MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 7TH JUNE 2022 - DAY 2

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APPEARANCES

CHAIRPERSON:	MR. TOM KARK QC
INQUIRY PANEL:	MR. TOM KARK QC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN QC MS. DENISE KILEY BL MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MR. JAMES TOAL BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY MS. KAREN MCGUIGAN MS. FINOLA FRIEL
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES QC MS. HELENA WILSON MR. STEPHEN McQUITTY
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE QC MS. VICTORIA ROSS
INSTRUCTED BY:	O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN QC MS. ANNA McLARNON BL MR. MATTHEW YARDLEY BL MS. LAURA KING BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH:	MR. ANDREW McGUINNESS BL MS. EMMA TREMLETT BL MRS. SARA ERWIN BL
INSTRUCTED BY:	DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES
FOR PSNI:	MR. MARK ROBINSON QC
INSTRUCTED BY:	MR. COLIN HANNA DCI JILL DUFFIE

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INDEX

PAGE

CONTINUED OPENING SUBMISSION BY MR. DORAN 5

1 THE INQUIRY RESUMED ON TUESDAY, 7TH JUNE 2022 AS
2 FOLLOWS:
3
4 CHAIRMAN: Good morning everybody. Just two very
5 shorts bits of housekeeping before Mr. Doran continues 10:31
6 his opening.
7
8 Can I just remind everybody that 8:30 is the start time
9 and I'm afraid if you do turn up early, you won't be
10 able to get in. And if people could leave their 10:31
11 lanyards rather than take them home, otherwise we're
12 going to rapidly run out, so leave them on the desk or
13 leave them at the front reception. Thank you,
14 Mr. Doran.
15 10:31
16 CONTINUED OPENING SUBMISSION BY MR. DORAN:
17
18 MR. DORAN: Thank you, Chair. Yesterday I covered the
19 first five topics in my opening introduction: Core
20 Participants, background to the Inquiry, legal 10:31
21 framework and the history of Muckamore Abbey Hospital.
22 Today I hope to finish my opening. The remaining
23 topics are: Snapshot of the Hospital today, position
24 of the Hospital within the health and social care
25 structure, provisions governing admission, terms of 10:32
26 reference, witness evidence, production of documents,
27 history of reporting on the hospital, criminal
28 proceedings, schedule and conclusion.
29

1 I should flag up at this stage that topic 9, terms of
2 reference, and topic 12, history of reporting on the
3 Hospital, will take considerable time. The other
4 topics, I will deal with more briefly.
5 10:32
6 Yesterday I closed my survey of the history of the
7 Hospital with the observation that patient numbers had
8 fallen to 41 by August 2021. That leads me on to a
9 snapshot of the Hospital and its patients today.
10 10:32
11 I want to look at the physical composition of the
12 Hospital first. You can see on the screen a
13 colour-coded map or site plan of the premises. The
14 Inquiry has also had video footage taken of the
15 Hospital buildings and the grounds. I'm going to ask 10:33
16 for that footage to be played in a few minutes' time.
17 Many of those present today will be very familiar with
18 the Hospital, others may not. I hope that the footage
19 will assist in setting the scene for the Inquiry. The
20 footage lasts around nine minutes or so. 10:33
21
22 Just before we play the footage, we can have a brief
23 look at the site plan. The colour-coding indicates the
24 state of play in May 2020. The areas highlighted in
25 green are known as the core hospital. These areas are 10:33
26 the Cranfield Ward, number 13 on the plan; Six Mile
27 Ward, number 3; the Social Training Centre, number 2;
28 the Ardmore Ward, number 14 - and as we will see in a
29 moment in the footage, Ardmore is now known as the

1 Donegore and Killead Wards; the Erne Ward, number 4,
2 which closed in August 2021; the Moyola Day Care Ward,
3 number 17; the community centre, called the Cosy
4 Corner, number 9; and lastly, the swimming pool, which
5 is marked number 23. 10:34
6
7 You can see that the support services and
8 administration buildings are highlighted in light blue.
9 The library is located on the right-hand side as one
10 drives into the Hospital. On the opposite side is the 10:35
11 Administration building, marked number 26. The other
12 buildings in blue are Estates, number 19; the boiler
13 house, number 20; the general stores, number 21; the
14 garages for vehicle repairs, number 22; and the
15 laundry, number 24. 10:35
16
17 The buildings in red show the areas which are now
18 closed, which are the Greenan Ward, marked 5; the
19 Moylena Ward, marked number 6; the Mallow Ward, marked
20 15; and the Moyle Ward, marked 16. 10:35
21
22 The dark blue buildings are the ones which have been
23 identified as suitable to be demolished.
24
25 Finally, you will see some buildings highlighted in 10:36
26 yellow to the top left-hand side of the plan. These
27 are bungalows and houses which are used for
28 resettlement. I will come back to the wards in a
29 moment. First, we are going to play the footage,

1 which, as I've said, lasts for about nine minutes or
2 so.
3 CHAIRMAN: Okay.
4
5 10:36
6 VIDEO FOOTAGE PLAYED TO THE INQUIRY
7
8 CHAIRMAN: Mr. Doran, can I just mention, for the sake
9 of transparency, that I have visited, as you know, the
10 Hospital and the grounds on two occasions; once with 10:46
11 many members, I think, or a number of members of the
12 counsel team and once with the Panel. Those were
13 simply familiarisation visits - obviously it's a very
14 large site - and on the last occasion we went into, I
15 think, two of the wards. But obviously we didn't 10:46
16 receive any information, other than familiarisation
17 with the Hospital. Thank you.
18 MR. DORAN: Today, the Hospital provides inpatient
19 assessment and treatment facilities for adults aged 18
20 years and over who have severe learning disabilities 10:46
21 and mental health needs, forensic needs or challenging
22 behaviour. It provides that assessment and treatment
23 in an acute psychiatric care setting. The Inquiry
24 asked the trust to provide details of the current
25 number of patients at the hospital. The total number 10:47
26 of patients at the hospital today is 37.
27
28 Inpatient assessment and treatment now takes place
29 across three units on the Hospital site. We can see

1 those units on the map that is now to the right of the
2 screen. Those buildings contain the following wards:
3 Cranfield 1, marked 13, is an adult male admission ward
4 for assessment and treatment of those with a learning
5 disability and challenging behaviour. Seven patients 10:47
6 currently reside in Cranfield 1.
7
8 Cranfield 2, also at 13, provides ongoing treatment for
9 adult males. Eight patients currently reside at
10 Cranfield 2. 10:48
11
12 The Psychiatric Intensive Care Unit Cranfield PICU was
13 closed in December 2018. At that time, the Trust
14 stated that ward closure was temporary, to ensure safe
15 staffing levels across the site. No patients have 10:48
16 resided there since December 2018.
17
18 Six Mile, marked 3 on the site plan, provides forensic
19 services for the assessment and treatment of men with a
20 learning disability who have been referred by the 10:48
21 criminal justice system and require low secure
22 accommodation. Three patients currently reside in the
23 Six Mile assessment ward and six patients reside in the
24 treatment ward.
25 10:49
26 Killead and Donegore, formerly Ardmore, marked 13 on
27 the site plan, are female admissions wards for
28 assessment and treatment. Eight patients currently
29 reside in Killead and five patients reside in Donegore.

1 Patients also have access to the on-site day care
2 centre, called Moyola, which is marked 17 on the plan.
3
4 The Inquiry will, of course, be hearing more about the
5 working arrangements in the Hospital in due course. In 10:49
6 very general terms, treatment is provided by a core
7 multidisciplinary team, consisting of psychiatrists,
8 psychologists, social workers and nurses. Patients can
9 also be referred to other disciplines, such as
10 physiotherapy, speech and language therapy, dietetics, 10:50
11 behavioural services, pediatry, occupational therapy
12 and therapeutic services. The most recent RQIA report
13 on the Hospital, dated July 2021, noted that admission
14 to wards within the Hospital is now significantly
15 restricted, any decision to admit new patients is risk 10:50
16 assessed on an individual patient basis, alternative
17 options must be fully explored before admission is
18 made.
19
20 Of course, the Panel will be aware that the broad 10:50
21 policy objective of resettlement remains in place. As
22 a result of that policy and the limited number of new
23 admissions, the patient population is now significantly
24 lower than before. The current patient profile is very
25 far removed from that of earlier years of the Hospital 10:51
26 that I described yesterday afternoon.
27
28 I hope that this synopsis of the current position at
29 the hospital will be of assistance to the Panel. The

1 Panel will receive more evidence about that in due
2 course.
3
4 I will now look at the position of the Hospital within
5 the health and social care structure in Northern 10:51
6 Ireland. The Inquiry will be receiving documentation
7 and hearing detailed evidence about this matter in the
8 course of its work. There are two basic flowcharts
9 that may be helpful for illustrative purposes at this
10 stage. They have been prepared by Inquiry counsel to 10:51
11 assist with the opening. I fully acknowledge that
12 these are attempts at simplification and will not
13 capture all of the intricacies of the true position.
14
15 If one looks at the first flowchart, one can see that 10:52
16 overall responsibility for health and social care in
17 Northern Ireland lies with the Department of Health,
18 with certain duties delegated to organisations which
19 report to the Department. Those organisations can be
20 seen at the second tier of the flowchart. 10:52
21
22 The Public Health Agency provides specialist clinical
23 advice and guidance in relation to the health of the
24 general population. This includes advising on the
25 effectiveness of healthcare initiatives, providing 10:53
26 guidance on health protection measures, monitoring
27 health needs and undertaking work to promote better
28 health in the population.
29

1 The Business Services Organisation provides key
2 business support right across the health and social
3 care service. Its functions include paying salaries,
4 recruitment of new staff, providing legal advice and
5 procuring supplies and vital equipment. Services were, 10:53
6 until very recently, commissioned by the Health and
7 Social Care Board. The Board was dissolved on 31st
8 March 2022 and, from 1st April 2022, its functions
9 transferred to a new body. The new body is called the
10 Strategic Planning and Performance Group, or SPPG, 10:53
11 which is part of the Department of Health.
12
13 While services are commissioned by the Strategic
14 Planning and Performance Group, they are provided by
15 five health and social care trusts. Muckamore Abbey 10:54
16 Hospital today, as one can see from the flowchart, is
17 operated by the Belfast Health and Social Care Trust.
18 The Belfast Trust was established in April 2007. It is
19 the largest integrated Health and Social Care Trust in
20 the United Kingdom. The Inquiry will receive more 10:54
21 detailed information about the governance, management
22 and accountability structures of the Belfast Trust at a
23 later stage. The Inquiry will also wish to hear about
24 how those structures have evolved over the years. For
25 present purposes, this is a just a brief synopsis in 10:55
26 order to assist in understanding where the Hospital
27 sits within the Trust today.
28
29 Looking now at the second flowchart, the Trust is

1 managed by a Board of Directors. The Board is made up
2 of a chairperson, seven non-executive directors, five
3 executive directors and seven other directors. There
4 are a further three directors who are not members of
5 the Trust Board. 10:55
6
7 The Director For Mental Health and Intellectual
8 Disability Services is responsible for the efficient
9 and effective running of all mental health and learning
10 disability services for the Trust. This, of course, 10:55
11 includes Muckamore Abbey Hospital.
12
13 Learning disability services are headed up by a senior
14 team, which includes a co-director and the Chair of
15 Division, working alongside professional group leaders 10:56
16 for medical, nursing and social care staff.
17 Professional leaders are managerially responsible to
18 the Director For Mental Health and Intellectual
19 Disability Services, but also report to the executive
20 director for their professional group on any 10:56
21 profession-specific issues.
22
23 Medical leadership is provided by the clinical
24 director, who manages all of the medical staff within
25 the division. Nursing leadership is provided by the 10:56
26 divisional nurse, to whom all nursing staff are
27 expected to report any professional issues. The
28 divisional social worker is the professional lead for
29 all social care staff within the division.

1 Under the senior divisional team, learning disability
2 services are managed by service managers, who report to
3 the co-director. There is a specific service manager
4 for Muckamore Abbey Hospital who is responsible for the
5 day-to-day running of the Hospital. That includes all 10:57
6 of the services that are provided at the hospital,
7 including inpatient care, day services and outpatient
8 clinics. The service manager is then supported by
9 three assistant service managers and together they are
10 responsible for the delivery of care within the 10:57
11 Hospital. Now, whilst it is managed by the Belfast
12 Trust, Muckamore Abbey Hospital provides services to
13 people with learning disabilities from the Belfast, the
14 Northern and the Southeastern Health and Social Care
15 Trust. 10:58
16
17 I should say, Panel, that the transcript, the site
18 plan, the footage and, of course, the slides will be
19 available for all to peruse at their leisure after
20 today's sessions. 10:58
21 CHAIRMAN: Thank you.
22 MR. DORAN: Before I turn to the Terms of Reference, I
23 want to touch upon a topic that will require more
24 focused examination at a later stage in the Inquiry.
25 This relates to the law on mental health in Northern 10:58
26 Ireland and, in turn, to the legal basis for admission
27 of patients to the Hospital.
28
29 Patients can be admitted on a voluntary basis or

1 detained. The central piece of legislation governing
2 admission to the Hospital as a detained patient has
3 been the Mental Health (Northern Ireland) Order 1986.
4 The 1986 Order contains detailed provisions governing
5 the care, treatment and protection of persons with a 10:59
6 mental disorder. The Order distinguishes between
7 detention in hospital for assessment and detention for
8 treatment. The Order prescribes detailed criteria that
9 must be met for admission, founded on examination and
10 recommendation by a suitably qualified medical 10:59
11 professional. The Order also contains multiple
12 provisions governing continued authorisation for
13 detention and for the discharge of patients. The Order
14 further provides for the constitution of a Mental
15 Health Review Tribunal, now known simply as the Review 11:00
16 Tribunal. Detained patients or their nearest relative
17 may apply to the Tribunal, which has power to direct
18 discharge of the patient from hospital.
19
20 The law in this area is in a state of flux in this 11:00
21 jurisdiction. I've already mentioned the Bamford
22 Review and its recommendations for reform of learning
23 disability services. Another of Bamford 's
24 recommendations was total reform of mental health
25 legislation in Northern Ireland. It recommended a 11:00
26 single comprehensive legislative framework governing
27 both mental health and mental capacity. It proposed
28 legislation based on respect for decision-making
29 capacity, where it exists, regardless of whether a

person has a mental health issue.

Considerable time was taken to develop the new legislative framework and in May 2016 the Mental Capacity Act was enacted by the Northern Ireland Assembly. The Act's provisions are being implemented in phases. Phase 1 implementation took place between October and December 2019. However, until the Act is fully commenced, the provisions of the 1986 Order will continue to operate alongside the provisions of the new legislation. Crucially, for our purposes, the 1986 Order was the sole legislation governing admission to the Hospital until late 2019. Since that time, and even today, where the critical for admission under the 1986 Order are met, the framework of the 1986 Order must be applied. That will continue to be the case for some time while the new provisions are being introduced in stages.

I do not need to say anything more about these provisions for the purposes of the opening. The Inquiry will have the opportunity to examine the relevant provisions in greater detail at a later stage. The Inquiry will also, at an appropriate time, wish to consider the provisions of the 2016 Act in greater detail. The Inquiry will also, of course, wish to be kept fully informed of the progress of the Act's implementation.

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1 This leads me to the Terms of Reference. I've already
2 referred to the Terms of Reference and to their
3 fundamental place in the Inquiry. I'm now going to
4 look at those terms in some detail. I will pause,
5 where appropriate, to reflect on how the Inquiry might 11:03
6 address the various issues raised.
7
8 The Terms of Reference begin by stating the Inquiry's
9 core objectives. Those are: To examine the issue of
10 abuse of patients at Muckamore Abbey Hospital; to 11:03
11 determine why the abuse happened and the range of
12 circumstances that allowed it to happen; to ensure that
13 such abuse does not occur again at Muckamore Abbey
14 Hospital, or any other institution providing similar
15 services in Northern Ireland. 11:04
16
17 It is, I think, helpful to have the core objectives of
18 the Inquiry set out in such concise terms. The core
19 objectives remind us that this Inquiry is not only
20 committed to investigating past abuse, it is also 11:04
21 charged with the significant responsibility of seeking
22 to ensure that such abuse does not occur again in the
23 future.
24
25 Importantly, the Inquiry must not only investigate what 11:04
26 happened, it must also determine why it happened and
27 the range of circumstances that allowed it to happen.
28 This will, of course, require the Inquiry to receive
29 evidence from a wide range of sources, both through

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1 witness evidence and the receipt of relevant
2 documentation. I will say more about the Inquiry's
3 approach to those matters in due course.
4
5 The next part of the Terms of Reference deals with 11:05
6 timeframe. Paragraph 2 says that the Inquiry will
7 report and make findings on events that occurred
8 between 2nd December 1999 and 14th June 2021. At
9 first, the date of 2nd December 1999 may appear
10 artificial. The reason for that date is related to the 11:05
11 legislation. Section 30(3) of the Inquiries Act 2005
12 provides that the Minister may not, without the consent
13 of the Secretary of State, include in the Terms of
14 Reference anything that would require the Inquiry to
15 inquire into events during certain specified periods. 11:06
16 Those periods are (a) before 2nd December 1999 or (b) a
17 period when devolved government in Northern Ireland is
18 suspended.
19
20 Importantly, however, paragraph 3 provides that the 11:06
21 Inquiry will be able to receive and take account of
22 evidence outside of the timeframe of the Terms of
23 Reference where such evidence will assist the Inquiry
24 in examining, understanding and reporting on matters
25 within these Terms of Reference. That is very 11:07
26 important, as otherwise the Inquiry would be precluded
27 from hearing evidence predating 1999 that may be
28 capable of assisting it to address the Terms of
29 Reference. On the other hand, the timeframe cannot

1 simply be ignored. When confronted with evidence
2 relating to earlier events, the Inquiry would have to
3 consider carefully whether that evidence should be
4 received and whether it ought to be taken into account
5 by the Inquiry. 11:07
6
7 The next part of the Terms of Reference relates to the
8 next part of the core objective. It is titled simply
9 "What Occurred".
10 11:08
11 Paragraph 4 provides generally that the Inquiry will
12 examine the nature and extent of abuse of patients at
13 Muckamore Abbey Hospital.
14
15 Paragraph 5 goes on to provide a non-exhaustive 11:08
16 definition of abuse. It states that the term "abuse"
17 may include, but is not restricted to, the following:
18 (a) physical abuse; (b) sexual abuse; (c) psychological
19 abuse; (d) mental or emotional abuse; (e) patient
20 neglect; (f) inappropriate or negligent care; (g) 11:08
21 appropriation of, or improper interference with,
22 patients' finances or belongings; and (h) other
23 misbehaviour towards patients.
24
25 The words "may include but is not restricted to" are 11:09
26 significant. It would arguably be quite wrong to adopt
27 a rigid definition of abuse. The examination of abuse
28 does not lend itself to a tick-box exercise. The
29 Inquiry Panel may hear evidence of conduct involving

1 one of the above forms of abuse or a combination of
2 different forms of abuse. The Panel may be told about
3 other forms of misbehaviour that can be characterised
4 as abusive. Critically, the definition in paragraph 5
5 is non-exhaustive. It should not be regarded as a 11:09
6 restrictive provision; rather, it should be regarded as
7 an aid to identifying the types of conduct that
8 resulted in this Inquiry being established.
9
10 Paragraph 6 states that: 11:10
11
12 "The Inquiry will examine the role of frontline staff,
13 those with responsibility for clinical and professional
14 oversight, those with leadership and/or management
15 responsibilities within the relevant Health Trusts and 11:10
16 any other relevant persons or bodies in respect of such
17 abuse."
18
19 This paragraph makes it clear that the Inquiry will be
20 looking at the role of staff at all levels - staff on 11:10
21 the wards, those with oversight roles and those in
22 positions of management and leadership. The Inquiry
23 will not only examine those roles on paper, it will
24 seek to hear evidence from relevant personnel at all of
25 those different levels of responsibility. 11:11
26
27 The Panel will also be aware of the important footnote
28 to paragraph 6, which says:
29

1 "Note that all references in this document to the
2 Health Trusts and other bodies with roles and
3 responsibilities in respect of health and social care
4 shall include any precursors of such bodies that
5 existed within the timeframe of these Terms of 11:11
6 Reference."
7
8 Within the Inquiry timeframe there have been
9 significant structural changes within the healthcare
10 system. This note makes it clear it that the Inquiry's 11:12
11 remit extends to the pre-existing authorities, as well
12 as the present ones.
13
14 Paragraph 7 provides that:
15 11:12
16 "The Inquiry will also consider, to the extent
17 necessary to enable the Inquiry to examine the nature
18 and extent of abuse of patients, the adherence by staff
19 and management, the Trusts, the Board and the
20 Department of Health to relevant statutory obligations, 11:12
21 the regulatory framework, protocols, policies and
22 guidance in respect of all aspects of service
23 delivery."
24
25 This paragraph will require the Panel to become 11:12
26 familiar with the relevant law, protocols, policies and
27 guidance that govern working practices at the hospital
28 and that govern the management of the Hospital. It
29 will also require an understanding of the systems of

1 inspection and regulation. The paragraph invites the
2 Inquiry to consider the issue of compliance: To what
3 extent were governing rules, policy and guidance
4 complied with? Again, that applies to those working at
5 all levels, from those working on the ground right up 11:13
6 to those working within the relevant authorities.
7
8 Paragraph 8 provides that:
9
10 "The Inquiry will examine the primary and secondary 11:13
11 causes of such abuse and will address the question of
12 whether the abuse resulted from systemic failings
13 within Muckamore Abbey Hospital or the wider healthcare
14 system in Northern Ireland."
15 11:14
16 This paragraph makes it absolutely clear that the
17 Inquiry will not only look at the conduct of
18 individuals, but will also ask whether there were
19 broader issues in play that resulted in the need for
20 this Inquiry. 11:14
21
22 Looking beyond the conduct of individuals, the Panel
23 may wish to address questions such as: Was there a
24 culture within the Hospital that enabled abuse to go
25 unchallenged? If so, how and why did such a culture 11:14
26 develop? Were there failings at the level of
27 management and oversight that contributed to the abuse?
28 Moving beyond the Hospital itself, were there systemic
29 failings within our healthcare system that enabled

1 abuse at the hospital to go unchecked? That does not
2 mean that the Inquiry should undertake a general review
3 of healthcare provision in this jurisdiction. All
4 roads along which the Inquiry can travel must lead back
5 to the Hospital itself. Critically, however, 11:15
6 paragraph 8 will enable the Panel to examine the
7 Hospital within the broader context of the system in
8 which it is located.
9
10 Chair, that might be a suitable time to take a short 11:16
11 break.
12 CHAIRMAN: Certainly. I think you've got, is it four
13 sections that you're hoping to conclude today?
14 MR. DORAN: Yes. I can say that I will conclude today.
15 CHAIRMAN: Excellent. Well, thank you. It's much 11:16
16 cooler in here today, by a simple measure of opening
17 the windows, but that's a relief to all of us. Thank
18 you, Mr. Doran. Quarter of an hour? 15 minutes?
19 MR. DORAN: Yes. Shall we say 11:35?
20 CHAIRMAN: Yes, certainly. Fine. Thank you very much. 11:16
21
22 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
23
24 CHAIRMAN: Yes, Mr. Doran.
25 MR. DORAN: The next part of the Terms of Reference 11:36
26 addresses recruitment, retention, training and support.
27 Paragraph 9 provides that:
28
29 "The Inquiry will examine the policies and practices

1 relating to recruitment, retention, training and
2 support of staff and management at all levels within
3 the Hospital and, where necessary, within other
4 facilities offering comparable services."
5 11:37
6 The Terms of Reference then move on to deal with the
7 subject of identifying and responding to concerns.
8 Those paragraphs, 10 to 13, read as follows:
9
10 "10. The Inquiry will inquire the adequacy of methods 11:37
11 available to communicate concerns, including
12 allegations of abuse by staff, patients, relatives and
13 others about the treatment of patients at the Hospital.
14
15 11. The Inquiry will examine the response to such 11:38
16 concerns by frontline staff, those with responsibility
17 for clinical and professional oversight and those with
18 leadership and/or management responsibilities within
19 the relevant Health Trusts, the Health and Social Care
20 Board, the Public Health Agency and the Department of 11:38
21 Health.
22
23 12. The Inquiry will examine the operation of all
24 relevant commissioning, supervisory and regulatory
25 agencies, including, but not limited to, those agencies 11:38
26 specified in paragraph 11 to determine whether, and if
27 so why, there were failures in the early
28 identification, investigation and resolution of issues
29 raised about the treatment of patients."

1 Paragraph 13 reads:
2
3 "The Inquiry will also examine the response of other
4 relevant agencies, including the Police Service for
5 Northern Ireland (PSNI), the Patient and Client Council 11:39
6 (PCC), the Health and Safety Executive (HSE) and the
7 Regulation and Quality Improvement Authority (RQIA)
8 when allegations of abuse of patients at the Hospital
9 were reported to them."
10 11:39
11 Those paragraphs are largely self-explanatory: When
12 concerns arose, how could those concerns be ventilated?
13 How effective were the responses to those concerns?
14 Significantly, were there failures in the early
15 identification, investigation and resolution of issues 11:40
16 raised about the treatment of patients? This last
17 question, in particular, goes beyond the handling of
18 individual complaints; it will require the Inquiry to
19 consider whether there were earlier opportunities
20 missed to detect the issues that were brought to the 11:40
21 attention of the relevant authorities when the CCTV
22 footage was uncovered. I will return to this matter
23 when I look at earlier reviews and investigations that
24 have been conducted in respect of the Hospital.
25 11:40
26 The list in paragraph 13 is not exhaustive. It
27 mentions four organisations specifically, beginning
28 with the PSNI. I've already mentioned, briefly, the
29 remit of the RQIA, which is a Core Participant in this

1 Inquiry. The paragraph also mentions the Patient and
2 Client Council and the Health and Safety Executive for
3 Northern Ireland. The PCC was established by the
4 Health and Social Care (Reform) Act (Northern Ireland)
5 2009. In broad terms, it is an enabling body, helping 11:41
6 to articulate the voice of patients and service users
7 in the planning and delivery of health and social care
8 services. The PCC interacts and undertakes
9 consultations with the public to help to ascertain
10 their views about care services available and also 11:41
11 about proposed changes. The PCC also liaises with
12 health and social care organisations to channel the
13 views of the public. The PCC may also support
14 individuals who wish to complain about care standards
15 or who need assistance with expressing their views on 11:42
16 the provision of services. As I mentioned yesterday,
17 the PCC played a role in the public engagement
18 regarding the Terms of Reference of this Inquiry.
19
20 HSENI is an executive non-departmental body sponsored 11:42
21 by the Department for the Economy. It was established
22 in 1999. It is the enforcing authority for health and
23 safety standards in the workplace in Northern Ireland.
24 Its remit covers many areas of employment, including
25 hospitals. Its focus in respect of Muckamore has been 11:42
26 on regulating the legal duties owed by the Hospital
27 authorities to the staff working there.
28
29 There's one further important point to be made in

1 respect of paragraph 13 of the Terms of Reference. The
2 Inquiry will, of course, be looking at how complaints
3 of a criminal nature were dealt with historically in
4 accordance with that paragraph. As the Panel is aware,
5 however, there is an ongoing police investigation that 11:43
6 resulted from the recovery of CCTV footage at the
7 Hospital. There is also, or there are also
8 prosecutions arising from the investigation. I will be
9 saying something more about these criminal proceedings
10 later in my opening statement. Importantly, these are 11:44
11 ongoing, live proceedings. It goes without saying that
12 the subject matter of those proceedings is of direct
13 interest to the Inquiry. The Inquiry will need to be
14 fully informed of the basis of the evidence within
15 those criminal proceedings. It will also need to be 11:44
16 fully informed of the progress of those proceedings.
17 Importantly, however, the Inquiry will not be examining
18 how those ongoing proceedings are being managed by the
19 PSNI and the PPS.
20 11:44
21 As I will discuss in greater detail later, the Inquiry
22 entered into a Memorandum of Understanding with the
23 PSNI and the PPS in March of this year. The MoU is
24 published on the Inquiry website. The MoU sets out how
25 the Inquiry, the PSNI and the Inquiry -- and the PPS, 11:45
26 I'm sorry, are going to manage their respective
27 responsibilities as the criminal proceedings and the
28 Inquiry move forward.
29

1 Paragraph 17 of the MoU states:
2
3 "The subject matter of the investigation and
4 prosecutions is of direct interest to the Inquiry, but
5 the Inquiry is not examining the response of the PSNI 11:45
6 and the PPS that has followed from the seizure of the
7 CCTV footage."
8
9 So, to summarise, the Inquiry will be examining how
10 complaints arising from the Hospital have been managed 11:46
11 historically by the police and prosecuting authorities,
12 but this does not apply to the current criminal
13 investigation and prosecutions. And as I've said, I
14 will be coming back to that matter later.
15 11:46
16 Returning to the text of the Terms of Reference.
17 Paragraphs 14 to 17 address a number of discrete
18 issues. I do not propose to elaborate on those issues
19 at this stage.
20 11:47
21 Paragraph 14 relates to the installment of CCTV at the
22 Hospital. The Inquiry will examine the effects of
23 installment, operation and use of CCTV at Muckamore
24 Abbey Hospital.
25 11:47
26 Paragraph 15 deals with safeguards, mechanisms and
27 policies regarding other patients:
28
29 "The Inquiry will examine the safeguards, mechanisms

1 and policies in place to ensure that patients were not
2 subject to abuse or other disturbing behaviour by other
3 residents/patients and whether those controls and
4 policies were sufficient."
5 11:47
6 Paragraph 16 addresses resettlement:
7
8 "The Inquiry will examine the adequacy and workings of
9 the policy and process of discharge and resettlement of
10 patients of Muckamore Abbey Hospital." 11:48
11
12 Paragraph 17 raises the wider issue of resourcing:
13
14 "The Inquiry will consider the adequacy of financial
15 resources to ensure: 11:48
16
17 (a) appropriate numbers, skills, quality and training
18 of staff;
19
20 (b) appropriate care, treatment and accommodation for 11:48
21 patients with mental health conditions and/or learning
22 disabilities treated or cared for at Muckamore Abbey
23 Hospital."
24
25 I have already touched on the legal and regulatory 11:48
26 framework. This is dealt with specifically in
27 paragraphs 18 and 19. Paragraph 18 states:
28
29 "The Inquiry will examine the following:

1 (a) the relevant primary and secondary legislation;
2
3 (b) the regulatory framework;
4
5 (c) any relevant codes, policies, guidelines, reports 11:49
6 and other documentation relating to management,
7 administration and working practice at Muckamore Abbey
8 Hospital and, where necessary, of other comparable
9 facilities."
10 11:49
11 And paragraph 19 states:
12
13 "The Inquiry will consider the adequacy of the above to
14 provide a framework to prevent abuse of patients with
15 mental health conditions or learning disability in 11:49
16 Muckamore Abbey Hospital and other such settings in
17 Northern Ireland."
18
19 I've mentioned some of the relevant legislation and I
20 have referred, in passing, to the regulatory framework. 11:50
21 As I will be explaining shortly, the Inquiry is
22 currently receiving documentation from many different
23 sources. This will include codes, policies,
24 guidelines, reports and suchlike. The counsel team
25 will, in due course, collate all material of this kind 11:50
26 for the Panel and Core Participants in order that this
27 aspect of the Terms of Reference can properly be
28 addressed.
29

1 Paragraphs 20 to 22 address matters of practice and
2 procedure. Paragraph 20 echos Section 17 of the
3 Inquiries Act 2005 that I mentioned yesterday
4 afternoon:
5 11:51
6 "The Inquiry Chair will determine how the Inquiry is
7 conducted, including the procedure, the nature of
8 evidence and calling of witnesses to the Inquiry."
9
10 Paragraph 21 provides: 11:51
11
12 "Aspects of practice and procedure may be governed by
13 protocols to be established at the outset of the
14 Inquiry."
15 11:51
16 And as I've already mentioned, to date the Inquiry has
17 published protocols relating to production and receipt
18 of documents, Core Participants, funding of legal
19 representation and redaction, anonymity and Restriction
20 Orders. And those protocols have been augmented, where 11:52
21 necessary, by Chair's statements. All of this material
22 is published on the Inquiry's website.
23
24 Paragraph 22 refers to witness services:
25 11:52
26 "Appropriate witness services will be made available in
27 the course of the Inquiry."
28
29 And that is important. I will return to the matter of

1 support for witnesses later when I have finished with
2 the Terms of Reference.
3
4 The final part of the Terms of Reference relates to the
5 report and recommendations. The three paragraphs read 11:52
6 as follows:
7
8 "23. The Inquiry will submit its report to the Minister
9 of Health. The Inquiry may make findings on matters
10 within the Terms of Reference as outlined above, 11:52
11 including the issue of abuse and whether such abuse
12 resulted from systemic failings."
13
14 Paragraph 24:
15 11:53
16 "Having regard to, and dependent on, those findings,
17 the Inquiry will make recommendations in respect of the
18 following:
19
20 (a) the core objective of ensuring that any such abuse 11:53
21 and any such failings do not recur at Muckamore Abbey
22 Hospital or at any other facility providing similar
23 services in Ireland;
24
25 (b) improvement of the training of staff and management 11:53
26 at Muckamore Abbey Hospital and comparable facilities;
27
28 (c) improvement of management, policies, systems and
29 processes within Muckamore Abbey Hospital, including

1 those relating to whistleblowing and corporate
2 governance;
3
4 (d) improvement of competence, quality and internal
5 governance of the Board of such hospitals; 11:54
6
7 (e) to the extent that it is necessary and appropriate,
8 the role of wider adult social care services and the
9 relevant health and social care bodies (including, but
10 not limited to, the Health and Social Care Trusts, the 11:54
11 Health and Social Care Board, the Public Health Agency
12 and the Department) in ensuring the safety of patients
13 and best practice in service delivery at Muckamore
14 Abbey Hospital and comparable facilities;
15 11:54
16 (f) the legal and regulatory framework and related
17 matters;
18
19 (g) the requirement or desirability of the provision of
20 redress to meet the particular needs of victims of 11:55
21 abuse within Muckamore Abbey Hospital."
22
23 Paragraph 25:
24
25 "The Inquiry Chair may, if necessary and appropriate, 11:55
26 issue an interim report or reports with
27 recommendations."
28
29 As we embark on the Inquiry, the report and

1 recommendations may appear to be beyond the horizon.
2 Paragraph 5 is, however, worth noting, and you
3 mentioned it specifically yesterday, Chair --
4 CHAIRMAN: Paragraph 25.
5 MR. DORAN: Sorry? 11:55
6 CHAIRMAN: Paragraph 25?
7 MR. DORAN: Paragraph 25.
8 CHAIRMAN: You said 5.
9 MR. DORAN: Oh, sorry. Paragraph 25 is worth noting.
10 It affords you, Chair, with the discretion to issue an 11:56
11 interim report with recommendations. And that is
12 obviously an option that you will wish to keep under
13 review at all times as the Inquiry proceeds.
14
15 I'm conscious that it has taken some time to cover the 11:56
16 Terms of Reference. They are wide ranging. There are
17 multiple issues to be addressed. The Inquiry will, of
18 course, be mindful of the need to adopt a proportionate
19 approach to its work where that is appropriate. The
20 nature of the issues that have given rise to this 11:56
21 Inquiry clearly required the timeframe to be an
22 extended one. It was also important that the Inquiry's
23 work should not be confined to a narrow fact-finding
24 exercise. The core issue of abuse cannot be examined
25 in isolation from the context and structures within 11:57
26 which it occurred. Recommendations to improve future
27 practices, procedures and structures cannot properly be
28 made without a sound basis in evidence. The Inquiry
29 will need to draw upon a significant body of evidence

1 and information in order to discharge its
2 responsibilities.
3
4 It is, however, worth sounding a slight note of caution
5 at this point. The Terms of Reference do indeed cover 11:58
6 multiple issues, but the core objectives must always be
7 kept in plain view. The Inquiry will need to adopt a
8 suitably proportionate approach to the issues in order
9 to complete its work within a reasonable timeframe. It
10 would be virtually impossible to pursue every single 11:58
11 line of inquiry that will arise from the evidence in
12 the same degree of detail. As the Inquiry moves
13 forward, it will have to make decisions as to where its
14 resources will most effectively be channelled. It
15 would be quite wrong to be prescriptive about this at 11:59
16 the beginning of the Inquiry. I am raising the matter
17 now as counsel to the Inquiry because it is important
18 to be realistic about what the Inquiry can achieve.
19
20 The Inquiry will hear from as many people as possible 11:59
21 who were affected by the events at Muckamore. The
22 Inquiry will also hear from staff, the various
23 organisations and public authorities that are connected
24 to the Hospital or that have an interest in the
25 Hospital. Individuals, patient groups, and indeed the 12:00
26 relevant authorities will have their own particular
27 concerns and their own particular priorities. They
28 will naturally wish those concerns and priorities to be
29 addressed by the Inquiry. The Inquiry will, of course,

1 be responsive to matters that are raised by Core
2 Participants and by others with an interest in the
3 Inquiry's work. The Inquiry does, however, have a
4 wider responsibility to deliver on the core objectives
5 within a reasonable time. 12:00
6
7 It is also to be remembered that the role of a Core
8 Participant is wider than the Core Participant's own
9 particular interest. Core Participants have a role in
10 furthering the work of the Inquiry and assisting it in 12:01
11 fulfilling its Terms of Reference. Therefore, I trust
12 that everyone involved in the Inquiry will understand
13 that not every single matter raised by them will be
14 capable of being explored to an equivalent degree.
15 12:01
16 I have looked in detail at the Terms of Reference, I
17 now want to consider what the Inquiry will need in
18 order to address those Terms of Reference.
19
20 The Inquiry will be assisted both by witnesses 12:01
21 providing evidence to the Inquiry and by individuals
22 and organisations providing relevant materials to the
23 Inquiry. As regards both witnesses coming to give
24 evidence and as regards the provision of documents, the
25 Inquiry intends to rely on voluntary cooperation, where 12:02
26 possible.
27
28 Having said that, as I outlined earlier in the opening,
29 the Chair of a Public Inquiry is vested with important

1 powers to compel the attendance of witnesses to give
2 evidence and to compel the production of documents.
3 I'll just pause for a moment. (Short pause)
4 CHAIRMAN: Thank you.
5 MR. DORAN: In the Inquiry protocol on the production 12:03
6 and receipt of documents, that is Protocol No. 1, dated
7 10th November 2021, it is made clear that the Chair
8 will exercise those compulsory powers if that should
9 become necessary. Paragraph 18 of that protocol reads:
10 12:03
11 "The Chair will exercise his powers under Section 21 to
12 obtain relevant documents where, for example, a request
13 is refused, the response to a request is incomplete,
14 there has been no response to a request by a stated
15 deadline or a delay is requested which appears to the 12:03
16 Chair not to be reasonable. Some document providers
17 may be facilitated in their production of documents by
18 receipt of a Section 21 Notice, whether in general
19 terms or in respect of certain documents or categories
20 of document. Such document providers should alert the 12:04
21 solicitor to the Inquiry promptly."
22
23 It has not been necessary, to date, for the Chair to
24 issue a Section 21 in the face of resistance, although
25 understandably, some document providers have requested 12:04
26 the issue of a Section 21 Notice in order to facilitate
27 them in the production of documents. Such notices have
28 been issued accordingly. Many documents will be of a
29 personal and sensitive nature. The notice provides a

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1 clear and unambiguous legal basis for the production of
2 such documents to the Inquiry.
3
4 Similar principles will be at play as regards witness
5 evidence. It is anticipated that voluntary cooperation 12:05
6 will be the norm, but resort to compulsory powers will
7 be considered where that is necessary to enable the
8 Inquiry to do its work.
9
10 Very soon after the establishment of the Inquiry, you, 12:05
11 Chair, encouraged engagement with the Inquiry by those
12 who had relevant information to provide. An early
13 notice issued on the Inquiry's website read as follows:
14
15 "One of the Inquiry's core objectives is to examine the 12:05
16 issue of abuse and neglect of patients at Muckamore
17 Abbey Hospital. It is important that we hear from as
18 many people as possible about their experience of
19 Muckamore Abbey Hospital, regardless of when it
20 occurred or what information they want to give. At 12:06
21 this stage we are interested in hearing from anyone who
22 feels that they have information that the Inquiry
23 should consider, whether they are a current or former
24 patient, a relative, a carer, a current or former
25 member of staff, or a member of the public who 12:06
26 witnessed events at Muckamore and whether they had a
27 negative or positive experience of Muckamore. We need
28 your help to conduct our Inquiry fairly and fully."
29

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1 That message was reinforced in engagement sessions that
2 were held to promote and publicise the work of the
3 Inquiry. The message was also reiterated in Chair's
4 statements on the website. More recently, you, Chair,
5 have issued a similar invitation by way of a local 12:07
6 radio announcement. It may be that the opening of the
7 Inquiry will prompt others with relevant information to
8 come forward.
9
10 Witnesses were asked to fill in a short contact form in 12:07
11 the first instance. The form asks witnesses to provide
12 basic details about their connection with Muckamore and
13 the kind of information that they may have to give. To
14 date, 126 individuals have made contact with the
15 Inquiry in this way. The Inquiry has appointed Cleaver 12:08
16 Fulton Rankin Solicitors to take statements from those
17 witnesses who have relevant evidence to give. That
18 work is being undertaken by a statement team. The team
19 has received training in working with witnesses who may
20 be vulnerable or who may be anxious. Where necessary, 12:08
21 the team has access to specially appointed registered
22 intermediaries who can assist witnesses in
23 communicating. The intermediaries can also be called
24 upon to assist witnesses when they are giving their
25 evidence. 12:09
26
27 There will also be witness support available throughout
28 the hearings to ensure that witnesses have the support
29 that they need. As you have indicated Chair, if anyone

1 needs to speak to a witness supporter, they can easily
2 identify them, as they will be wearing a yellow lanyard
3 within this chamber. During hearings, they will be in
4 the back row of the public gallery. The support
5 services we have in place have been sourced directly by 12:09
6 the Inquiry, but they are, of course, totally
7 independent of the Inquiry. If, for any reason,
8 someone cannot find the witness support person who is
9 attending, they should ask a member of the Inquiry team
10 and the member of the team will find that person for 12:09
11 them.
12
13 Up to today's date, the statement team has been in
14 contact with 111 witnesses. The team has taken
15 statements from 40 individuals. That figure includes 12:10
16 some statements that have been completed but not yet
17 formally signed. Some of those witnesses are scheduled
18 to give evidence in the final week of this month and in
19 the first week of July. A provisional schedule for
20 those weeks will be issued very soon to Core 12:10
21 Participants. I'm going to say something a little bit
22 more about those evidence sessions later in the
23 opening.
24
25 Beyond this first phase of evidence, the Inquiry 12:10
26 intends to hear, also, from staff, ranging from
27 frontline staff to those in positions of management and
28 leadership. The Inquiry will also seek evidence from
29 relevant persons within the various authorities that

1 have responsibility for the organisation, management,
2 oversight and inspection of the Hospital. The Inquiry
3 may also seek assistance from independent expert
4 witnesses where it appears necessary to do so. This
5 will be an incremental process. Core Participants will 12:11
6 be kept fully informed of progress as the Inquiry
7 proceeds with its work.
8
9 Before I leave the topic of witnesses, I want to draw
10 attention to the undertaken given by the Director of 12:12
11 Public Prosecutions. You mentioned that undertaking in
12 your opening remarks, Chair. The undertaking is dated
13 6th June. It is worth rehearsing the precise wording.
14 The undertaking reads as follows:
15 12:12
16 "1. No oral evidence given by a natural person before
17 the Inquiry will be used in evidence against that
18 person in any criminal proceedings, or for the purpose
19 of deciding whether to bring such proceedings, save as
20 provided in paragraph 3 herein. 12:12
21
22 2. No written statement drafted for the purpose of
23 giving evidence to the Inquiry by or for such a person
24 identified at paragraph 1 will be used in evidence
25 against that person in any criminal proceedings or for 12:13
26 the purpose of deciding whether to bring such
27 proceedings, save as provided in paragraph 3 herein.
28 This shall include any statement made by or for such a
29 person for that purpose preparatory to giving evidence

1 to the Inquiry or during the course of their testimony
2 to the Inquiry."
3
4 And then paragraph 3 states:
5 12:13
6 "Paragraphs 1 and 2 do not apply to:
7
8 (a) a prosecution in which that person is charged with
9 having given false evidence in the course of this
10 Inquiry or having conspired with or procured others to 12:13
11 do so; or
12
13 (b) a prosecution in which that person is charged with
14 any offence under Section 35 of the Inquiries Act 2005
15 or with having conspired with or procured others to 12:14
16 commit such an offence."
17
18 I mentioned Section 35 yesterday afternoon, Chair. And
19 the undertaking is, I understand, available on the
20 Inquiry's website. 12:14
21
22 I want to make four observations on the undertaking.
23 First, undertakings of this kind are frequently given
24 in the context of public inquiries. Prominent recent
25 examples are the Historical Abuse Inquiry and the 12:14
26 Grenfell Tower Inquiry.
27
28 Secondly, it is very important not to confuse an
29 undertaking of this kind with immunity from

1 prosecution. It is, categorically, not an immunity.
2 It prevents the use of evidence given to the Inquiry in
3 criminal proceedings, it does not shield an individual
4 from criminal proceedings that are instituted on the
5 basis of evidence other than evidence given to the 12:15
6 Inquiry.
7
8 Thirdly, as you have indicated, Chair, the effect of
9 the undertaking is, effectively, to deprive an
10 individual of the evidential protection of the 12:15
11 privilege of self-incrimination at the Inquiry. This
12 privilege is preserved in the Inquiry context by
13 Section 22 of the Inquiries Act 2005. The undertaking
14 means that a person cannot say 'I will not speak to the
15 Inquiry, because that might leave me open to criminal 12:16
16 charges'. Because of the undertaking, that would not
17 be a legitimate basis on which to refuse to give
18 evidence or to refuse to answer questions when giving
19 evidence.
20 12:16
21 Fourthly, and critically, the rationale for seeking an
22 undertaking of this kind is to ensure that the Inquiry
23 will hear from the widest possible spectrum of
24 witnesses. Put simply, the absence of the undertaking
25 would make it more difficult for the Inquiry to achieve 12:17
26 its core objectives.
27
28 Chair, I'm wondering if that might be a suitable time
29 to break for lunch today?

1 CHAIRMAN: Yes, you've warned me that you might want to
2 stop a bit early today. But you're still satisfied, as
3 I understand it, that you will finish today? Would it
4 be sensible to start rather earlier than two o'clock,
5 say quarter to? 12:17
6 MR. DORAN: 1:45 would be perfect, Chair, yes.
7 CHAIRMAN: 1:45?
8 MR. DORAN: Yes.
9 CHAIRMAN: All right. Well, it's a slightly extended
10 lunch break, but provided we're going to get you done, 12:17
11 as it were, in the afternoon, that will be absolutely
12 fine. All right, thank you very much.
13 MR. DORAN: Thank you.
14 CHAIRMAN: Can I just mention that the undertaking
15 which you have just referred to, there is an area on 12:17
16 the website for it to go up and it will be going up in
17 fact at lunch today. It couldn't go up earlier because
18 apparently it mucks up the streaming. But it will be
19 there.
20 MR. DORAN: Thank you for that clarification. 12:18
21 CHAIRMAN: Thank you very much. Thank you.
22
23 THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS
24 FOLLOWS:
25 12:18
26 CHAIRMAN: Thank you.
27 MR. DORAN: Chair, I can confirm that the transcript of
28 yesterday's hearing and the undertaking given by the
29 DPP have both been posted on the Inquiry's website.

1 CHAIRMAN: Indeed they have. Thank you.
2 MR. DORAN: I return to the issue of production of
3 documents to the Inquiry. This process remains
4 ongoing. I've referred to the timeframe of the
5 Inquiry, which extends back to 1999. I've also 13:49
6 referred to multiple organisations and authorities with
7 a connection to Muckamore, or with responsibilities
8 touching on Muckamore, including the Belfast Trust and
9 other Trusts, the Department, the RQIA and the PCC.
10 13:50
11 In addition to those authorities, the professional
12 regulatory bodies have handled complaints arising from
13 the Hospital. Representative bodies will have provided
14 assistance to persons subject to disciplinary
15 proceedings. The PSNI and PPS will have been involved 13:50
16 in handling complaints of a criminal nature. Patients
17 from Muckamore will have been resettled at a range of
18 locations.
19
20 These are just examples of organisations and 13:50
21 authorities that may be in possession of material that
22 will assist the Inquiry. "Document provider" is the
23 shorthand term we have been using to describe
24 organisations and authorities of that kind.
25 13:51
26 The Inquiry has contacted 73 different potential
27 document providers within the last six months. The
28 Inquiry has obtained details of documents held by them
29 that may assist the Inquiry. The process of having

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1 documents produced to the Inquiry is, as I have said,
2 ongoing. You, Chair, have also directed that all
3 material that may be relevant to the Inquiry's work
4 must be retained by the relevant authorities and must
5 not be destroyed. 13:51
6
7 This exercise is onerous and time-consuming. It is
8 important that I should acknowledge the work that is
9 being conducted by the document providers and their
10 representatives to assist the Inquiry in this regard. 13:52
11 It is also important that I should emphasise the need
12 to ensure that this exercise is conducted in a
13 proportionate, properly organised and properly targeted
14 manner.
15 13:52
16 In a large scale exercise of this nature, care is
17 needed to ensure that the Inquiry's focus is not
18 distracted by an avalanche of material that is
19 peripheral to the issues that the Inquiry must
20 consider. The Inquiry team has spent considerable time 13:52
21 engaging with the various document providers to
22 identify the material that needs to be obtained. The
23 material that is obtained then requires to be assessed
24 to determine whether it will in fact assist the Inquiry
25 in addressing its Terms of Reference. Prior to 13:53
26 disclosure to Core Participants, material may need to
27 be redacted - for example, I've referred to the orders
28 that you have made, Chair, that require redaction of
29 personal details and that grant anonymity to patients,

1 unless that anonymity is waived.
2
3 As you said yesterday, Chair, one possible approach to
4 adopt would be to wait until all of this work is
5 completed before starting the oral hearings. You have, 13:53
6 understandably, decided that such an approach would
7 unduly delay the important public-facing work that the
8 Inquiry must undertake. I have mentioned the lengthy
9 wait that patients, their families, friends and carers
10 have had for this Inquiry. I have also emphasised the 13:54
11 forward-looking aspect of the Inquiry, the need to
12 ensure that abuse does not occur in the future at the
13 Hospital or at any comparable facility in Northern
14 Ireland. Having regard to those considerations, it was
15 imperative that the Inquiry should move on to the stage 13:54
16 of oral hearings at the earliest opportunity.
17
18 One consequence of that is that Core Participants will
19 not, at this early stage, have received disclosure of
20 documents. They ought not to feel in any way 13:54
21 disadvantaged by that. The work on obtaining documents
22 and preparing documents for disclosure will continue.
23 Core Participants will, of course, be updated on
24 progress and will receive material on an ongoing basis.
25 13:55
26 The Inquiry counsel team has prepared a preliminary set
27 of documents for the Panel. That preliminary set of
28 documents will be shared with Core Participants very
29 shortly, although there are some of the documents that

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1 remain to be redacted. Some further time will be
2 needed before those particular documents can be shared.
3
4 Another consequence of this approach is that the
5 Inquiry is not going to retrieve records and other 13:55
6 documents relating to a particular patient before a
7 witness can come along and speak to the Inquiry about
8 that patient's experience. As witnesses make their
9 statements and give evidence, the Inquiry team will
10 constantly monitor what records and other material the 13:56
11 Inquiry will need to obtain in relation to the patient
12 concerned. The Inquiry will strive to ensure that no
13 one is disadvantaged by this approach.
14
15 If records are later produced that the Inquiry thinks 13:56
16 the witness should be asked about or should have the
17 opportunity to comment on, the necessary arrangements
18 will be made for that to happen. If there is a
19 particular situation in which the Inquiry feels that
20 some records simply must be retrieved before a witness 13:57
21 gives their account, the Inquiry can adapt its
22 appropriate accordingly.
23
24 The objective, therefore, is to hear what witnesses
25 have to say at the earliest opportunity, while 13:57
26 remaining alert to matters arising in the course of
27 their evidence that might need to be further explored.
28
29 I am now going to move on to the topic of history of

1 reporting on Muckamore Abbey Hospital. I've looked at
2 the background to the Inquiry, the Terms of Reference
3 and the work that is being done to enable the Inquiry
4 to address its Terms of Reference. I now want to
5 mention some previous investigations and reports that 13:58
6 relate to Muckamore.
7
8 In the course of the oral evidence, the Inquiry will
9 hear about individual complaints and how they were
10 dealt with. It will also hear about disciplinary 13:58
11 proceedings and criminal proceedings that have arisen
12 as a result of complaints at the Hospital. As I have
13 mentioned, the Inquiry will also be considering the
14 work of the RQIA and its predecessor, the Mental Health
15 Commission. That work has resulted in multiple 13:58
16 inspection reports. The Inquiry has been gathering in
17 those reports and, where relevant, they will be made
18 available to Core Participants in due course.
19
20 Going beyond these individual cases and individual 13:59
21 inspection reports, however, there have also been a
22 number of exercises aimed at addressing broader or
23 systemic issues affecting the patient experience and
24 the management of the Hospital. I want to review those
25 exercises at this stage, as I anticipate that they will 13:59
26 be mentioned frequently in the course of the hearings.
27
28 The first exercise that I want to address dates back to
29 2013. This was the Ennis Ward adult safeguarding

1 investigation. The investigation was prompted by
2 concerns raised by a care assistant employed by a
3 private care provider. She was working on the ward as
4 part of an induction programme for patients who were
5 moving to a care home managed by the private provider. 14:00
6 The care assistant alleged that, while working on the
7 ward in November 2012, she witnessed staff being
8 physically and verbally abusive to four named patients.
9 The safeguarding investigation was established on
10 receipt of the allegations. This was led by a 14:00
11 designated officer from outside the Hospital, who was
12 assisted by two social workers from the Trust's
13 Community Learning Disability Team. As some of the
14 allegations were of a criminal nature, the
15 investigation was carried out jointly by the Trust and 14:01
16 the PSNI.
17
18 As well as the care assistant who initially raised the
19 concerns, other employees of the private care provider
20 also then expressed concerns about conduct that they 14:01
21 had witnessed during shifts at the Hospital. As a
22 result of these allegations, three staff members - that
23 is, two nurses and a healthcare assistant and a student
24 nurse - were placed on precautionary suspension. The
25 nurses were referred to the Nursing and Midwifery 14:01
26 Council and the Assistant to the Disclosure and Barring
27 Service.
28
29 I'm not going to delve into the detail of the

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1 investigation. The investigation report was produced
2 in October 2013. As a result of the PSNI
3 investigation, a nurse and a healthcare assistant were
4 charged with assault and ill-treatment. The nurse was
5 acquitted. The healthcare assistant was found guilty 14:02
6 of one count of common assault, which was subsequently
7 overturned on appeal. The healthcare assistant
8 retired. And there was also a disciplinary process
9 conducted in respect of the nurse.
10 14:02
11 The Inquiry will have the opportunity to consider the
12 Ennis investigation and the materials generated by the
13 investigation in due course. There are four reasons
14 for drawing attention to the Ennis report at this
15 stage. 14:03
16
17 First, the concerns that triggered the investigation
18 fall squarely within the Inquiry's Terms of Reference.
19 I would refer the Panel in particular to the
20 non-exhaustive definition of abuse at paragraph 5. The 14:03
21 allegations encompassed both verbal and physical abuse.
22
23 Secondly, the concerns went beyond a single allegation
24 of assault perpetrated by a single individual on a
25 single patient. The concerns related to four staff, 14:03
26 four patients and encompassed multiple allegations.
27
28 Thirdly, the concerns were the subject of investigation
29 by the Trust and by PSNI.

1 Fourthly, the concerns were the subject of multiple
2 case conferences and strategy meetings in the months
3 after the concerns were first voiced. As a result,
4 various steps were taken, aimed at improving staffing
5 levels, improving the living environment and enhancing 14:04
6 patient support on the ward.
7
8 The Inquiry will no doubt wish to examine the
9 out-workings of the Ennis review carefully. The issue
10 of identifying and responding to concerns is integral 14:04
11 to the Terms of Reference. There are, in fact, three
12 fundamental and closely related questions arising from
13 the Ennis episode that the Inquiry may wish to
14 consider, albeit with the benefit of hindsight: First,
15 can it be said that the evidence considered in the 14:05
16 course of that review was possibly indicative of a
17 wider culture of abuse within the Hospital? Secondly,
18 given the nature of the allegations, were the
19 investigation and the response sufficiently
20 far-reaching and robust? Thirdly, was this a missed 14:05
21 opportunity to detect and to address the very problems
22 that are now the subject of this Inquiry?
23
24 The second report that I want to address, at this
25 stage, is the report of November 2018 titled "A Review 14:06
26 of Safeguarding at Muckamore Abbey Hospital: A Way to
27 Go." This report postdated the allegations of abuse
28 that surfaced in 2017.
29

1 In January 2018, the Belfast Trust commissioned an
2 independent review team, chaired by Dr. Margaret Flynn,
3 to examine safeguarding issues at the hospital between
4 2012 and 2017. Dr. Flynn had previously led a serious
5 case review into abuse at Winterbourne View private 14:06
6 hospital in Gloucester in 2012. The review's broad
7 remit was to identify the principal factors responsible
8 for the historic and recent safeguarding incidents at
9 the Hospital. The review examined safeguarding files,
10 RQIA reports and Health and Social Care Board 14:07
11 information from the relevant period. The team
12 interviewed patients, families and staff and
13 representatives of the RQIA.
14
15 Again, I'm not going to go into the review in detail 14:07
16 for the purpose of the opening, the Panel will have the
17 opportunity of considering its work and its findings in
18 due course. I would just like to flag up some of the
19 themes that emerge from the review that this Inquiry
20 will have the opportunity of exploring in greater 14:08
21 depth.
22
23 First, the review commented on the fact that the RQIA
24 inspection process tended to be word-specific and,
25 therefore, did not present an overarching view of the 14:08
26 Hospital. As the review commented, a hospital is more
27 than the sum of its wards.
28
29 Secondly, the review commented on inconsistencies and

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1 gaps in records relating to safeguarding events and
2 concluded that it could not be determined how closely
3 adult safeguarding practice accorded with operational
4 safeguarding procedures.
5 14:09
6 Thirdly, on the question of culture, the review
7 observed:
8
9 "There was, indeed, a culture, a tolerated set of norms
10 or work practices which were harmful and 14:09
11 disproportionate. It was shaped by the use of power,
12 relationships and place in which the wards were closed.
13 Visitors, relatives, as well as professionals were
14 advised whether or not they could visit due to
15 'unsettled patients'. Individual staff members were 14:09
16 comfortable working with certain staff and cut and
17 paste records concerning the use of seclusion, for
18 example, were not challenged."
19
20 Fourthly, the review also contrasted that culture with 14:10
21 valued practice. The report recorded the wish of
22 families for it to be known that there were some staff
23 who conscientiously provide compassionate care and
24 treatment. That is, of course, important. In the
25 engagement sessions that have been conducted by the 14:10
26 Inquiry, you, Chair, have emphasised that the Panel
27 will wish to hear of experiences, both good and bad,
28 positive and negative. Just as abusive conduct on the
29 part of some must be investigated, so too must

1 diligence and care on the part of others be recognised.
2
3 Fifthly, the report questioned the use of "seclusion"
4 and commented:
5 14:11
6 "Current scrutiny of seclusion would suggest that the
7 use of seclusion was not benign in all circumstances."
8
9 Sixthly, the report commented on the frequent use in
10 safeguarding files of the term "has a history of making 14:11
11 allegations". The review questioned whether the use of
12 that term might risk the assumption being made from the
13 outset that an allegation lacks credibility. The
14 review also considered whether perhaps too much was
15 expected of patients with learning difficulties in 14:12
16 terms of identifying the times or dates when incidents
17 may have occurred. The team envisaged a much more
18 proactive role for advocacy to ensure that the voice of
19 the patient was heard.
20 14:12
21 Seventhly, the report highlighted delays in discharge
22 and commented:
23
24 "The Hospital is plagued by mental health delayed
25 discharges; that is, although a clinical 14:12
26 multidisciplinary decision has been made that a patient
27 is ready to be discharged and the patient is safe to be
28 discharged, the Hospital's delayed discharges are
29 compromising its capacity to provide assessment and

1 treatment. While the reasons behind the delayed
2 discharges are multifactorial, patients subjected to
3 protracting waiting for non-acute hospital provision
4 are likely to deteriorate."
5 14:13
6 This is, by necessity, a selective survey of the Way to
7 Go findings. There may be other aspects of the report
8 that the Inquiry and Core Participants will wish to
9 examine. There may be aspects of the report with which
10 some will take issue. I hope, however, that I have 14:13
11 fairly represented the tenor of the report and
12 identified some of the key themes that will be of
13 interest to the Inquiry.
14
15 That, then, leads me to the third report in this 14:13
16 sequence. This report is titled "A Review of
17 Leadership and Governance at Muckamore Abbey Hospital"
18 and it's dated 31st July 2020. This report was
19 produced by an independent review team commissioned by
20 the Health and Social Care Board and Public Health 14:14
21 Agency at the request of the Department of Health. The
22 remit was to review leadership and governance
23 arrangements within the Belfast Trust between 2012 and
24 2017. The team was also asked to consider the degree
25 to which those arrangements may have contributed to the 14:14
26 abuse of vulnerable patients going undetected. The
27 Department of Health sought this further review
28 because, in its view, the Way to Go report had not
29 sufficiently addressed matters of leadership and

1 governance.
2
3 The review examined a range of Trust documents and
4 conducted meetings with a range of individuals and
5 authorities. The team identified the Ennis Ward 14:15
6 concerns, the incidents revealed by the CCTV footage of
7 2017 and the handling of a specific complaint in 2017
8 as key events in its review. This is a very detailed
9 report. Again, I do not propose to drill into the
10 detail. It is, however, worth highlighting a number of 14:15
11 the key findings.
12
13 First, the Trust had extensive governance systems in
14 place, but their complexity hindered the ability to be
15 responsive. 14:16
16
17 Secondly, there was an apparent disconnect between the
18 governance arrangements in place at Trust level and
19 what was occurring on the ground at the Hospital. High
20 level strategies and leadership frameworks did not 14:16
21 result in good practice at the Hospital. To quote the
22 report:
23
24 "The review team concluded that there was a culture
25 within MAH of trying to resolve matters on site. The 14:16
26 location of MAH at some distance from the Trust and the
27 lack of curiosity about it at Trust level caused the
28 review team to view it as a place apart. Clearly, it
29 operated outside the sight lines and under the radar of

1 the Trust."
2
3 Thirdly, the team found the leadership team at the
4 Hospital to be dysfunctional. The report identified a
5 lack of continuity and stability at directorate level 14:17
6 and a lack of interest and curiosity at board level.
7
8 Fourthly, the report concluded, bluntly, that these
9 failings resulted in harm to patients. The team
10 concluded that while senior managers at MAH may not 14:17
11 have been aware of the culture of abuse, their
12 responsibility for providing safe and compassionate
13 care remained. The review team also acknowledged the
14 more recent efforts of the Trust to promote and monitor
15 a safe, person-centred environment at the Hospital. 14:18
16 The report made 12 recommendations directed at the
17 Department of Health, the Health and Social Care Board
18 and the Public Health Agency and the Trust.
19
20 A public inquiry will, by its very nature, require a 14:18
21 broader and more penetrating investigation than would
22 have been possible in any of the three review processes
23 that I have mentioned. The Inquiry will not, of
24 course, be bound by the conclusions of those previous
25 reviews. It will have the benefit of the evidence and 14:18
26 material presented to those reviews and it will, where
27 appropriate, revisit the matters addressed in
28 accordance with the Terms of Reference.
29

1 As I have mentioned, the concerns that gave rise to the
2 Ennis review emerged in 2012. Before I complete this
3 section of the opening, I'm going to go further back in
4 time and flag up an earlier episode for the attention
5 of the Inquiry. The beginning of this episode predates 14:19
6 the Terms of Reference. As I have indicated, however,
7 paragraph 3 of the Terms of Reference permits the
8 Inquiry:
9
10 "To receive and take account of evidence outside of the 14:19
11 timeframe where such evidence will assist the Inquiry
12 in examining, understanding and reporting on matters
13 within these Terms of Reference."
14
15 I should say that the Inquiry is still in the process 14:20
16 of obtaining all relevant material relating to this
17 episode. I simply want to provide a broad outline of
18 what occurred at this stage for contextual reasons.
19 The Inquiry and Core Participants will be in a position
20 to analyse the relevant events in appropriate detail in 14:20
21 due course.
22
23 In 1996 a former patient of the Hospital made
24 allegations that he had been sexually abused by other
25 patients at the Hospital and one member of staff. The 14:20
26 allegations related to a period predating the Terms of
27 Reference from 1970 to 1982. The allegations were
28 referred to the DPP, but there was no prosecution. The
29 case was also the subject of civil proceedings that

1 ultimately resulted in a civil settlement in 2004.
2
3 Subsequent to that, the Eastern Health and Social
4 Services Board, one of the Boards that amalgamated to
5 become the HSCB, appointed a review group to undertake 14:21
6 a fact-gathering review of all clinical records
7 relating to the care of the complainant while he was at
8 Muckamore. The review group had a representative from
9 the Board and the North and West Belfast Trust. It was
10 chaired by the Assistant Director of Legal Services in 14:22
11 the Central Services Agency. The review group was also
12 asked to identify any other salient information arising
13 from this review relating to activity of a similar
14 nature involving any other patients in the care of the
15 Hospital from in or around 1971 to 1986. In addition 14:22
16 to that, the group was asked to identify and document
17 other sources of potentially relevant information that
18 might require further exploration.
19
20 The review group undertook a review of records relating 14:22
21 to the complainant and other patients. They extracted
22 what they described as "the most significant entries in
23 which staff have documented inappropriate behaviour
24 between patients and other entries which may be
25 relevant." They also highlighted that some records 14:23
26 were missing and others difficult to decipher. They
27 also advised that it was difficult to identify which
28 members of staff had made the various entries in the
29 records.

1 The review group reported their findings to the Board
2 in November 2005. The work of the group did not end at
3 that point and it went on to review further files in
4 addition to those covered by the initial exercise.
5 Some of the records identified by the review in the 14:23
6 course of its work dated back to the early 1960s.
7
8 That was not the end of the matter. The results of
9 this process were referred to the PSNI. The PSNI then
10 undertook a phased investigation into the matters that 14:24
11 had been identified by the review group. The
12 investigation was conducted in and around 2006 to 2008.
13 The investigation was primarily focused on alleged
14 incidents between patients that had been identified in
15 the records by the review group. 14:24
16
17 As I have said, the Inquiry and Core Participants will
18 have the opportunity of analysing the relevant material
19 in due course.
20 14:24
21 It appears that the investigation did not ultimately
22 result in prosecutions for a variety of reasons,
23 including, first, the historical nature of the
24 allegations and the consequent loss of forensic
25 opportunities; secondly, the lack of supporting 14:25
26 evidence; and thirdly, in some instances, the lack of
27 capacity of alleged victims to be interviewed.
28
29 Aside from the PSNI investigation, the Eastern Health

1 and Social Services Board and the North and West
2 Belfast Trust also conducted a review of policies and
3 procedures to safeguard children and vulnerable adults
4 in Muckamore Abbey Hospital. This review team was
5 chaired by the Director of Hospital and Community 14:25
6 Learning Disability Services. The group produced a
7 report in December 2005 that "set out current practice
8 at Muckamore Abbey Hospital which seeks to ensure that
9 children and vulnerable adults are safe during their
10 stay at the Hospital." The report included a number of 14:26
11 recommendations that were aimed at improving
12 safeguarding practices within the Hospital.
13
14 Again, it is not necessary for me to go into the finer
15 detail of that report for the purpose of my opening 14:26
16 statement.
17
18 It is important to draw attention, at this stage, to
19 these earlier reviews in 2005 and to the police
20 investigation that followed. The allegations that were 14:26
21 being investigated were, for the most part, different
22 in character to the more recent allegations of abuse
23 perpetrated by staff on patients. Nonetheless, the
24 allegations gave rise to serious safeguarding concerns.
25 There was an awareness of those concerns at a high 14:27
26 level within the relevant public authorities at the
27 time.
28
29 In determining why the abuse happened and the range of

1 circumstances that allowed it to happen, as required by
2 the Terms of Reference, the Inquiry will need to
3 consider carefully the response of the authorities to
4 those earlier allegations: Ought those earlier
5 allegations to have prompted a root and branch review 14:27
6 of policy and practice at the Hospital? Ought there to
7 have been more radical intervention at that point in
8 time? What was the reason for decisions taken at that
9 point in time? Were decisions that ought to have been
10 taken not taken? Again, was this an earlier missed 14:28
11 opportunity to consider deep-seated cultural issues
12 within the Hospital which were later identified in the
13 Way to Go report?
14
15 Chair, I'm going to move on shortly to deal with the 14:28
16 present criminal proceedings. I think this would be an
17 appropriate time to take a short break. I will then
18 have a fairly short closing sequence.
19 CHAIRMAN: Shall we say quarter to?
20 MR. DORAN: Yes, that's very helpful. 14:29
21 CHAIRMAN: Does that give you enough time?
22 MR. DORAN: Oh, yes indeed. Thank you, Chair.
23 CHAIRMAN: And just to say, I'm not giving the five
24 minute warning when we have these short breaks, I'm
25 afraid it's up to you to make sure that you are nearby 14:29
26 when the gong goes. But I do, obviously, in the
27 morning and after the lunch adjournment.
28
29 Then in the break, if you could just confirm the order

1 in which Core Participants are going to address us. It
2 may be you know that already, but I just want to make
3 sure we know who is speaking when.
4 MR. DORAN: I'll confirm that after the break.
5 CHAIRMAN: Thank you very much. Okay, thank you. 14:29
6
7 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
8
9 CHAIRMAN: Thank you.
10 MR. DORAN: Chair, I will confirm the order of play for 14:46
11 the rest of this week later in my opening.
12 CHAIRMAN: Okay, thank you.
13 MR. DORAN: I'm now going to move on from past reviews
14 to other significant processes that are going on at
15 present. 14:46
16
17 The allegations of abuse at the Hospital that first
18 came to public attention in late 2017 are the subject
19 of an ongoing police investigation and prosecutions.
20 There are two preliminary points to be made about this 14:47
21 investigation: First, the subject matter of the
22 investigation - that is, allegations of abuse at the
23 Hospital - falls squarely within the Inquiry's Terms of
24 Reference; secondly, and importantly, the remit of the
25 Inquiry extends significantly beyond the incidents that 14:47
26 are being investigated.
27
28 When announcing the Inquiry in the Assembly on 8th
29 September 2020, the Minister commented:

1 "We must take account of the ongoing major police
2 investigation, because I want to ensure that any
3 process that is put in place does not jeopardise this
4 investigation."
5 14:47
6 The Inquiry itself has taken steps to ensure that its
7 work does not jeopardise the investigation. A
8 Memorandum of Understanding was agreed following
9 consultations between the Chair of the Inquiry, the
10 Police Service of Northern Ireland and the Public 14:48
11 Prosecution Service for Northern Ireland. The MoU is
12 dated 9th March 2022 and is published on the Inquiry's
13 website.
14
15 The PSNI investigation to date has been primarily 14:48
16 focused on Cranfield Psychiatric Intensive Care Unit,
17 or PICU to use the acronym. PICU was a secure unit for
18 patients with learning disabilities who presented a
19 risk of harm to themselves or others. Patients were
20 either detained under the Mental Health Order or 14:49
21 admitted on a voluntary basis. Only patients and staff
22 had access to the ward. The ward was staffed primarily
23 by healthcare support workers and staff nurses.
24
25 CCTV was installed in the Hospital in or around early 14:49
26 2017, including a number of cameras being installed
27 within PICU. The system was tested in March 2017 and
28 was, it appears, mistakenly left operational. The
29 system was recording in the period before it was

1 officially due to go live. The fact that the system
2 was recording was not known to staff on the ward. This
3 was discovered in September 2017, after it was reported
4 to PSNI that a PICU patient, Aaron Browne, had been
5 assaulted by a staff member. The patient's father, 14:50
6 Glynn, whom I have mentioned, raised concerns that he
7 had not been informed about the incident at the time
8 that it had occurred. Mr. Browne requested that the
9 CCTV be checked. It became apparent, then, that the
10 CCTV had in fact been operative and footage of the 14:50
11 incident had, in fact, been captured.
12
13 If I could just have one moment, Chair? (Short pause)
14
15 Thank you, Chair. As I said, it became apparent that 14:51
16 the CCTV had in fact been operative and footage of the
17 incident had in fact been captured. This discovery
18 prompted further examination of the footage. In the
19 first instance, the Trust dip-sampled the footage and
20 this revealed further evidence of abuse committed by 14:51
21 staff on PICU patients. The footage was then subject
22 to review by senior social workers and designated adult
23 protection officers appointed from outside the Hospital
24 staff. The Trust referred 143 incidents to police
25 relating to PICU, involving eight patients and 90 staff 14:52
26 members between March and September 2017.
27 Subsequently, in February 2019, PSNI seized the
28 entirety of the footage, reviewed the footage and noted
29 728 incidents in the course of that review. Given the

1 large scale of the investigation, PSNI decided that
2 suspects would be split into groups for the purposes of
3 police investigation and prosecution.
4
5 PSNI submitted its first investigation file to the PPS 14:53
6 on 10th April 2020. That file related to seven staff
7 and alleged offences committed against eight patients.
8 The reported offences included common assault,
9 ill-treatment, wilful neglect, false imprisonment,
10 fraud and forgery of notes and misconduct in public 14:53
11 office.
12
13 On 6th April 2021, the PPS confirmed that a decision
14 had been taken to prosecute those seven individuals in
15 relation to alleged ill-treatment of patients at the 14:53
16 hospital. A further staff member was added to the
17 first file in August 2021, as the staff member in
18 question had similar shift patterns to the other
19 suspects. Those cases are before the Magistrates
20 Court, with committal proceedings yet to take place. 14:54
21
22 A second file, relating to eight staff members on PICU
23 was submitted in late 2020. A third file, relating to
24 nine suspects was submitted in June 2021. A fourth
25 file has also been submitted. 14:54
26
27 This is an ongoing investigation. Arrests continue to
28 be made. On 19th May it was reported that the 34th
29 arrest had been made in connection with this

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1 investigation. There may be further arrests, there may
2 be further prosecutions.
3
4 The live nature of these ongoing criminal proceedings
5 is fully acknowledged in the Memorandum of 14:55
6 Understanding. The MoU sets out a shared understanding
7 of how the Inquiry, the PSNI and the PPS will discharge
8 their respective responsibilities as the Inquiry, the
9 investigation and the prosecutions move forward.
10 14:55
11 I do not need to go through the MoU in detail for the
12 purpose of the opening, the document is available on
13 the website. I do, however, want to draw attention to
14 some of its key features.
15 14:56
16 Paragraphs 16 to 18 enshrine the Inquiry's basic
17 commitment to respecting the integrity of the
18 investigation, while at the same time getting on with
19 the work required to address the Terms of Reference.
20 Those paragraphs read as follows: 14:56
21
22 "16. The Chair of the Inquiry acknowledges the need to
23 make every effort to ensure that the work of the
24 Inquiry does not impede, impact adversely on or
25 jeopardise in any way the PSNI investigation into abuse 14:56
26 at the Hospital and the prosecutions that result from
27 that investigation.
28
29 17. The subject matter of the investigation and

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1 prosecutions is of direct interest to the Inquiry, but
2 the Inquiry is not examining the response of the PSNI
3 and the PPS that has followed from the seizure of the
4 CCTV footage.
5 14:57
6 18. The Chair, in accordance with Section 17(1) of the
7 Act, shall make every effort to ensure that the
8 procedure and conduct of the Inquiry respects the
9 integrity of the investigation and prosecutions, while
10 continuing to address its Terms of Reference." 14:57
11
12 Given the importance of the subject matter of the
13 investigation and prosecutions to the Inquiry, the MoU
14 provides that the Inquiry will be provided with
15 material relating to the investigation. Documents 14:57
16 relating to the ongoing criminal proceedings will not
17 be disclosed to Core Participants without reasonable
18 notice having been given to the PSNI and the PPS.
19 Where the PSNI or PPS adopt the view that there would
20 be a risk of disclosure impeding, adversely impacting 14:58
21 on or jeopardising the criminal proceedings, they may
22 ask the Chair to make an order restricting what can be
23 disclosed. The Chair will have due regard to the live
24 nature of the investigation when determining such
25 applications. 14:58
26
27 Where material is not disclosed, there is provision for
28 Core Participants to be provided with a summary or gist
29 of the material in question. This will ensure that

1 Core Participants are properly informed of the
2 Inquiry's ongoing work, while at the same time
3 respecting the autonomy of the criminal proceedings.
4
5 The MoU also provides for the viewing of the CCTV 14:59
6 footage under restricted conditions by the Inquiry
7 Panel. The first phase of that viewing is scheduled
8 for next week. Importantly, paragraph 41 of the MoU
9 provides that:
10 14:59
11 "The Chair of the Inquiry, in consultation with the
12 PSNI and the PPS, will keep under review the matter of
13 whether wider viewing of the CCTV footage on behalf of
14 Core Participants may be appropriate or necessary,
15 while at all times making every effort to ensure that 14:59
16 the integrity of the investigation and the prosecutions
17 is protected."
18
19 Paragraph 43 restates a recurring theme within the MoU:
20 15:00
21 "In considering any issue relating to the viewing of
22 CCTV footage, the Chair will have particular regard to
23 the live nature of the investigation and any ongoing or
24 prospective prosecutions."
25 15:00
26 The MoU includes detailed provisions on witness
27 statements and the giving of oral evidence to the
28 Inquiry. Those provisions are also designed to ensure
29 that the Inquiry can conduct its work in parallel with

1 the criminal proceedings and in such a way as to avoid
2 hampering the criminal proceedings. Within the MoU,
3 there is also a mechanism for resolving any issue that
4 appears to give rise to a risk of the criminal
5 proceedings being jeopardised. 15:01
6
7 That is all I need to say at this stage about the
8 criminal proceedings.
9
10 Before I finish my opening remarks, Chair, I want to 15:01
11 mention, briefly, the schedule from now until the
12 summer recess. Representatives of Core Participants
13 will be addressing the Panel tomorrow, Thursday and
14 first thing Monday. Tomorrow's hearing will be
15 starting at 2:00 p.m. and the Panel will hear from 15:01
16 Mr. Andrew McGuinness on behalf of the Department of
17 Health. And the opening statement on behalf of the
18 Department of Health will be followed by the opening
19 statement on behalf of the PSNI, which will be
20 presented by Mr. Mark Robinson QC. There is a 10:30 15:02
21 start on Thursday morning and the first Core
22 Participant to provide an opening statement on Thursday
23 will be the Trust, and that will be presented by
24 Mr. Joseph Aiken QC. The Trust's opening statement
25 will be followed by the opening statement on behalf of 15:02
26 the RQIA, given by Mr. Michael Neeson. At 2:00 p.m. on
27 Thursday the Panel will hear the closing statement on
28 behalf of the unaffiliated Core Participants --
29 CHAIRMAN: It should be the opening, I think.

1 MR. DORAN: Did I say closing? Wishful thinking,
2 Chair!
3 CHAIRMAN: Yes, two o'clock Thursday.
4 MR. DORAN: Two o'clock Thursday. That's for the
5 unaffiliated Core Participants represented by O'Reilly 15:03
6 Stewart. And that statement will be given by
7 Mr. Connor Maguire QC.
8 CHAIRMAN: Yes.
9 MR. DORAN: Then the final opening statement will be
10 given on Monday morning at 10:00 a.m. by 15:03
11 Monye Anyadike-Danes QC on behalf of individuals
12 affiliated to Action For Muckamore and individuals
13 affiliated to the Society of Parents and Friends of
14 Muckamore Abbey.
15 15:04
16 So, that's the running order for the next few days.
17 And that timetable has, I think, been formally issued
18 to all.
19
20 As I've mentioned, next week has been set aside for the 15:04
21 closed viewing by the Panel of the CCTV footage. The
22 Inquiry intends to have seven days of witness evidence
23 at the end of June and the beginning of July. The
24 first day of oral evidence will be on Tuesday, 28th
25 June. The Inquiry will also sit on Wednesday 29th and 15:04
26 Thursday 30th June and then again from Monday 4th July
27 to Thursday 7th July. And the hearings will then
28 resume in September on a date to be fixed.
29

1 As you have said, Chair, the questioning of witnesses
2 will be conducted by Inquiry counsel. Core
3 Participants will be issued later this week with a
4 document that sets out the timetable for witness
5 statements to be provided to Core Participants and for 15:05
6 Core Participants to propose questions to Inquiry
7 counsel in advance of a witness' evidence. And there
8 is also a form on which the proposed questions must be
9 submitted. The actual schedule for those hearing days
10 will be issued at the earliest possible opportunity. 15:05
11 CHAIRMAN: Yes.
12 MR. DORAN: Now, It is, of course, a matter for Core
13 Participants as to whether they wish to propose
14 questions for a witness. It should be borne in mind
15 that this first phase of evidence is all about the 15:06
16 patient experience. The witnesses will have made their
17 statements. Inquiry counsel will try to assist those
18 witnesses in telling their stories to the Inquiry.
19
20 It may be that the procedure for proposing questions 15:06
21 will be utilised more extensively at a later stage of
22 the Inquiry when we come to hear from those in
23 positions of responsibility within the Hospital and
24 within the various relevant authorities. I do not, of
25 course, wish to discourage questions being proposed - 15:06
26 it's entirely a matter for Core Participants and their
27 representatives to decide what, if any, questions they
28 wish to propose to Inquiry counsel - I just want to
29 emphasise that this first phase of evidence is devoted

1 to the evidence of people affected by the events at
2 Muckamore; it is for them to come and tell the Inquiry
3 about their experience or the experience of someone
4 close to them.
5 15:07
6 Chair, that brings me to the conclusion of my opening.
7 I would like to thank my counsel team for their
8 assistance and support in the preparation of these
9 opening remarks. I'm very grateful to the Panel and to
10 all of the others in attendance for bearing with me 15:07
11 over the past day and a half. I've covered a wide
12 range of topics. We shall, of course, be returning to
13 those topics in varying degrees of detail in the months
14 ahead.
15 15:08
16 Panel, finally, my counsel team and I look forward to
17 assisting you throughout the course of the Inquiry
18 hearings. Thank you.
19 CHAIRMAN: Well, Mr. Doran, thank you very much indeed.
20 You've managed to be both concise and comprehensive, so 15:08
21 we're very grateful.
22
23 I think to add to your programme, there is going to be
24 training tomorrow morning at 11 o'clock in this room
25 for those who are going to be using CaseView. So, the 15:08
26 room will be available to you and there will be
27 somebody -- some of you may already know how to use
28 CaseView, but it may be worth attending in any event to
29 make sure everything is actually working properly.

1 I also want to thank our AV technicians, because in
2 fact, given that these are the first two days of the
3 Inquiry, it's, if I may say so, a masterful art of
4 getting everything up and running as they have. And
5 also, thanks to our stenographer; it's extremely useful 15:09
6 to have CaseView and to be able to follow what's
7 happening on screen. But it is an arduous job doing
8 it, as I know, so thank you very much to her.
9
10 Could I ask that we have the room cleared in the next 15:09
11 sort of ten minutes, because I need to come in and do
12 various things. But in the meantime, thank you very
13 much indeed. Those who want to attend tomorrow for
14 training at 11 o'clock, please. Otherwise we'll start
15 at 2:00. Thank you very much indeed. 15:09
16 MR. DORAN: Thank you, Chair.
17
18 THE INQUIRY WAS THEN ADJOURNED UNTIL WEDNESDAY, 8TH
19 JUNE 2022 AT 2:00 P.M.
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