate the unexpected through rigorous risk assessments at individual, team and organisational level. Identification of risk by staff is encouraged and commended as an opportunity to avoid a problem, rather than as a failure of the service. HROs conduct ‘rubber windmill’ exercises (originally a simulation exercise to test the impact of internal market reforms on the English NHS in the 1990s to ‘test to destruction’ how the health system would respond to competitive pressures).¹³
15. Risk is managed or mitigated at the level at which it is identified. If it cannot be locally managed, it is escalated to the next layer of management. Risks that remain unmitigated are reported to the Board, which must make a choice from three options: accept the risk; terminate the risk by ceasing to provide that service; or take actions that reduce the risk to an acceptable level.

¹¹ K.E. Weick (1987) Organizational culture as a source of high reliability, *California Management Review*, 29(2) - Pages 112-127 – <https://doi.org/10.2307/41165243>

¹² K.M. Sutcliffe (2011) High reliability organizations (HROs), *Best Practice & Research Clinical Anaesthesiology*, 25(2) - Pages 133-144 – <https://doi.org/10.1016/j.bpa.2011.03.001>

¹³ D. Cohen, A. Darzi and I. Vlaev (2013) Behavioural simulations in health care policy: Current uses and future developments, *Journal of Health Services Research & Policy*, 18(2) - Pages 98-106 – <https://doi.org/10.1177/1355819612473591>

16. It is for the Board to determine what is an acceptable level of risk (known as the 'risk appetite') and to ensure that those with delegated authority understand this and refer unacceptable risks to the Board for a decision. Health and social care organisations are often unable to stop providing a service, however risky, and the Board considers risks in terms of what the UK Health and Safety Executive defines as risk that is 'as low as reasonably practicable' (ALARP) in a given set of circumstances.¹⁴ This means that the lack of resources to provide the gold standard of service is not a reason for the Board or other managers failing to continue to discuss, monitor and take action to reduce the risk within the constraints they face.

Reluctance to simplify

17. HROs avoid simple explanations and seek out alternate interpretations. They encourage their staff to question received wisdom and to consider the different contexts in which services are provided. NEDs also have a particular role in challenging assumptions presented to them, as critical friends to the executive directors who, through their close involvement with day-to-day operations, may not be able to see the wood for the trees. Using multiple different sources of information to triangulate conclusions can illuminate issues that may be masked when data is flattened as it is collated and summarised across multiple units.

Sensitivity to operations

18. HROs build systems of real-time (or as near to real-time as possible) information so that issues can be identified early or even predicted. This occurs at all levels of the organisation and includes bringing together staff with different skill sets and professions on a regular basis, such as daily or shift-based 'safety huddles'.¹⁵ These perform a two-way function where staff can raise things that they have niggling concerns about (described as 'weak signals') but which do not warrant a formal report, and also where current constraints and challenges can be shared

¹⁴ P. Baybutt (2014) The ALARP principle in process safety, *Process Safety Progress*, 33(1) - Pages 36-40 – <https://doi.org/10.1002/prs.11599>

¹⁵ S.M. Provost, H.J. Lanham, L.K. Leykum, R.R. McDaniel Jr and J. Pugh (2015) Health care huddles: Managing complexity to achieve high reliability, *Health Care Management Review*, 40(1) – Pages 2-12 – <https://doi.org/10.1097/HMR.0000000000000009>

so that all staff are alert to potential problems and therefore exhibit a high level of vigilance on the increased risks.

19. Medium-term sensitivity to operations can be achieved by audit programmes, including clinical audits (covering both adherence to process and to patient outcomes)¹⁶ and ward or unit accreditation audits.¹⁷ Sensitivity to operations must not be interpreted as lack of confidence in individual staff but as an early warning system for things that may be beyond their individual control.
20. It is important that services are considered in the round and the emphasis is not skewed to one element of performance. Balanced scorecards are a useful way of presenting information in a holistic way, with performance across different strategic goals (e.g. finance, waiting times and complaints) presented together.¹⁸

Commitment to resilience

21. HROs know that they cannot create procedures to anticipate all situations or eliminate all risk and uncertainty. They therefore develop their staff's skills to adapt to changing circumstances.¹⁹
22. HROs have clear processes to learn after the unexpected happens, or when a risk is realised. Staff are encouraged to debrief and discuss how they feel, and how they would act differently in the future. Processes might include, for example, Schwartz rounds, which are structured, monthly, one-hour, confidential forums for healthcare staff to discuss the emotional and social challenges of patient care, rather than clinical problems.²⁰ The aim is both to support the welfare of staff and

¹⁶ E. Maxwell (2017) 'Measuring for Healthcare Improvement' in L. Baillie and E. Maxwell Improving Healthcare – A Handbook for Practitioners. Routledge, Abingdon – Pages 157-174

¹⁷ J. Braithwaite, D. Greenfield, J. Westbrook, M. Pawsey, M. Westbrook et al. (2010), Health service accreditation as a predictor of clinical and organisational performance: a blinded, random, stratified study, *BMJ Quality & Safety*, 19(1) - Pages 14-21 – <https://doi.org/10.1136/qshc.2009.033928>

¹⁸ W.N. Zelman, G.H. Pink and C.B. Matthias (2003), Use of the balanced scorecard in health care, *Journal of Health Care Finance*, 29(4) - Pages 1-16.

¹⁹ M. Sujan (2017) 'High Reliability Organisations: Making Care Safer through Reliability and Resilience' in L. Baillie and E. Maxwell Improving Healthcare – A Handbook for Practitioners. Routledge, Abingdon – Pages 101-114

²⁰ J. Goodrich (2012) Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine*, 105(3) – Pages 117-122 – <https://doi.org/10.1258/jrsm.2011.110183>

to ensure they are able to retain their compassion towards patients in similarly challenging circumstances in the future.

Deference to expertise

23. HROs recognise that standardising practice creates discipline that can increase reliability. However, if it is applied rigidly, it can reduce reliability by preventing staff from reacting swiftly to unexpected or unusual situations. The stated goal of healthcare is person-centred care, which by definition means that care cannot be completely standardised. In these circumstances, reliability (and safety) is maintained by moving away from written protocols and allowing the most expert person closest to the process to make a best decision in relation to the specific incident, regardless of their role title. To do this, managers must ensure that expertise is on hand at all times, even during apparently routine processes. Deviation from standard practice must be justified and recorded and regularly reviewed to ensure that it has provided better outcomes than following generalised rules.
24. Johns Hopkins Medicine in the USA has been working towards high reliability since 2012²¹ and is creating a culture of ‘systems thinking’.²² This means moving from a linear investigation of failures or harm to thinking about the impact of actions across the whole system. An example of systems thinking is the Johns Hopkins Capacity Command Center, which brings data analysts and senior managers together with artificial intelligence tools to make decisions to manage patient care and improve the patient experience.²³

²¹ P.J. Pronovost, C.M. Armstrong, R. Demski, T. Callender, L. Winner et al. (2015) Creating a high-reliability health care system: improving performance on core processes of care at Johns Hopkins Medicine, *Academic Medicine*, 90(2) - Pages 165-172 – <https://doi.org/10.1097/ACM.0000000000000610>

²² R.M. Day, R.J. Demski, P.J. Pronovost, K.M. Sutcliffe, E.M. Kassa et al. (2018) Operating management system for high reliability: Leadership, accountability, learning and innovation in healthcare, *Journal of Patient Safety and Risk Management*, 23(4) - Pages 155-166 – <https://doi.org/10.1177/2516043518790720>

²³ E.M. Kane, J.J. Scheulen, A. Püttgen, D. Martinez, S. Levin et al. (2019) Use of systems engineering to design a hospital command center, *The Joint Commission Journal on Quality and Patient Safety*, 45(5) – Pages 370-379 – <https://doi.org/10.1016/j.jcjq.2018.11.006>

Organisational culture

25. Implementing the principles of HROs requires embedding them in the organisational culture. Culture cannot be dictated, and values cannot be enforced by a Board mandate. Edgar Schein defines culture as 'a pattern of assumptions that a group has invented, discovered, or developed in learning to cope with its problems. These assumptions are considered valid because they have worked well enough to be taught to new members as the correct way to perceive, think, and feel in relation to those problems'.²⁴ Culture emerges from staff experience, and managers can only influence culture through the way they manage staff experiences.
26. A group's shared assumptions are often tacit and unknown to managers unless they actively seek them out. Where management actions do not reflect the stated organisational values, or those actions are ineffective, staff develop an alternative set of assumptions to manage their work. Changing unhelpful or undesirable culture can only happen if there is a good understanding of why it developed in the first place. Without an understanding of how it arose, it can be easy to blame individuals for poor practice without doing anything to prevent it happening again.
27. Where ideal conditions cannot be created due to financial constraints or staff shortages, good managers work with staff to develop practices that are as low risk as reasonably practicable, while they continue to work to improve conditions in order to move towards best practice.

Management competencies

28. The knowledge and skills required for health and social care managers have been subjected to a number of reviews, from the 1983 Griffiths review, which led to the introduction of general managers in the NHS, through a number of Public Inquiry recommendations and NHS-commissioned reviews.²⁵ Since 2013, at least seven reports have been published with recommendations on NHS leadership or

²⁴ E.H. Schein (2010) *Organizational Culture and Leadership* (Vol. 2), fourth edition. John Wiley & Sons.

²⁵ R. Griffiths (1983) *NHS Management Inquiry*. London: Department of Health and Social Security

leadership training in England.²⁶ However, while good management is universally agreed to be important, the evidence basis on what it comprises remains weak.

29. In England, the NHS Leadership Academy was created in 2012 to provide leadership training, but this is not mandatory.²⁷ There have also been calls for regulation of managers – although concerns have been recognised in relation to the danger of double regulation of clinical staff already regulated by the Nursing and Midwifery Council (NMC), General Medical Council (GMC) or Health and Care Professions Council (HCPC) – following the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust, under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (NHS England), which requires that Board members and individuals who perform the functions equivalent to the functions of a Board member are fit and proper to carry out the role.²⁸
30. A review of this requirement was published in 2019.²⁹ It concluded that while obvious issues such as bankruptcy and convictions were being addressed, competence to perform the role was not. This was partly due to the lack of a set of agreed criteria for competencies of Board directors.
31. In England attempts have been made to address this lacuna by the Fit and Proper Person Test Framework and associated guidance to Boards.³⁰

²⁶ D. Berwick (2013) A promise to learn – a commitment to act: Improving the safety of patients in England – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf; D. Dalton (2014) Examining new options and opportunities for providers of NHS care: The Dalton Review – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/383270/Dalton_Review_Summary.pdf; Lord Rose (2015) Better leadership for tomorrow: NHS Leadership Review – <https://www.gov.uk/government/publications/better-leadership-for-tomorrow-nhs-leadership-review>; E. Smith (2015) Review of centrally funded improvement and leadership development functions – https://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2017/10/improv-ldrshp-dev-rev-sept15.pdf; R. Kerr (2018) Empowering NHS leaders to lead – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759623/Ron_Kerr_Report_-_Empowering_NHS_leaders_to_lead.pdf; G. Messenger (2022) Leadership for a collaborative and inclusive future – <https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future>; T. Kark and J. Russell (2018) A review of the Fit and Proper Person Test – <https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test>

²⁷ NHS England Board meeting October 2016 <https://www.england.nhs.uk/wp-content/uploads/2016/10/private-board-item4-appx-b-mar-15.pdf>

²⁸ Care Quality Commission (2022) Fit and proper persons: directors – <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/fit-proper-persons-directors>

²⁹ T. Kark and J. Russell (2018) A review of the Fit and Proper Person Test – <https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test>

³⁰ NHS England (2023, updated 2025) NHS England fit and proper person test framework for board members – <https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members>

32. The Northern Ireland Collective Leadership Strategy³¹ sets a guide for the Health and Social Care system in Northern Ireland, recognising that leadership occurs at all levels of an organisation and the need to invest in developing leadership skills at all levels. The HSC Leadership Centre provides discretionary leadership training,³² however there appears to be no commitment to a minimum level of competence at any grade, either in Belfast Health and Social Care Trust (BHSCT) or any other HSC NI organisation.

Conclusion

33. Good management requires good governance to ensure high-quality services are delivered. While aspects of both can be delegated, they ultimately remain the responsibility of the Board of the responsible organisation.
34. In Northern Ireland, policy direction and commissioning are the responsibility of the Department of Health, while delivery of services commissioned to deliver the policy are the responsibility of HSC Trusts. HSCTs have unitary Boards, meaning that the non-executive and executive directors are equally responsible for this, and it is best practice to have an external review every three years to ensure that the Board has suitable systems and that the Board is using them effectively.
35. Research has demonstrated that good management goes beyond planning services. It requires a constant awareness of events and conditions that might prevent delivery or may prevent good outcomes even if the service is delivered. This includes considering risks but also changes in the conditions in which services are delivered and red flags that service outcomes are deteriorating. This must not be confused with risk appetite (the level of risk an organisation is prepared to tolerate). Managers must also understand the difference between 'work as imagined' (set out in contracts, policies and guidance) and 'work as done' (what is achieved with available resources, and the practices that have developed and are now 'how we do things here' despite deviating from policies). Local managers must have near real-time data to monitor services so they can make

³¹ Department of Health (2020) HSC Collective Leadership Strategy – <https://cec.hscni.net/wp-content/uploads/2020/01/hsc-collective-leadership-strategy.pdf>

³² HSC Business Services Organisation: Leadership Centre – <https://leadership.hscni.net/>

early adaptations where required. A well-managed service that has predicted the potential (or actual) challenges also has a set of contingency plans, well known to staff, that can be swiftly enacted when the unexpected happens, without seeking authorisations from senior management, and consequently prevent destabilisation of the service.

36. Trusts must have systems in place that inform their Boards how the services are being delivered and if the policy objectives are being achieved. Understanding challenges to compliance with the agreed plan for service delivery requires the Board to avoid aggregation of all its services into a single measure of complaints or incidents, but instead to look holistically at a diverse range of measures to build a picture of how each service is working and what the potential threats are. Achieving good management and governance does not happen automatically. It requires leaders and managers to have the knowledge and skills to flexibly respond to complex and changing situations and to have information that allows them to do so in real time.

Summary of the Six Independent Reports Received by the BHSCT Board after 2017

Independent Assurance Team Muckamore Abbey draft report (April 2018) and final report (September 2018)¹

1. A team comprising a Professor of Learning Disability Nursing, a member of Northern Ireland Practice and Education for Nursing and Midwifery and a Belfast Health and Social Care Trust (BHSCT) Adult Safeguarding Specialist were commissioned to provide independent assurance of the response to the safeguarding revelations to the Directorate Governance and Improvement Board. The team noted that a number of key policies were overdue for review by up to four years.
2. The team recommended that there should be a standardised approach to the review of decisions about staff suspensions or restriction of duties, and that these should be recorded individually and not in group emails. It also advised that the unintended consequences of interim decisions should be actively considered and reflected in the notes.
3. The team noted that concerns about staffing levels had been documented on the Risk Register since 2014, supported by information provided from the electronic rostering system. Staff had raised concerns about the impact of staff shortages, including *'lack of staff to allocate to take patients out on social outings'* and *'cancelled training sessions resulting in poor compliance with mandatory training updates'*, but staff shortages persisted.

¹ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 4 (Exhibit 1) – Draft Report of Independent Assurance Team Muckamore Abbey Hospital April 2018; Page 24 – (Exhibit 2) – Final Report of Independent Assurance Team Muckamore Abbey Hospital September 2018

4. The team recommended clear processes for escalating concerns about staffing levels and the ability to provide safe nursing care to the Executive Director of Nursing, and that a Task and Finish Group should be established to review and analyse the use of e-rostering, including robust monitoring of staff working additional shifts above their contracted hours.

SAI Level 3 'A Way to Go' report (November 2018)²

5. Following the viewing of CCTV in September 2017, a Level 3 serious adverse incident (SAI) independently chaired review was commissioned in January 2018.
6. The review team noted little consistency of recording across safeguarding files, meaning it was not possible to determine how closely safeguarding investigations between 2012 and 2017 had adhered to Trust and regional policies. There was evidence of confusion between complaints and safeguarding processes, with safeguarding not progressing if the patient (or their family) did not wish to make a complaint. In other cases, patient testimony was sometimes dismissed as '*patient has a history of making complaints*'.

Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust (2019)³

7. East London NHS Foundation Trust (ELNHSFT) was asked by BHSCT to review services at Muckamore Abbey Hospital (MAH). It found unregistered staff were completing seclusion observations but could not record them directly as they had no access to the electronic record. Seclusion was being instigated in rooms other than the official seclusion room for the service and BHSCT did not have a formal process for the use of segregation (such as patient 'pods'). ELNHSFT was concerned by the number of patients who needed enhanced observations. On most wards, staff did not know how this was reviewed or discontinued, and some

² Margaret Flynn 1st Statement (Evidence Modules) – 24/04/23 – Page 4 (Exhibit MF/1) – A Review of Safeguarding at Muckamore Abbey Hospital A Way to Go November 2018

³ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Page 1572 (Exhibit T06.01) – East London NHS Foundation Trust Report 'Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to BHSCT' Njovana et al August 2019

service users had been on 1:1 or 2:1 observations since. The review team recommended a review of a number of policies.

8. ELNHSFT reported that ward teams were not sure of trends and learning in relation to seclusion practices. Some staff were not aware of the situation report (SITREP) meetings and how these were part of local ward governance processes.
9. The review team noted that admitting people with a learning disability who display challenging behaviour in the absence of a serious mental illness can lead to an increase in challenging behaviour (National Institute for Health and Care Excellence (NICE) guideline NG11, 2015). The team recommended that admissions:

*'... be agreed via an admission panel and that no emergency/direct admissions to specialist hospitals should be permitted. Where a person with a learning disability is experiencing a relapse in their mental health, LD community teams should be available and should work with mainstream adult mental health provisions including using their gateway pathways (crisis teams, home treatment teams, or admission to mainstream mental health units)'.*⁴

Review of Leadership and Governance at Muckamore Abbey Hospital (July 2020)⁵

10. Following the receipt of the SAI Level 3 'A Way to Go' report, the Department of Health (DoH) commissioned a review of leadership and governance, both at MAH and across BHSCT. The team examined three key events: the Ennis Ward investigation, the installation of CCTV, and a complaint about an assault on a patient at the Psychiatric Intensive Care Unit (PICU) on 12 August 2017.
11. BHSCT had governance structures in place; however, the annual discharge of Delegated Statutory Functions (DSF) reports did not provide assurance on how statutory duties were discharged and that there was no challenge at Trust, HSC Board or DoH level regarding the adequacy of reports. There was a lack of

⁴ Martin Dillon 2nd Statement (Evidence Modules) – 26/04/23 – Pages 1588-1589 (Exhibit T06.01) – East London NHS Foundation Trust Report 'Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to BHSCT' Njovana et al August 2019

⁵ Department of Health (2020) A Review of Leadership & Governance at Muckamore Abbey Hospital – <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mah-review.pdf>

continuity and stability at Directorate level and a lack of interest and curiosity at Trust Board level.

12. There was no indication that findings from the Regulation and Quality Improvement Authority (RQIA) triggered actions until the 2019 RQIA Improvement Notices. There was no evidence of analysis of the data or the production of trend data, no indication that staff from different professional groups were voicing concerns about the level or the nature of adverse incidents or complaints, and the Directorate clinical audit meetings did not review the nursing audits undertaken at MAH and instead focused on mental health audits.
13. BHSCCT champions its practice development and quality improvement methods but there was limited evidence that it was used to improve patient care at MAH.

Muckamore Abbey Hospital: Adult Safeguarding File Review (September 2021)⁶

14. A multidisciplinary team reviewed safeguarding referrals from MAH between 1 January 2020 and 30 April 2021 at the request of the DoH. The review focused on two key areas: (a) the appropriateness of the thresholds in operation for initial referral and screening outcomes (based on the Northern Ireland Adult Safeguarding Operational Procedures, 2016),⁷ and (b) the levels of actual and/or potential harm caused to patients by the incidents that had been reported.
15. Consistent concerns were identified in relation to the quality of record-keeping, with a lack of firm evidence in many cases. The actual and/or potential harm caused to patients was often difficult to determine and the impact on the patient was often not well articulated.
16. A number of the incidents could have been dealt with in other ways. However, in the context of issues at MAH there was a lowered threshold. Physical abuse of a minor nature was the dominant issue noted but there was limited attention given

⁶ Owen Barr 2nd Statement (Evidence Modules) – 25/04/24 – Page 47 (Exhibit 3) – Muckamore Abbey Hospital: Adult Safeguarding Review File September 2021

⁷ Health and Social Care Board (2016) Adult Safeguarding Operational Procedures – https://online.hscni.net/wpfd_file/adult-safeguarding-operational-procedures/

to the potential for emotional distress, with an emphasis on physical examination. A significant number of incidents were linked to a small number of patients, but there was a lack of evidence that these were being considered in the round and they seemed to be largely dealt with as entirely separate incidents.

17. There was variation in records kept by Designated Adult Protection Officers (DAPOs). Some were very thorough and comprehensive, with clear documentation of professional decision-making. Others were much less so, with the factors considered in their decision-making not recorded. There was limited evidence of protection plans being reviewed and no clear information on the limitations the protection plans might place on the social or therapeutic activities patients would be able to engage with.

Independent Review of the Learning Disability Resettlement Programme in Northern Ireland (2022)⁸

18. The review concluded that leadership and governance with regard to the resettlement programme in Northern Ireland had been less than adequate at all levels. The HSCB had made efforts to support regional coordination of the resettlement programme, but these were not effective; in particular, HSCB monitored rather than managed performance. Across registered care and supported living settings in NI there were approximately 2,500 places for people with learning disabilities, but commissioners and resettlement teams tended not to engage with providers to consider potential existing opportunities, and the overall trend within supported living schemes was towards smaller size provision, with the largest number of schemes offering three places. However, the biggest single issue and risk facing the range and quality of the provision was workforce.
19. Following the revelations on CCTV, the focus at BHSCT shifted away from resettlement to crisis management of MAH. Northern HSCT and South Eastern HSCT had plans that were proactive and generally well progressed, but the BHSCT plans failed to move beyond the preliminary stages. The executive directors reassured the non-executive directors of the Trust Board that there were

⁸ Bria Mongan 1st Statement (Organisational Modules) – 14/03/24 – Page 3 (Exhibit 1) – Independent Review of the Learning Disability Resettlement Programme in Northern Ireland July 2022

plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust.

Previous Inquiries into Services at BHSCT

Inquiry name, type and publication date	HSC Trust involved	Summary	Recommendations
Inquiry into Hyponatraemia-related Deaths (IHRD) Inquiry under Article 54 and Schedule 8 of the Health and Personal Social Services (Northern Ireland) Order 1972, commissioned by the Department of Health, Social Services and Public Safety Published January 2018	Various (including BHSCT for all five children)	The Inquiry considered the care and deaths of five children over an eight-year period, across three HSC Trusts, concluding four were avoidable. All five children died in the Royal Belfast Hospital for Sick Children, three having been transferred from other Trusts in critical condition. All were being treated for different conditions. The cause of death for all was the mismanagement of fluid replacement therapy, in particular the use of intravenous hypotonic saline solution. This was a result of lack of knowledge and lack of monitoring of electrolytes. The Inquiry found lessons were not learnt from each case as staff were not candid about what had happened and the families were not told of the failings.	96 recommendations relating to: ➤ Duty of candour ➤ Leadership ➤ Clinical paediatric standards ➤ SAI reporting and investigation ➤ Trust governance ➤ Training and learning ➤ Culture and litigation
Belfast Health and Social Care Trust (BHSCT) Audiology Patient Recall Internal review, reported to Public Health Agency (PHA) Published November 2019	BHSCT	In May 2018 the Irish Health Service Executive (HSE) published its report into audiology services provision in Mayo and Roscommon between 2011 to 2015. During this time, BHSCT had provided audiologists to work in Mayo and Roscommon. In June 2018, BHSCT was advised that one of its employees was at the centre of concerns. BHSCT commissioned an internal review, which identified 45 patients' records that were incomplete and missing key	The issues were primarily record-keeping and documentation. The review highlighted the importance of robust clinical record-keeping and data governance.

		information (this related to a different audiologist to the one at the centre of the HSE report), suggesting wider governance failings. In May 2019 an audit of all the adults seen by the audiology team at weekend clinics was commissioned and submitted to PHA.	
Independent Neurology Inquiry Public Inquiry under the Inquiries Act 2005 Published June 2022	BHSCT	Following an internal Trust review of a sample of patients of one consultant neurologist, a larger review was carried out by the Royal College of Physicians, with a final report received on 26 April 2018. Concerns were raised around the use of unorthodox interventions. A non-statutory public inquiry was announced 10 May 2018. The Inquiry was subsequently converted to a statutory public inquiry on 11 December 2020 in order to consider the Trust's system of governance. The Inquiry found a 'truly extraordinary' rise in the use of a new intervention between 2014 and 2017, but that none of the existing BHSCT management arrangements were effective in querying or questioning this. Concerns had been raised by doctors in training, nursing staff and patients (through the complaints process) but were often not properly recorded. Concerns raised in different systems were not integrated and information remained in silos.	The Inquiry made 76 recommendations, some of which were for independent providers and the General Medical Council. Those relevant to BHSCT include: ➤ Healthcare organisations should promptly investigate safety concerns. The existence of a separate legal process (such as a coroner's hearing or litigation, including criminal proceedings) should not prevent a healthcare organisation from investigating patient safety concerns promptly, without waiting for the outcome of any separate legal process. ➤ Healthcare organisations should ensure that complaints are either upheld, dismissed or appropriately determined, and this conclusion shared with all parties, including the complainant. ➤ Healthcare organisations should

Appendix 6

			make it clear that staff are expected to follow national and local patient management guidelines. If there are pressing reasons not to do so, this must be explained fully in the notes. ➤ Healthcare organisations should make clear to their employees that when an issue that may have patient safety implications is raised, a robust process needs to be put in place to provide positive assurance that patient safety is secure, rather than assuming that there is an alternative explanation. Separately to the Public Inquiry, in 2018 the Department of Health announced a neurology workstream to consider a potential neurology redress scheme. A project board was established and work undertaken to identify a way forward. The board decided that: 'Taking account of the complexities of neurology cases, a neurology redress scheme or early resolution scheme is not a suitable method to address neurology recall claims. It is clear a "one size fits all" scheme would not be in the best interests of those affected.

Appendix 6

			It is only fair that each case is considered on its own merits to ensure a just outcome for those affected, and to ensure that patients receive the compensation they deserve where appropriate, subject to legal and expert opinion on liability and causation'.

Acronyms

A

A&E	ACCIDENT AND EMERGENCY
ACS	ACCOUNTABLE CARE SYSTEMS
ADB	ACUTELY DISTURBED BEHAVIOUR
ADHD	ATTENTION-DEFICIT/HYPERACTIVITY DISORDER
AFM	ACTION FOR MUCKAMORE
AHP	ALLIED HEALTH PROFESSIONAL
AJP	ADULT JOINT PROTOCOL
APGA	ALL-PARTY GROUP ON AUTISM
ARMADILO	ASSESSMENT OF RISK AND MANAGEABILITY OF INDIVIDUALS WITH DEVELOPMENTAL AND INTELLECTUAL LIMITATIONS WHO OFFEND
ASG	ADULT SAFEGUARDING
ASPC	ADULT SOCIAL AND PRIMARY CARE

B

BAF	BOARD ASSURANCE FRAMEWORK
BHSCT	BELFAST HEALTH AND SOCIAL CARE TRUST
BILD	BRITISH INSTITUTE OF LEARNING DISABILITIES
BPD	BORDERLINE PERSONALITY DISORDER
BSO	BUSINESS SERVICES ORGANISATION

C

CAMHS	CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES
CBT	COGNITIVE BEHAVIOURAL THERAPY
CCTV	CLOSED-CIRCUIT TELEVISION
CDU	CARE DELIVERY UNIT
CEO	CHIEF EXECUTIVE OFFICER
CFT	COMPASSION FOCUSED THERAPY
CJI	CRIMINAL JUSTICE INSPECTION
CMO	CHIEF MEDICAL OFFICER
CNO	CHIEF NURSING OFFICER
CPI	CRISIS PREVENTION INSTITUTE

CQC	CARE QUALITY COMMISSION
CRU	CENTRAL REFERRAL UNIT
CSWO	CHIEF SOCIAL WORK OFFICER

D

DAPO	DESIGNATED ADULT PROTECTION OFFICER
DBT	DIALECTICAL BEHAVIOUR THERAPY
DCN	DEPUTY CHARGE NURSE
DETI	DEPARTMENT OF ENTERPRISE, TRADE AND INVESTMENT
DFC	DEPARTMENT FOR COMMUNITIES
DHSS	DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DHSSPS	DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY
DOH	DEPARTMENT OF HEALTH
DOLS	DEPRIVATION OF LIBERTY SAFEGUARDS
DPP	DIRECTOR OF PUBLIC PROSECUTIONS
DRO	DESIGNATED REVIEW OFFICER
DSD	DEPARTMENT FOR SOCIAL DEVELOPMENT
DSF	DELEGATED STATUTORY FUNCTIONS

E

ECT	ELECTROCONVULSIVE THERAPY
EHSSB	EASTERN HEALTH AND SOCIAL SERVICES BOARD
EMDR	EYE MOVEMENT DESENSITISATION AND REPROCESSING
ERRG	EXTERNAL REPORTS REVIEW GROUP

F

FLO	FAMILY LIAISON OFFICER
FOI	FREEDOM OF INFORMATION

G

GAIN	GUIDELINES AND AUDIT IMPLEMENTATION NETWORK
GMC	GENERAL MEDICAL COUNCIL
GP	GENERAL PRACTITIONER

H

HCA	HEALTHCARE ASSISTANT
HCPC	HEALTH AND CARE PROFESSIONS COUNCIL
HCR-20	HISTORICAL, CLINICAL AND RISK MANAGEMENT-20 ASSESSMENT TOOL
HCSW	HEALTHCARE SUPPORT WORKER
HPSS	HEALTH AND PERSONAL SOCIAL SERVICES
HSC	HEALTH AND SOCIAL CARE
HSCB	HEALTH AND SOCIAL CARE BOARD
HSCT	HEALTH AND SOCIAL CARE TRUST
HSENI	HEALTH AND SAFETY EXECUTIVE FOR NORTHERN IRELAND
HSSB	HEALTH AND SOCIAL SERVICES BOARD
HSST	HEALTH AND SOCIAL SERVICE TRUST

I

ICS	INTEGRATED CARE SYSTEM
ICU	INTENSIVE CARE UNIT
IPT	INVESTMENT PROPOSAL TEMPLATE

L

LASP	LOCAL ADULT SAFEGUARDING PARTNERSHIP
LCG	LOCAL COMMISSIONING GROUP
LD	LEARNING DISABILITY

M

MAH	MUCKAMORE ABBEY HOSPITAL
MAPA	MANAGEMENT OF ACTUAL OR POTENTIAL AGGRESSION
MCA	MENTAL CAPACITY ACT
MDAG	MUCKAMORE DEPARTMENTAL ASSURANCE GROUP

MDT	MULTIDISCIPLINARY TEAMS
MDTM	MULTIDISCIPLINARY TEAM MEETING
MEWS	MODIFIED EARLY WARNING SCORE
MHC	MENTAL HEALTH COMMISSION
MHLD	MENTAL HEALTH AND LEARNING DISABILITY
MHO	MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986
MLA	MEMBER OF THE LEGISLATIVE ASSEMBLY
MOU	MEMORANDUM OF UNDERSTANDING
MVPO	MISSING AND VULNERABLE PERSONS OFFICERS

N

NED	NON-EXECUTIVE DIRECTOR
NHS	NATIONAL HEALTH SERVICE
NHSCT	NORTHERN HEALTH AND SOCIAL CARE TRUST
NHSSB	NORTHERN HEALTH AND SOCIAL SERVICES BOARD
NIAO	NORTHERN IRELAND AUDIT OFFICE
NIASP	NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP
NICE	NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE
NICTS	NORTHERN IRELAND COURTS AND TRIBUNALS SERVICE
NIE	NORTHERN IRELAND EXECUTIVE
NIHE	NORTHERN IRELAND HOUSING EXECUTIVE
NIPEC	NORTHERN IRELAND PRACTICE AND EDUCATION COUNCIL FOR NURSING AND MIDWIFERY
NMC	NURSING AND MIDWIFERY COUNCIL
NPM	NATIONAL PREVENTIVE MECHANISM
NWBHSST	NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

O

OPCAT	OPTIONAL PROTOCOL TO THE CONVENTION AGAINST TORTURE AND OTHER CRUEL INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT
OT	OCCUPATIONAL THERAPIST

P

PARIS	PATIENT RECORD SYSTEM
PBS	POSITIVE BEHAVIOURAL SUPPORT
PCC	PATIENT AND CLIENT COUNCIL
PDR	PATIENT DOCUMENT REQUEST
PECS	PICTURE EXCHANGE COMMUNICATION SYSTEM
PEI	PATIENT EXPERIENCE INTERVIEW
PHA	PUBLIC HEALTH AGENCY
PICU	PSYCHIATRIC INTENSIVE CARE UNIT
PIPA	PURPOSEFUL INPATIENT ASSESSMENT
POMH	PRESCRIBING OBSERVATORY FOR MENTAL HEALTH
PPB	PUBLIC PROTECTION BRANCH
PPS	PUBLIC PROSECUTION SERVICE
PRN	PRO RE NATA
PSNI	POLICE SERVICE OF NORTHERN IRELAND
PTSD	POST-TRAUMATIC STRESS DISORDER

Q

QIP	QUALITY IMPROVEMENT PLAN
QNLD	QUALITY NETWORK FOR LEARNING DISABILITY SERVICES
QUB	QUEEN'S UNIVERSITY BELFAST

R

RAG	RED, AMBER AND GREEN RISK GRADING
RIDDOR	REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS
RN	REGISTERED NURSE (ADULT)
RNLD	REGISTERED NURSE (LEARNING DISABILITIES)
RNMH	REGISTERED NURSES (MENTAL HEALTH)
RPA	REVIEW OF PUBLIC ADMINISTRATION
RQIA	REGULATION AND QUALITY IMPROVEMENT AUTHORITY
RUC	ROYAL ULSTER CONSTABULARY
RVH	ROYAL VICTORIA HOSPITAL

S

SAE	SERIOUS ADVERSE EVENT
SAI	SERIOUS ADVERSE INCIDENT
SALT	SPEECH AND LANGUAGE THERAPIST
SEA	SIGNIFICANT EVENT AUDIT
SEHSCT	SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST
SHO	SENIOR HOUSE OFFICER
SHSCT	SOUTHERN HEALTH AND SOCIAL CARE TRUST
SPC	STATISTICAL PROCESS CONTROL CHARTS
SPFM	SOCIETY OF PATIENTS AND FRIENDS OF MUCKAMORE ABBEY HOSPITAL
SPPG	STRATEGIC PLANNING AND PERFORMANCE GROUP
SQV	SAFETY AND QUALITY VISIT
STOMP	STOPPING OVER MEDICATION OF PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE'

T

TDP	TRUST DELIVERY PLAN
TILII	TELL IT LIKE IT IS
TOR	TERMS OF REFERENCE
TYC	TRANSFORMING YOUR CARE

U

UNCRPD	UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES
UTEC	UNTOWARD EVENTS AND COMPLAINTS COMMITTEE

W

WHST	WESTERN HEALTH AND SOCIAL CARE TRUST
WTE	WHOLE-TIME EQUIVALENT

