MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 9TH JUNE 2022 - DAY 4

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

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THE INQUIRY RESUMED ON THURSDAY, 9TH JUNE 2022
AS FOLLOWS:

CHAIRMAN: Thank you.
MR. DORAN: Good morning. 10:30
CHAIRMAN: Good morning.
MR. DORAN: Chair, the Inquiry will hear three opening statements today. First, Joseph Aiken QC, will speak on behalf of the Belfast Health and Social Care Trust. Following a short break, Michael Neeson will then make 10:31
the opening statement on behalf of The Regulation Quality Improvement Authority. And after Mr. Neeson's statement we will have another short break and Conor Maguire QC, will then speak on behalf of the individual Core Participants, represented by O'Reilly Stewart. 10:31
CHAIRMAN: Excellent.
MR. DORAN: I think the original plan was to run into the afternoon, Chair, but I've spoken to all three representatives and we're all confident that the three statements can be accommodated in the morning session. 10:31
CHAIRMAN: Okay. Well that's fine if they can that's all well and good, but obviously I don't want anybody to rush, but if we can do that then that will free up the afternoon for other work. So we'll see. Okay.
MR. DORAN: Absolutely. Just one short matter to bring 10:32
to the attention of the Panel. Mr. McGuinness, who gave the opening statement yesterday for the Department of Health, has asked me to mention this matter. When giving his opening on behalf of the Department he

referred to the Health and Social Care Act Northern Ireland. He referred to the year of the Act as 2002, and he's asked me to remind the Panel that the correct year is of course 2022, and that was in fact the Act that led to the dissolution of the Board. 10:32

CHAIRMAN: Yes, that was picked up by the Panel in fact, but thank you very much.

MR. DORAN: Yes, indeed.

CHAIRMAN: All right. Thank you. Yes, Mr. Aiken. Thank you. 10:32

SUBMISSION BY MR. AIKEN:

MR. AIKEN: Sir, members of the Panel. First an apology, I'm afraid the head cold, not Covid, has not 10:32 entirely cleared and therefore the voice is more croaky than it would normally be. I think the official medical diagnosis is "man flu" in this jurisdiction, but I'll soldier on and anything that's not clear no doubt you'll indicate and I'll repeat it, but I would 10:33 be grateful if you bear with me.

Chairman, members of the Panel, and as you, sir, have already indicated, as has Mr. Doran, I am Joseph Aiken QC. In respect of this Public inquiry I am the 10:33 senior counsel instructed on behalf of the Belfast Health and Social Care Trust, which I will, from now on, refer to before the Inquiry as the Belfast Trust.

I lead Ms. Anna McLarnon who is present with me, Ms. Laura King and Mr. Matthew Yardley, all of the Bar of Northern Ireland. We are instructed by solicitors within the Directorate of Legal Services, which provides legal services to health and social care bodies in Northern Ireland. Those solicitors are Ms. Aideen Ward, Mr. John Johnson and Ms. Jane McManus. Ms. McManus is here this morning.

10:34

Also, in attendance today, members of the Panel, during the making of this opening statement on behalf of the Belfast Trust, is the Chairman of the Belfast Trust, Mr. Peter McNaney, and the Chief Executive of the Belfast Trust, Dr. Cathy Jack. Their presence should be understood to indicate, amongst others, two important matters. First, recognition that the Belfast Trust failed in its core duty to look after the safety of its patients at Muckamore Abbey Hospital. And second, a demonstration of the commitment of the Belfast Trust to the work of this Inquiry, if that's not already evident from the extent of the ongoing collaboration over the provision of very large volumes of relevant documentation to assist with the Inquiry's work.

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The Belfast Trust is grateful for the opportunity to make a short opening statement acknowledging, as I do, that the Inquiry is at a very early stage of its work. The Belfast Trust recognises that the Inquiry's Terms

of Reference are broad and extensive. The Belfast Trust appreciates that for the Inquiry to fulfil its Terms of Reference, then, in addition to examining and acknowledging the unacceptable abuse of patients which occurred at Muckamore Abbey Hospital - a subject to 10:35 which I will shortly return - and trying to understand why it occurred, the Inquiry will also have to examine complex and difficult issues surrounding the provision of learning disability care, or what's now referred to within the Belfast Trust as intellectual disability 10:36 care. It is complex care to provide and it is provided in a context that continues to be challenging.

It is not possible for me to address you in the present context on the myriad of issues that are likely to 10:36 require detailed examination by the Inquiry. However, I can assure the Inquiry, on behalf of the Belfast Trust, that it is committed to engaging openly, honestly and transparently in the Inquiry process. The Belfast Trust has openly encouraged and will continue 10:36 to encourage its relevant staff to participate in the Inquiry and, importantly, to say whatever it is they wish to say to the Inquiry.

The Belfast Trust recognises that some of the evidence 10:37 the Inquiry will gather will not be edifying of the Belfast Trust and its staff. It will be difficult for patients, and former patients, families, and the Belfast Trust and its staff to hear. However, the

Belfast Trust is 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 as safe and as fulfilling for patients as it possibly can. 10:38

The Belfast Trust was formed in 2006 and became operational in 2007. It was formed through the amalgamation of six health and social services trusts in Belfast, often now referred to as Legacy Health and 10:38
Social Services Trusts. The formation of the Belfast Trust was the result of the wider review of public administration in Northern Ireland that commenced in 2002. One of those six Legacy Trusts that merged to form the Belfast Trust, and that is the North and West 10:38
Belfast Health and Social Services trust, had been responsible for the operation of Muckamore Abbey Hospital at the time of the amalgamation that created the Belfast Trust in 2006. That is how Muckamore Abbey Hospital came to be within the Belfast Trust when it 10:39
was formed.

The Belfast Trust recognises that the Inquiry's Terms of Reference extend back to the time when the Legacy North and West Belfast Health and Social Services trust 10:39
was responsible for the operation of Muckamore Abbey Hospital, and the Belfast Trust will do all it can to provide relevant information about matters that predate 2007 and about which the Inquiry considers require

investigation.

The Belfast Trust is, on any analysis, a vast and complex organisation. It is one of the largest Health Trusts in the United Kingdom, and given health and social care is integrated in Northern Ireland, unlike elsewhere in the United Kingdom, it is by far the largest integrated Health and Social Care Trust in the United Kingdom. 10:39 10:40

It delivers a wide array of treatment and care to around 340,000 citizens of Belfast, as well as providing the majority of regional specialist services for Northern Ireland. It operates across a number of hospital sites, such as the Royal Victoria Hospital, the Belfast City Hospital, the Mater Hospital, Musgrave Park, the Royal Jubilee Maternity Hospital, and the Royal Belfast Hospital for Sick Children. The Belfast Trust contains the major teaching and training hospitals in Northern Ireland. 10:40 10:41

The Belfast Trust also provides and operates facilitates at Knockbracken, which provides various inpatient mental health services; Beechcroft, a child and adolescent mental health unit; the Ivy Centre, an inpatient facility for young people with a learning disability and mental health needs; and Muckamore Abbey Hospital, which, as you're aware, provides assessment and treatment for people with severe learning 10:41

disabilities and mental health needs.

The work of the Belfast Trust is not limited to the care and services it provides in hospitals. It also delivers a vast range of health and social care services across Belfast to support service users to live within their communities. Those social care services include the provision of elderly care home placements, domiciliary care to over 4,000 service users across Belfast, the provision and operation of fourteen day centres, five residential homes, five supported living facilities, together with the provision and operation of eleven children's homes. The children's services part of the Belfast Trust has, amongst other things, responsibility for over 950 looked after children. 10:41 10:42 10:42

The Belfast Trust has a workforce of almost 21,500 full and part-time staff. To try to put that in some context: the largest private employer in Northern Ireland employs less than 11,000 people. The combined total staff of the entire Northern Ireland Civil Service employed across all the Government departments here is some 21,400 staff, approximately 500 of whom are in the Department of Health. 10:42 10:43

The Belfast Trust has approximately twice as many employees as each of the other regional Health Trusts in Northern Ireland.

In the intellectual disabilities division of the Belfast Trust, which is where Muckamore Abbey Hospital now sits, and which is within the mental health intellectual disability and psychological services directorate, one of eight service facing directorates that make up the service provision of the Belfast Trust, there are over 2,000 members of staff, over 1,000 of whom are involved in the provision of acute care, and over 1,000 of whom are involved in the provision of community services. 10:43 10:44

The Belfast Trust has an annual budget of approximately £1.9 billion. To try to put that in context, that is about one sixth of the entire core Dell funding provided to the Northern Ireland executive by the United Kingdom government, what would be commonly referred to as "the block grant". Almost half the block grant received into Northern Ireland from Westminster moves through the Department of Health, at present approximately £6.5 billion, just under one-third of that health funding allocation is then utilised to fund the Belfast Trust and the care it provides. 10:44 10:44 10:45

Those statistics demonstrate that the Belfast Trust is a very large health and social care organisation. It has, by necessity, a complex governance structure. The 2020 leadership and governance review - which was

referred to by Mr. Doran QC during his opening statement on Tuesday - variously described the complex governance structure and governance arrangements as "comprehensive and appropriate". As the Inquiry will appreciate, the provision of health and social care is not without risk, and there is a detailed and complex structure in place in the Belfast Trust to try to manage the inevitable risk. It will not always succeed. A system relies on people. It relies on people to do the right thing at the right time. When that does not happen then the system will fail. Trying to understand what lies behind someone not doing the right thing is an examination that is welcomed by the Belfast Trust. It is a problem in the present context that is unlikely to be confined to the staff of the Belfast Trust.

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However, it is also important to recognise that the vast majority of care delivered by the Belfast Trust, in hospitals and in the community, day in and day out, including today, and some of which is extremely difficult and complex care to provide, is delivered safely by a highly skilled and highly dedicated staff where significant risks are managed by the complex governance structure that the Belfast Trust has in place.

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I spoke just now, Chairman, members of the Panel, of the excellent care routinely provided by the staff of

the Belfast Trust. The abuse that occurred at Muckamore Abbey Hospital, some of which has ultimately led to the establishment of this Public inquiry is the antithesis of care. It is a source of shame for the Belfast Trust and its dedicated staff. It involved a betrayal of the values of the Belfast Trust. Those values are upheld day after day, year after year, by the vast majority of the staff of the Belfast Trust. They are adhered to by the very large numbers of staff of the Belfast Trust who provide health and social care and related services to hundreds of thousands of patients and service users every year. 10:48 10:48

In addition to the immediate and unacceptable harm caused to patients, abhorrent as that was, it has further exacerbated the difficulties in operating Muckamore Abbey Hospital, examples of which are set out in the two reports that Mr. Doran QC referred you to on Tuesday and which preceded the work of this Inquiry. 10:48

The Belfast Trust has, rightly, on a number of occasions since the summer of 2017, publicly apologised for the abuse that occurred at Muckamore Abbey Hospital. Before I, at the first opportunity during the Inquiry's public hearings, give an apology on behalf of the Belfast Trust to all of the patients affected by abuse at Muckamore Abbey Hospital and to their families, I want to refer the Panel to some of what the Belfast Trust has already said on the subject. 10:49 10:49

On 26th July 2018, following a newspaper report about the growing number of staff suspensions at Muckamore Abbey Hospital arising from the Belfast Trust's ongoing review of CCTV footage, and due to the growing realisation of the extent of what was being uncovered, the Belfast Trust issued a public statement that said: 10:50

"From the outset, the Belfast Trust wishes to apologise unreservedly to those patients and to their families who have been affected by treatment which falls significantly below acceptable professional standards and which our patients have every right to expect. We are in the process of meeting with the families so that we can apologise to them directly and to explain in further detail the actions we are taking. We wish to assure all of the patients who we care for in Muckamore Abbey Hospital, and their families, that their safety is our absolute priority at all times. An adult safeguarding investigation was initiated." 10:50 10:50 10:51

- as the quotation went on:

"...in September 2017, following reports of inappropriate behaviour and the alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital, one of which was the Psychiatric Intensive Care Unit. At that time we took swift action and suspended four members of staff. Since then, we have 10:51

put in place enhanced arrangements to ensure high standards of care are maintained. As part of the ongoing investigation and a review of archived CCTV footage, a further number of past incidents have been brought to our attention in the last week. Due to the serious nature of this evidence we have taken immediate action to suspend nine staff, the majority of whom are nurses, and we are currently in the process of interviewing ten further staff who were reported to us as witnesses to these events. 10:52

Belfast Trust has secured the services of an expert panel, which includes a carer, to independently review the standard of care in Muckamore Abbey Hospital."

Chairman, members of the Panel, that was the position at the time of the statement made in July 2018, and the statement concluded:

"This regrettable and unacceptable situation in no way reflects the work of our 500 dedicated and professional staff who provide excellent care every day to the 80 patients in Muckamore [as it was at the time]. Finally, we wish to emphasise our profound sadness at this situation and our commitment to ensure patients are cared for safely in Muckamore Abbey Hospital."

On 24th September 2018 - so two months later - which was the day that representatives of the Belfast Trust

met with families affected by abuse to discuss the Draft Level 3 Independent Serious Adverse Incident Report, which, as you know, is entitled "A review of safeguarding at Muckamore Abbey Hospital - a way to go", the Belfast Trust made the following public apology: 10:53

"Today senior trust staff met with families to discuss the findings and draft recommendations of the report commissioned by Belfast Trust into a review of safeguarding at Muckamore Abbey Hospital. We want to place on record our sincere apologies to those patients and their families affected by staff behaviours which fell significantly below professional standards and were unacceptable. An adult safeguarding investigation was initiated in September 2017 following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the PSNI and adult safeguarding social workers. We have taken..." 10:53 10:54 10:54

- the statement went on:

"...decisive action, which included placing, at that time, 13 members of staff on precautionary suspension. We're actively working on improving leadership and management arrangements at Muckamore Abbey Hospital with the goal of ensuring that the voices of patients, 10:54

family carers, advocates and others are clearly and effectively part of the future arrangements in Muckamore Abbey Hospital. A director oversight group led by the director of nursing and the director of then the adult social and primary care directorate is in place." 10:55

The statement went on:

"Everyone has the right to be safe and free from harm. Safeguarding means having measures in place to protect human rights, health and wellbeing, particularly for vulnerable people. In recognition of this, the Trust separately commissioned a fully independent team to undertake a review of the broader factors in Muckamore Abbey Hospital to provide a clear picture as to what happened, and to make recommendations on how to improve safeguarding. 10:55 10:55

The review team brought a wide range of experience, perspectives and expertise as advocates, practitioners clinicians, researchers and managers in service provision for people with learning disabilities and autism. The findings of the review team highlighted that improvements are required in leadership and management, adult safeguarding approaches, advocacy, access to meaningful activities for patients and physical healthcare. We fully accept all the findings and will now work to ensure these are delivered." 10:56 10:56

The statement went on that:

"The report strongly urges the Trust and the wider health and social care and housing organisations to redouble their efforts to ensure that patients do not have to live in hospital environments. It recommends patients are enabled to live full lives in the community with access to the right specialist multidisciplinary support in the right accommodation. The key recommendations were..." 10:57 10:57

- and I quote:

"No one should have to live their lives out in hospital. The report recommends a renewed commitment to enabling people with learning disabilities and autism to have full lives in their communities. 10:57

Secondly, to delivery robust multidisciplinary community services which recognise the full range of needs of people and families throughout their lives; and, thirdly, that assessment and treatment units closer to home and effective long-term quality accommodation options are provided." 10:57 10:58

The Belfast Trust went on to say:

"We are committed to ensuring patients are cared for

safely in Muckamore Abbey Hospital and we recognise and pay tribute to the many highly skilled and dedicated staff who remain working in Muckamore Abbey Hospital."

The statement concluded: 10:58

"We wish to emphasise our commitment to openness and transparency to families and others in relation to sharing information appropriately. We are truly sorry that we have let our patients and their families down. 10:58 Our priority now, and in the future, is to engage with the patients, families, staff, the Department of Health and the Health and Social Care Board (as it was at the time) to deliver a future model of care for learning disability and autism." 10:59

Having received the final version of the safeguarding report, "A review of adult safeguarding at Muckamore Abbey Hospital - a way to go", the Belfast Trust met with the families of patients in order to share and 10:59 discuss the content of the report with them. Having done so, the Belfast Trust publicly acknowledged on 11th December 2018, and I quote:

"Following receipt of the final report of the expert 10:59 independent team reviewing safeguarding at Muckamore Abbey Hospital, the service director of the Trust, alongside the independent Chair of the review team have this week met individually with the families of those

affected to share and discuss the report with them. The Trust has previously met with families in late September to discuss the findings and recommendations of the draft version of the report. At each meeting with the families this week Belfast Trust, again, wholly and unreservedly apologised for the unacceptable behaviour of some members of staff, which is a matter of profound regret. 11:00

On 15th February 2019, when the Belfast Trust published a summary of the SAI report..." 11:00

The "a way to go" report.

"...the Belfast Trust said publicly that it: 11:00

"Reiterates its unreserved apology to those families who have been affected by staff behaviours which fell significantly below professional standards and our profound regret in letting parents and family carers down. The Trust gives its full assurance that it welcomes ongoing scrutiny and is committed to ensuring that patients are cared for safely in the Hospital, that a positive way forward is provided for patients and families and that the recommendations in the review are realised." 11:01 11:01

Shortly thereafter, on the evening of 18th February 2019, the Chair of the Board of the Belfast Trust,

Peter McNaney, and the then Chief Executive of the Belfast Trust, Martin Dillon, met with families to restate in person the Belfast Trust's previous apologies for the unacceptable behaviours of staff in Muckamore Abbey Hospital and to discuss the proposals to respond to the recommendations of the "a way to go" Serious Adverse Incident Report. 11:01

The present Chief Executive of the Belfast Trust, Dr. Jack, took up her role in 2020. On 5th August 2020, following the publication of the leadership and governance report commissioned by the PHA and HSCB, as it was then, at the request of the Department of Health, that's the Bingham, Devlin and Reynolds report entitled "A review of leadership and governance at Muckamore Abbey Hospital", Dr. Jack made a video statement on behalf of the Belfast Trust in response. Dr. Jack said, and I quote: 11:02 11:02

"I want to put on the record my deep sense of shame and profound regret that this happened within the Belfast Trust. Some of the most vulnerable who were entrusted to our care were maltreated and harmed, and for that I am truly sorry. We failed these patients and their families and we betrayed their trust. Today..." 11:02 11:03

- said Dr. Jack:

"...I pledge my commitment and that of my senior team

that we will tirelessly work to ensure that Muckamore Abbey Hospital is a safe place for our patients. We need to rebuild trust and confidence, and I do not underestimate this challenge, and this will be difficult given the scale of hurt we have caused." 11:03

Dr. Jack went on to say:

"The CCTV has given a voice to our patients and tells their story that they could not tell themselves. How an organisation cares for the most vulnerable determines who we are and what we stand for, and that is the responsibility of everyone who works here. 11:03

Muckamore Abbey Hospital..." 11:04

- said Dr. Jack:

"...is a different place today, much safer, but still not perfect. Incidents do still happen, and will happen, but I am confident that with the systems and checking in place, including ongoing monitoring of CCTV and the new management team who are nurturing a different culture, these incidents will be detected promptly and not allowed to perpetuate unseen." 11:04 11:04

As well as unreservedly apologising, Dr. Jack was acknowledging, as I do on behalf of the Belfast Trust before the Inquiry, that the provision of high quality

intellectual disability care is challenging. Realistically it will not be provided without further incidents occurring. Physical intervention will unfortunately at times be necessary. Difficult situations develop that can and do mean that staff and 11:05
patients can experience injury, sometimes serious injury. It can be a very difficult work environment for staff. No system, no matter how well developed and implemented, will always prevent incident or injury in the type of dynamic and difficult situations that can 11:06
arise and are an unfortunate part of caring for patients with highly complex needs and behaviours. However, that is entirely different from staff abusing highly vulnerable patients. That cannot and never will be acceptable in the Belfast Trust. That abuse was not 11:06
and is not acceptable, is demonstrated by the response of the Belfast Trust.

By 24th May 2022 - so this year - arising from CCTV viewing by a dedicated adult safeguarding team, some 83 11:07
members of staff had been placed on precautionary suspension and a further 68 members of staff have been placed on a form of supervision and training. On any level, those are remarkable and disturbing statistics. No doubt the response was not perfect, responses to 11:07
crises rarely are, but nonetheless extensive steps have been taken to deal with the quite exceptional situation that developed following the viewing of CCTV from Muckamore Abbey Hospital relating to a period of months

in 2017. The consideration of how that quite exceptional situation was and is being managed will itself, no doubt, be a subject from which learning can be derived. However, the Belfast Trust does not seek to say that 2017 is the only time during the history of Muckamore Abbey Hospital when staff conduct towards vulnerable patients in their care unfortunately met the broad definition of abuse as set out in paragraph 5 of the Terms of Reference of this Inquiry, and was consequently unacceptable. 11:08 11:09

That is why the apology I now give on behalf of the Belfast Trust is to all patients affected by abuse by staff at Muckamore Abbey Hospital at whatever point in time that abuse occurred. 11:09

Today, Chairman, members of the Panel, before the Inquiry, on behalf of the Board of the Belfast Trust, and the Chief Executive and her senior executive team, I, on behalf of the Belfast Trust, give an unreserved and unequivocal apology to all those patients, and their families, who suffered abuse at Muckamore Abbey Hospital. 11:09

Whilst there will, of course, have to be a detailed examination of procedures and systems, scrutiny of the adequacy of various responses to incidents that occurred over the time period being investigated, and a potentially very important discussion as to the correct 11:10

answer or answers to the "why" question posed by Mr. Doran QC, it must continue to be heard loud and clear that this formal apology to all those patients and their families who suffered abuse at Muckamore Abbey Hospital stands regardless. 11:10

The Belfast Trust is ashamed that some of its staff employed in caring professions were involved in the abuse of individuals living in Muckamore Abbey Hospital, individuals who were, and are, amongst the 11:11 most vulnerable patients cared for by the Belfast Trust. The Belfast Trust is profoundly sorry that occurred. Abusive behaviour has no place in the Belfast Trust. It is against the values of the Belfast Trust and every professional Code of Conduct that 11:11 applied to the staff concerned. The Belfast Trust is determined to do all that it can to root it out. Only by this means can families be assured that when they entrust their loved ones to the care of the Belfast Trust, their loved ones are as safe as they can 11:12 possibly be and that their loved ones are receiving the highest quality care that the Belfast Trust can provide.

Some other staff of the Belfast Trust allowed some of 11:12 the abuse that occurred and which they witnessed to go unchallenged and unreported. As well as perpetrating abuse, walking past abuse is not acceptable; it is behaviour that is also contrary to both the values of

the Belfast Trust and to every professional Code of Conduct that applied to the staff concerned. The Belfast Trust is profoundly sorry that that occurred.

Failing to recognise unacceptable behaviour by other staff, or turning a wilful blind eye to unacceptable behaviour that was recognised, will render care unsafe. The Belfast Trust is clear and unequivocal; that can have no place in the Belfast Trust. 11:13

Further, the Belfast Trust recognises that the individual failings of the staff who abused patients, or of the staff who failed to report and escalate abuse they witnessed, also means that the governance systems operated by the Belfast Trust, however well developed in principle, failed to prevent abuse, failed to detect abuse when it occurred or, when detected, failed to escalate the fact it had occurred. The Belfast Trust apologises for those systems failures. It is a fact that governance systems, however well developed in principle, rely on human beings. Consequently, there will be times when they do not function as designed and fail as a result. 11:13 11:14

The Belfast Trust, Chairman, members of the Panel, recognises that it can be of little comfort to patients abused at Muckamore Abbey Hospital, and their families, that significant changes have since been made at the Hospital by the Belfast Trust. It will no doubt be 11:14

hurtful that the changes can be said to arise as a result of the abuse they suffered and which has since been brought to light.

It does mean that Muckamore Abbey Hospital, though obviously not perfect, is a much safer place for patients to live today. While work continues at the Belfast Trust, and as part of a wider regional programme to develop the opportunities for patients with intellectual disabilities to live and be supported in a community setting rather than in a hospital. 11:15 11:15

With this, I conclude: The Belfast Trust, though profoundly sorry that it is necessary, welcomes a detailed and fair investigation from the Inquiry in respect of the matters that fall within the Inquiry's detailed Terms of Reference, which are both broad in scope and time. 11:16

The Belfast Trust pledges to play its part, including through extensive document provision, in helping the Inquiry, amongst other things, to establish the facts of what occurred, what may have caused what occurred, and what might be learned to improve the provision of intellectual disability care in the future, both in Northern Ireland and elsewhere. However, the Belfast Trust will not lose sight of the fact the events that led to the Inquiry should never have occurred in the first place, and that they did is something about which 11:16 11:16

the Belfast Trust will remain genuinely sorry.

END OF SUBMISSION BY MR. AIKEN

CHAIRMAN: Mr. Aiken, thank you very much indeed. 11:17
Thank you for struggling through your cold. I'm pleased to see, if I may say so, the attendance of Mr. McNaney and Dr. Jack, which I hope reflects the importance that the Trust places on the Inquiry and the cooperation that we will receive, and I also welcome 11:17
your words encouraging your staff, the Trust staff to come forward to the Inquiry either, obviously, under the auspices of the Trust, or if they want to come forward independently, and I would echo those words, and I am grateful for them. 11:18

We will now take a short break. At some point this morning I am going to read out a statement in relation to the dissemination of material to the Core Participants and the rules that are going to apply to 11:18
that, but I think we probably all need a break now. So we'll take - if we take our morning break of 15 minutes now, because I think the addresses that are going to follow are probably going to be a bit shorter than those of the Trust. Thank you very much. 11:18

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIRMAN: Thank you. Yes.

SUBMISSION BY MR. NEESON:

MR. NEESON: Yes. Good morning, Chair, and members of the Panel. My name is Michael Neeson. I appear on behalf of the RQIA. I'm instructed by Caroline Hannon of the Directorate of Legal Services. I am assisted by Daniel Lyttle of counsel. 11:37

Might I take this opportunity to introduce to the Panel and the wider Inquiry, the Chair of the RQIA who is in attendance, Christine Collins, and Briege Donaghy, the Chief Executive Officer. 11:38

Chair, and members of the Panel, on behalf of the Regulation and Quality Improvement Authority, the RQIA, I welcome the opportunity to provide a short statement to this Inquiry. 11:38

At the outset, the RQIA wishes to acknowledge the sincere and ongoing distress experienced by the victims of abuse at Muckamore, and the devastating impact this has and continues to have upon the families. The RQIA recognises failings in the oversight of the care provided to the patients in Muckamore and apologises to the victims and their families that it did not uncover the abuse they suffered. 11:38

The RQIA deeply respects the courage and resolution of

all those who have campaigned for this Inquiry and those who have come forward to provide important evidence to it. Their commitment, dedication and determination to have their voices heard will ensure this Inquiry is searching and open, and trust that it shall lead to lasting change. 11:39

The RQIA undertakes to engage fully and support this Inquiry. This is evidenced by the recent creation of a dedicated inquiry support team to ensure that all relevant evidence is sourced and available. As the body tasked with the oversight and provision of advice to the Department on the quality and availability of services, as well as encouraging improvement within the health and social care sector in Northern Ireland, the RQIA welcomes the Inquiry's investigation. 11:39 11:40

The authority recognises that the persistence of bad practice referred to by the Chair in his opening remarks, which occurred within Muckamore, indicates a lack of robust and effective oversight to keep people safe. Safeguarding people is at the cornerstone of the RQIA. The deeply distressing events in Muckamore have led to RQIA undertaking a comprehensive review of its practices and procedures to identify actions and areas of improvement, both within the RQIA itself and in its oversight of health and social care services. It may, Chair, members of the Panel, be helpful if I give a brief overview of the role and functions of the RQIA. 11:40 11:40

I should say, much of what I'm going to say in this preliminary address will be received in much greater evidence in due course by the Inquiry.

The RQIA was established by the health and personal Social Services Quality Improvement and Regulation Northern Ireland Order 2003, for the sake of convenience I shall refer to that from here in as the 2003 order. The RQIA is responsible for keeping the Department informed about the overall state and provision of services and, in particular, about their availability in quality and encouraging improvement in the quality of those services by conducting reviews of health and social care governance arrangements against overall quality standards, thematic service reviews, and reviews commissioned by the Department. 11:41 11:41 11:42

The 2003 order created a new legal framework for the oversight of the quality and availability of health and social care services in Northern Ireland and extended regulation and quality improvement to a wider range of services. 11:42

In April 2005, the Regulation Improvement Authority, which was subsequently renamed The Regulation Quality Improvement Authority by reason of the 2009 Health and Social Care Reform Act, began to function as the independent regulator of health and social care services in Northern Ireland. It was not, however, 11:42

until 2009, under the terms of the 2009 Reform Act, that the RQIA took over responsibility for the oversight for the care and treatment of patients with mental health and learning difficulties from the Mental Health Commission. 11:43

The overall remit and role of the RQIA are set out within Article 4 of the 2003 Order, which specifies the service providers who are subject to its oversight. It imposes the general duties of keeping the Department of 11:43 Health informed about the provision of services and, in particular, about their availability and quality and encouraging improvement in those services.

The RQIA has responsibility, under Part 3 of the 2003 11:43 Order, to regulate a wide range of prescribed establishments and agencies which are now set out within Article 8 of the 2003 Order.

Chair, I pause to observe that Muckamore does not fall 11:43 within the list of prescribed establishments within Article 8.

In Part 4, Article 35 of the Order sets out specific statutory functions for the RQIA in respect of the 11:44 quality of the provision of health and personal social services by statutory bodies. As a service provided by the Belfast Health and Social Care Trust, the provision of health services at Muckamore Abbey Hospital does

fall within Part 4.

The RQIA functions in accordance with Article 35, non-exhaustively include the conducting of reviews, carrying out of investigations, the making of reports and the carrying out of inspections within certain prescribed circumstances. Again, further detail will be provided in due course about the precise nature of the duties owed by the RQIA. 11:44

Part 6 of the 2003 Order sets out the powers available to the RQIA to record failures, to meet the statements of minimum standards set out by the Department and to set out improvements. Again, the Inquiry will hear evidence concerning the policy and procedures in place concerning the methods of implementation of those matters generally and specifically relevant to Muckamore. 11:45

A primary aspect of RQIA's role is its inspections of services. RQIA's inspections may either be announced or unannounced and seek to examine compliance with required standards in areas appropriate for that service. These inspections are conducted by a team of qualified and experienced staff, including nurses, social workers, pharmacists and estates and finance officers. RQIA published its inspection reports for adult services on its website. At present there are in excess of 150 RQIA inspection records pertaining to 11:45 11:46

Muckamore which can be accessed on the website at RQIA.org.UK. The Inquiry has received those reports as part of the RQIA's disclosure of documents, as well as a number of reports which predate the current website publications. 11:46

It is important to note that the RQIA's duties have grown since its inception in 2005. As noted briefly at an earlier stage in this statement, the responsibility for the protection and interests of mental health and 11:47 learning disability services lay with the Mental Health Commission. Under the 2009 Act, the functions of the Mental Health Commission, as prescribed within the terms of the Mental Health Northern Ireland Order 1986, the 1986 Order, transferred to the RQIA with effect 11:47 from 1st April 2009, and from that date the Mental Health Commission ceased to exist. The RQIA will provide the Inquiry with detailed evidence concerning the merger of those bodies and the work and cooperation between the Mental Health Commission and the RQIA. 11:47

The duties and functions of the RQIA, which devolved from the Mental Health Commission, and which are plainly of relevance to those receiving care within Muckamore, are largely provided within Part 6 of the 11:47 1986 Order, and include the general duty to keep under review the care and treatment of patients and the further duties provided for within Article 85(2) of the order. These include:

"The duty to make enquiry where it appears to the RQIA that there may have been ill-treatment, deficiency in care or treatment, improper detention in hospital or reception into guardianship, or where the property of a patient may be exposed to loss or damage."

Further, as often as the RQIA thinks appropriate to visit and interview in private patients who are liable to be detained in hospital under the Order, to bring to the attention of a number of bodies, including the Department and the Trusts, the facts of any case in which, in the opinion of the RQIA, it is desirable for that body to exercise its function to secure the welfare of any patient. To seek to discharge those duties, the RQIA roles include inspections of a wide range of mental health and learning disability services across Northern Ireland. At a general level, during the course of those inspections, RQIA seeks to engage with service users, with relatives and carers, and seeks the views of nursing staff, health professionals, advocates and other agencies.

In common with all RQIA's inspection activity, each inspection report provides details of the findings and includes a quality improvement plan, detailing those areas of improvement and the associated timescales. The provider is required to provide details of his actions to make the necessary improvements and this

forms an important part of the published inspection record.

The reports of abuse in Muckamore received widespread coverage in 2017. In response to reports of 11:50
inappropriate behaviour and the abuse of patients by some members of staff within Muckamore, as we have heard, the Belfast Trust commissioned an independent team to undertake a serious adverse impact review with a view to examining safeguarding practices at the 11:50
Hospital between 2012 and 2017. As a result of that report, received in November 2018, the RQIA undertook a number of improvements in its approach to inspection and assurance across mental health and learning disability wards. 11:51

From late 2018, the RQIA's inspections of mental health and learning disability wards within Muckamore incorporated what they describe as a whole site and systems approach, using a multidisciplinary team of 11:51
inspectors. Those teams aim to work collaboratively and intensively on site over many days gathering evidence from patients and staff. It is hoped this improved approach is now utilised so that it will continue to strengthen safeguarding and incident 11:51
management. The improved governance and oversight of these systems will serve to improve the RQIA's ability to identify issues such as those which were highlighted in 2018.

Now, by way of some history. Subsequent inspections which took place at Muckamore in 2019 led to the RQIA taking the discharge of its statutory functions to the highest level by writing to the Department of Health and highlighting the grave nature of the concerns it had in terms of significant failings in the way the service was being run and recommending that the Department impose special measures at Muckamore Hospital. 11:52

This ultimately led to the serving of three improvement notices relating to staffing, finance and safeguarding. These improvement notices resulted in evidence improvements in Muckamore during subsequent inspections and monitoring. 11:53

The learning from those matters identified within the report, and from a number of internal reviews and reassessments of policy, has undoubtedly resulted in improvements to processes, both in terms of the nature and quality of inspections and outside of those inspections. The RQIA continues to learn and can point to positive steps taken on foot of that learning. 11:53

Following the 2018 review, the RQIA has reflected upon its previous approach to intelligence gathering and monitoring in respect of mental health and learning disability services. It has undertaken a review of its

approach to the use of intelligence and identified and implemented a number of improvements with the oversight of its executive management team and of the authority. I do not propose to go into detail on the specifics of those improvements, that will be an important part of the evidence that the Inquiry will receive in due course from the RQIA. 11:54

In addition, the RQIA has undertaken significant improvement work to strengthen the assurance and oversight of mental health detention forms and improve its oversight and scrutiny of adverse incident reporting in mental health and learning disability services, which has increased its involvement in safeguarding oversight meetings regarding Muckamore Hospital. The RQIA continues to work to strengthen the input of relatives and service users during its inspections. 11:54 11:54

Chair, members of the Panel, it is important to recognise that the RQIA must operate within the constraints of the legislative framework on which it is founded. The RQIA has full confidence that those individuals tasked with undertaking the inspections and reviews at Muckamore carried out their duties in good faith and to the best of their abilities, however within the confines of policies and historic practices and procedures. 11:54 11:55

As the Inquiry has heard, the Department of Health commissioned leadership and governance review published in 2019, and this recognised and made recommendations regarding the limitation of the regulatory framework within which RQIA operates, and the gap in the RQIA's functions when compared to those relevant to, for example, the Care Quality Commission, the CQC. 11:55

The authority welcomes the 2018 review and the recommendations to strengthen the regulatory framework which would enable RQIA to effectively discharge its role in the safe care and protection provided to those in hospitals, including Muckamore. 11:56

It is of note that the Terms of Reference provide that the Inquiry shall examine the relevant primary and secondary legislation, and the regulatory framework, and the other matters set out within those Terms of Reference, and shall consider the adequacy of these to provide a framework to prevent abuse of patients with mental health conditions or learning difficulties in Muckamore and other settings within Northern Ireland. 11:56

The RQIA is committed to ensuring that the failings which occurred in the provision of care in Muckamore never happen again. 11:56

The RQIA will engage in an effective candid and open manner in with the public inquiry. It recognises and

embraces the positive opportunity afforded to it in working with a forward-looking inquiry. The RQIA embraces the broader and wider review referred to by counsel for the Inquiry in his opening given the extent of the Terms of Reference, and an examination of the roles of the main stakeholders within the broader HSE system. 11:57

The RQIA wishes to maintain focus upon the objects of keeping people safe and driving improvement across health and social services in Northern Ireland and looks forward to the assistance of this Inquiry in doing so. Thank you. 11:57

END OF SUBMISSION BY MR. NEESON 11:58

CHAIRMAN: Mr. Neeson, thank you very much indeed, and welcome, also, to Ms. Collins and Donaghy, again which I'll take to demonstrate their public commitment to assisting this Inquiry throughout its existence. 11:58

STATEMENT FROM THE CHAIRMAN

CHAIRMAN: Before we take a short break before the final address, I want to turn to the statement that I mentioned earlier in relation to how we propose to disseminate material to Core Participants and the rules that are going to apply to that dissemination via the Box system. 11:58

There are a number of competing interests which I've had to weigh up in formulating these rules. On one hand, of course, is the importance that this public inquiry is indeed public and that Core Participants have the access that they need to view the material so that they can assist the Inquiry. I also have to take account of the great sensitivity of much of the material that we will be dealing with, much of which is going to be special category information for GDPR purposes. And I also have to consider the sort of material that we may receive in the future which will include, by way of example, material from staff, and potentially even whistleblowers and others, who will reveal highly personal and sensitive information. 11:59

Let me turn to the statement. This is going to be published on the Inquiry website, so please don't feel you need to make a note as I read it out. It will be published before or at lunch, I imagine. 12:00

This statement relates to the sending of material to Core Participants by the Inquiry and the systems in place to protect the sensitivity of the material being disclosed. 12:00

Given the sensitivity of the material to be disclosed, the following requirements are being deemed necessary by the Chair to protect the information and to ensure

that every Core Participant can have equal access, subject to any restriction order.

1. All Core Participants will be able to view the material disclosed by the Inquiry subject to any restriction order placed on it by the Chair; 12:01

2. The system for disclosure will be via the Box document system employed by the Inquiry;

12:01

3. Prior to being provided with access to Box, every Core Participant, which means in the case of Groups 1, 2 and 3, each individual who is a Core Participant, and in relation to organisations, all those within the Core Participant organisation who wish to view material must sign a confidentiality undertaking. Each individual Core Participant in Groups 1, 2 and 3, and within the Core Participant organisations, will have a unique access log-in specific to them and which is only accessible using their e-mail address; 12:01 12:02

5. In relation to designated legal representatives, each person requiring access must sign an undertaking. The firm - that means the solicitor's firm involved - will be responsible for ensuring the confidentiality undertaking is fully complied with; 12:02

6. Each counsel requiring access will be asked to sign a confidentiality agreement and will be provided access

using an e-mail log-in;

7. No individual may pass on any material received by them to any person, nor publish it in any way. This does not prevent individual Core Participants discussing the content of the material with their designated legal representatives and counsel; 12:02

8. Each user will find that every document is watermarked with their individual identity; 12:03

9. Individual users who are not legal representatives will have viewing rights only. They will be able to view all the material disclosed but not download or print it; 12:03

10. Designated legal representatives will have the ability to download, and once saved separately to annotate, mark and print material. Further explanation and training can be given by the secretary to the Inquiry; 12:03

11. Special arrangements will be made for those who have signed a confidentiality agreement but do not have access to an electronic system which allows them to view disclosed material on Box. The Inquiry will allow the designated representatives for such individuals to assist them to view any relevant material electronically. Alternatively, printed material may be 12:03

shown by the designated representatives to individual clients, but the designated representative must retain the material thereafter securely. The Inquiry team can also assist such individuals to view material at the Inquiry premises;

12. Any breach of these requirements by way of deliberate unauthorised disclosure may result in the person involved being reported for possible prosecution, denial of access to the Box system and removal of Core Participant status.

That completes that statement. We'll now take a ten-minute break and look forward to the final address from Mr. Maguire. Thank you.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

SUBMISSION BY MR. MAGUIRE:

MR. MAGUIRE: Good afternoon, Chairman, Professor Murphy, Dr. Maxwell. My name is Conor Maguire. I am instructed as senior counsel by O'Reilly Stewart Solicitors for patient-related Core Participants, some of whom are already represented by the firm, and others with designated Core Participant status have approached O'Reilly Stewart Solicitors to represent them at this Inquiry.

I know already Core Participants represented by O'Reilly Stewart Solicitors have been joining the Inquiry via the online streaming facility.

I appear with Ms. Victoria Ross, junior counsel. The solicitors engaged by O'Reilly Stewart Solicitors firm that will deal with the Core Participants are a senior group of solicitors within the firm, and they are Mr. Tom Anderson; Mr. Joe Moore; and Mr. Patrick Mullarkey. 12:16 12:17

Thank you, Chair, for permitting me to make an opening statement today on behalf of a significant group of individuals whose contribution will be integral to this Inquiry. This is an important day for them. 12:17

Chair, I note from your opening remarks, and from Mr. Doran QC's opening statement, that this cohort of patient-related Core Participants is referred to, for ease, as Group 3. They are described as being: 12:18

"Patients and relatives of patients at Muckamore who are not affiliated to the other two groups but nevertheless have a close interest in the events at Muckamore." 12:18

As the Inquiry progresses, it is anticipated more Core Participants will come to be represented as part of Group 3. The size of the group, therefore, is yet to

be determined, and it is noted that Core Participant statements are still in the process of being taken.

Separately, Chair, it is also anticipated that non-patient-related Core Participants may also be represented by O'Reilly Stewart Solicitors. 12:19

In respect of the three patient-related groups, Group 1 consists of those Core Participants affiliated with the Society of Patients and Friends of Muckamore Abbey. 12:19

Group 2 consists of those Core Participants affiliated with Action for Muckamore.

Mr. Doran, in his opening, referred to these two groups and the significant positive impact each has had with the Society of Parents and Friends of Muckamore Abbey having, for decades, aimed at assisting patients in their daily lives in the Hospital, and having worked tirelessly to that end. And with Action for Muckamore having actively campaigned for this Inquiry, it is important, Chair, to acknowledge the efforts made by these two groups to bring many issues, which include those that are the subject matter of this Inquiry, into the public domain, and, whilst it is likely each group of patient-related Core Participants will have a similar set of aims and objectives, it is important to say that the Core Participants in Group 3 that I represent today are being represented as individuals 12:19 12:20 12:20

who are not aligned to or affiliated with the other groups.

It is a privilege, Chair, to be representing these Core Participants who, themselves, will have advocated, many quietly but firmly over the years, on behalf of their relatives who were patients at Muckamore and who suffered abuse there. 12:21

These patients were abused or were provided with substandard care within their care environment - a place in which they should have felt secure. And such abuse, whatever its form, took place without reasonable or appropriate scrutiny being brought to bear. 12:22

The patients and their families and their carers, as has been acknowledged, were let down. The patients themselves, by virtue of their disabilities, were often without a physical voice or the means to communicate to a caring third party about the abuse they suffered or were suffering. 12:22 12:23

The Panel will, in due course, hear evidence from Core Participants about their relatives who were patients at the Hospital. One Core Participant, whose adult brother was a patient at Muckamore, will give evidence to this Inquiry of how his limited voice was, in essence, removed from him. The patient - a young man - was assaulted and mistreated by some staff over a 12:23

two-year period in the mid 2010s. Actions which resulted in the suspension of a number of staff. The Core Participant, the sister of this patient, records in her written statement as follows:

12:24

"He was not the same after the incidents. He became very withdrawn and depressed. He was put on antidepressants. He enjoyed vocalising when he was happy but stopped vocalising at all. He would sit in his bedroom looking down. He never smiled. He didn't engage with others."

12:24

Chair, loving relatives and carers of these abused patients, when they brought issues to the fore, often did not have their voices listened to either, with devastating consequences for the patients and their families, and there remains anger and frustration that but for CCTV footage becoming available after having emerged in 2017, these matters that are the subject matter of the Inquiry would not be in the public domain and action would not have been taken.

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12:25

Mr. Doran said in his opening, the subject of abuse is at the core of this Inquiry, and the Inquiry has already heard apologies about appalling abuse suffered by patients at Muckamore. This Inquiry will now provide that all too often missing listening ear to the families as they present their harrowing stories of patient and family experiences, as they give their

12:26

graphic accounts of abuse and mistreatment, and as they recount their painful memories. Some in relation to patients that are now deceased.

It is clear that this cohort of individuals, the family members and carers of patients, have valuable and germane evidence to give to the Inquiry. It is apparent, Chair, from accounts already given and recorded in statement form with the assistance of Cleaver Fulton Rankin Solicitors, that the evidence of those Core Participants goes to the heart of the issues identified in the Terms of Reference for this Inquiry. 12:26 12:27

As Mr. Doran has indicated, further statements are expected from more patient-related Core Participants and for those to be represented by O'Reilly Stewart Solicitors, we will ensure that they are appropriately advised and guided through the Inquiry process. 12:27

Mr. Doran also referred to the assistance given to him by his counsel team in collating the materials relevant to the Inquiry. We are grateful to Mr. Doran for his engagement with us to date, and we are also grateful, Chair, to the solicitor for the Inquiry, Ms. Keogh, for her invaluable assistance to date on administrative matters. 12:28 12:28

It is anticipated there will be a considerable volume of material generated in this Inquiry and disclosed to

us as it progresses and, indeed, Chair, you gave a statement relevant to that just before I came to the lectern.

This will be a developing process and we are at an early stage. However, we do not underestimate the extent of this undertaking, and consistent with our obligation in representing and safeguarding the interests of our Core Participant group, we offer our assistance to the Inquiry. 12:29

We will ensure, Chair, that contributions made by the Core Participants in Group 3 will be presented clearly and concisely and we will engage in a collaborative way to complement the work of the Inquiry team. 12:29

As representatives of the unaffiliated Core Participants, we will ensure the voices of those most acutely affected by the matters under consideration are heard. Their active participation is vital to the proper consideration of the issues within the Inquiry's Terms of Reference. Their participation will, we say, Chair, whether or not they give evidence anonymously, be in the public interest, because you, Chair, said as follows: 12:30

"The Inquiry is important to the wider mental health and learning disability services here which need to learn from its mistakes. The treatment and care of

those with learning disabilities or with mental health illness who are, by their nature, vulnerable, should be of a high quality and safe in any civilised society. And without predetermining any issue, it is quite obvious that bad practices were allowed to persist at the Hospital to the terrible detriment of a number of patients."

Chair, our Core Participants will play an integral role within the Inquiry, and in doing so, hopefully, will contribute to the restoration of confidence in organisations tasked with the caring for the most vulnerable members of our society.

12:31

The Inquiry has already heard a lot of detail through the opening statements relating to legislation, regulatory frameworks, governance and management structures. Our Core Participants, and indeed those within Groups 1 and 2, are the relatives and carers of those who were abused within Muckamore Abbey Hospital. You, Chair, have already referred to the patients and their relatives as being "front and centre of this Inquiry". We will advise and guide those relatives as they present their individual patient experiences, and thereby we will seek to assist the Inquiry in furthering its stated aims, identified in the Terms of Reference and as summarised by you, Chair, in your opening address, and repeated in terms by others in their opening statements, and that is, in essence, to

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12:32

find out what happened and how it was allowed to occur.

Can I conclude this short opening, Chair, by reflecting back on the Minister for Health's statement when announcing a public inquiry back in September 2020, as he recorded his apologies to patients and their families who were, he said: "Let down by a shocking failure within the health and social care system in Northern Ireland", and he said as follows: 12:33 12:34

"However, families and patients want and deserve more than apologies. They want and need answers as to why this happened and how it was allowed to happen. I hope..." 12:34

- he said:

"...that the public inquiry that I have announced today will give them those answers." 12:34

Your expectation, Chair, which you set out in your written statement dated 10th November last year, is that the Core Participants will: "Go beyond giving a personal account of their experience of the matters under investigation by the Inquiry." 12:34

You said you "expect the involvement of Core Participants to further the work of the Inquiry and to assist it in fulfilling its Terms of Reference."

Myself and Ms. Ross, with the specialist support and advice provided by our experienced solicitor team, with the overriding objective of assisting the Panel in its examination of issues, will seek to do that comprehensively, and concisely, and expeditiously, and in doing so, Chair, consistent with the aims and objectives of the Inquiry, and within its Terms of Reference, we will assist in ensuring those patients that suffered appalling abuse as a result of acknowledged shocking failures will, along with their families, finally through this process, have their voices heard, and they will indeed be front and centre of this Inquiry. Thank you. 12:35 12:36

CHAIRMAN: Thank you very much indeed, Mr. Maguire. Just one correction, if I may. Group 1 is actually, of course, those affiliated to Action for Muckamore and Group 2 is Society of Parent and Friends of Muckamore. It's the other way round. 12:36

MR. MAGUIRE: I'm obliged. 12:36

CHAIRMAN: Thank you very much indeed.

END OF SUBMISSION BY MR. MAGUIRE

CHAIRMAN: That concludes our business today. We'll look forward to hearing from Ms. Anyadike-Danes QC on Monday at ten o'clock, please, we'll be starting. 12:36

Just one bit of housekeeping. Could you please ensure

that if you want to use one of our four conference rooms you do book it in advance with the secretary to the Inquiry, partly that's because we have a limited number of rooms, but also we need to know who has used them for cleaning purposes for the Covid protocol. So, please, just make sure you book a room before walking in. 12:37

Thank you all very much indeed. We will reconvene on Monday at ten o'clock. 12:37

THE INQUIRY WAS THEN ADJOURNED UNTIL MONDAY, 13TH JUNE 2022 AT 10:00 A.M.