MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 8TH JUNE 2022 - DAY 3

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

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THE INQUIRY RESUMED ON WEDNESDAY, 8TH JUNE 2022 AS FOLLOWS:

MR. DORAN: Chair, the Inquiry will hear two opening statements this afternoon. First, Andrew McGuinness will speak on behalf of the Department of Health. We then propose to have a short break, and after that, Mark Robinson QC, will be addressing you on behalf of the Police Service of Northern Ireland.

14:01

CHAIRMAN: Okay. Thank you very much indeed. Yes, Mr. McGuinness, thank you.

14:02

MR. McGUINNESS: Yes. Good afternoon, Chairman, hopefully everyone can hear me, and those on-line as well?

14:02

SUBMISSION BY MR. McGUINNESS:

MR. McGUINNESS: My name is Andrew McGuinness. I appear on behalf of the Department of Health. I am instructed by Mrs. Erwin of the Departmental Solicitors Office.

14:02

CHAIRMAN: Just hold on one second, Mr. McGuinness, because I think we might need to increase the volume. I am sorry, we have got to make sure -- because we've got a fan going, and we need to make sure that it's working on the feed. Okay. Okay. Thank you. I'm sorry to interrupt you.

14:02

MR. McGUINNESS: No, I'll start again and hopefully that does sound better now, sir. Sir, my name is

Andrew McGuinness. I'm a barrister instructed on behalf of the Department of Health. I am instructed by Ms. Sara Erwin of the Departmental Solicitors Office and also instructed with me, sir, and who wasn't introduced earlier on, is Ms. Tremlett, who you and the Panel will see more of in due course. 14:02

I have a number of departmental officials present today, including the Permanent Secretary of the Department of Health. 14:03

The Department of Health, sir, has been known as such from 2016. However, in December 1999, when the Terms of Reference for this Inquiry commenced, it was known as the Department for Health, Social Services and Public Safety. I intend to use the shorthand of the Department today when I refer to it in this statement. 14:03

It is intended that this opening statement be relatively short. That's not in any way to be disrespectful to this Inquiry or to those who have and will come to this Inquiry to give evidence about the abuse that they have suffered. Rather, it is intended to reflect the fact that the Department is conscious that at this stage we are at or close to the beginning of the hearing stage of this Public Inquiry process. A process that we are confident will be comprehensive, searching and probing. A process that is welcomed by the Department, and which the Department pledges to 14:03

engage in fully and transparently.

I intend, within this opening statement, to touch upon the following four issues. Panel, you will forgive me if I tread upon some of the information that you were provided both on Monday and yesterday by your counsel, Mr. Doran, however, I consider that the matters that I'm going to raise with you and bring to your intention bear some repetition, even if much more inelegantly given than that by Mr. Doran yesterday. 14:04

The first thing I intend to deal with is an outline of the health and social care system during the relevant time period. The second issue will be an outline of the Department's operational structures and their interaction with other healthcare providers. The third issue will be an outline of the Department's actions following the allegations of abuse at Muckamore arising. And, finally, to deal in a short fashion with the Department's engagement with this Inquiry so far. 14:05

The comments I make at this stage are very much intended to be embryonic. I will touch upon some reports already commissioned into the Muckamore Abbey Hospital, which I'm going to refer to as Muckamore, with your permission for convenience, and upon acceptances of the issues which the reports that have been compiled to date have identified.

These issues have been recognised by the Department, which has apologised for them on behalf of the health and social care family. The Department's acknowledgement of the issues identified in earlier reports is, however, not in any way to be taken as a comprehensive or completed view in respect of any failings and causes of abuse. Rather, it is a reflection of the more limited and focused nature of the reviews to date, along with the recognition of the need for a comprehensive overview which this Inquiry has been set up to facilitate. 14:05 14:05

Ultimately, this led to the Minister initiating this fully independent Inquiry process under the 2005 Act, with its attendant statutory powers and extensive terms of reference. The Department wish to make it clear at this stage that these comments are in no way an attempt to preempt the findings of this Inquiry. 14:06

Now if I can turn to the health and social care system in Northern Ireland at the time. Uniquely within the United Kingdom, Northern Ireland has a fully integrated system of personal social services with healthcare, and we refer to this as the health and social care family. Healthy and Social Services were integrated in 1973, following the Health and Personal Social Services Northern Ireland Order 1972. Since then there have been numerous restructuring exercises following broad patterns established across the United Kingdom. 14:06 14:06

The period of this Inquiry's Terms of Reference - December 1999 to June 2021 - have seen a number of significant structural changes and as of 1st April of this year, there was a further significant change. 14:07
Whilst the most recent changes are of some relevance, it is intended to concentrate on the health and social care structure prior to April of this year.

In terms of hierarchy of health and social care in 14:07
Northern Ireland, the Department of Health, headed by the Minister of Health, sits at the top of the tree. Essentially the Minister's strategic vision and priorities for health and social care within Northern Ireland are implemented by the Department. The 14:07
Department also manages the general funding of health and social care services from the allocation provided to it by the Northern Ireland Executive.

Section 2 of the Health and Social Care (Reform) Act 14:07
(Northern Ireland) 2009, places upon the Department a general duty to promote an integrated system of healthcare and social care. The statutory responsibility for the provision of services is placed upon the Department. The Department in turn secures 14:08
the provision of services through bodies with distinct delegated responsibilities. While services are provided via these arm's length bodies, or ALBs as I will refer to them, the department retains ultimate

responsibility and accountability for all aspects of the service.

Up until April this year the Department discharged its duty in terms of service commissioning and provision primarily by devolving the exercise of its statutory functions to the health and social care boards, or the Board, as I call it. And also to the Public Health Agency and to a number of other health and social care bodies created to exercise specific functions on its behalf. One such body is the RQIA, who is before you as a core participant. This is responsible for monitoring and inspecting the availability and quality of the regulated health and social care services in Northern Ireland and to encourage improvements in the quality of those services. All of these health and social care bodies are accountable to the Department, which is in turn accountable, through the Minister, to the assembly for the manner in which this duty is performed. 14:08 14:08 14:08 14:09

The Health and Personal Social Services Northern Ireland Order 1972, established the modern health and social care structure. It set up geographical health and social services boards, with Article 17 specifying the key functions of these boards with respect to the administration of health and personal social services. These included the exercise of such functions on behalf of the relevant predecessor to the Department as it 14:09

directed.

In December 1999, there were four Health and Social Services Boards. The Board with responsibility for Muckamore, as we heard yesterday, was the Eastern 14:09
Health and Social Services Board. These four boards function as agents of the Department and were charged with, amongst other things, identifying the health and social care needs of people living within their area and to commission services to meet those needs. This 14:10
involved commissioning contracts for care services with the Health and Social Care Trusts.

In December 1999, there were 18 Health and Social Care Trusts. These Trusts provided direct care services to 14:10
people, to include hospital and community care, and employed most of the staff in the Northern Ireland health and social services sector. The relevant Trust with responsibility for services at Muckamore in 1999 was the North and West Belfast Health and Social 14:10
Services Trust. Ultimately this Trust merged with five others to become the Belfast Health and Social Care Trust in April 2007.

As part of the Northern Ireland Executive Review of 14:10
public administration, subsequent reforms streamlined the health and social care system and led to the Health and Social Care (Reform) Act (Northern Ireland) 2009. This Act amalgamated and replaced the previous four

health and social services boards and replaced them with a single regional health and social care board, colloquially known as "the Board". This single health and social care board, working in conjunction with the Public Health Agency, commissioned services to assess needs and to promote general health and wellbeing. These services were provided by six newly established Health and Social Care Trusts and other health and social care ALBs. 14:11

The integration of the four boards was seen as facilitating strategic change. Such is the shifting away from institutional to community based case. It was designed to provide the opportunity for a comprehensive assessment of both health and social care needs. Local commissioning groups, which were committees of the Health and Social Care Board, were able to establish local priorities and commission services to meet the spectrum of care needs within their own areas. It was considered that a single budget located within the board would promote the coherent development of objectives within a unified strategic planning process, spanning acute and community based care. 14:11 14:12

The range of functions being performed by the board was three fold. Firstly, in response to the strategic context set by the Department through a commissioning direction to the Board, it was responsible for

commissioning the provision of health and social care and other related interventions. This was organised around a commissioning cycle. This cycle consisted of the assessment of need, strategic planning, priority setting and resource acquisition. It also addressed these by agreeing with providers the delivery of appropriate services. The Board also monitored delivery to ensure that services met established quality standards and evaluated how needs had changed. 14:12

The second function it undertook was performance management and service improvement. It was required to develop a culture of continuous improvement in the interests of patients, clients and carers, by monitoring health and social care performance against relevant targets and standards. This included promptly and effectively addressing poor performance through appropriate interventions and service development, as well as identifying and promulgating best practice and, where necessary, the application of sanctions. 14:13

Thirdly, the Board was responsible for resource management. That is ensuring the best possible use of the resources both in terms of quality, accessible services for users and value for money for the taxpayer. 14:13

The Board was accountable for its performance and for ensuring that appropriate assurance mechanisms were in

place. This obligation rested with the Board's board of directors. It was the responsibility of the Board to oversee the Trust's performance in delivery of commission services and to address emerging issues in the first instance. 14:13

The Board was responsible for monitoring and reporting to the Department on the implementation of statutory functions that had been delegated to the Trusts under schemes of delegation as part of its performance and assurance responsibilities. 14:14

The health and social care structures at that stage were unique to Northern Ireland because in England, Scotland and Wales Social Services remained the responsibility of local authorities. Trusts were independent, corporate ALBs within the health and social care system within Northern Ireland, responsible for the delivery of health and social care services in line with ministerial priorities, standards and targets, and as commissioned by the Board. Trusts were responsible for exercising the statutory functions which were delegated to them. 14:14

The 2009 Reform Act placed a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health and equalities between those for whom it provides health and social care. Each Trust 14:14

was accountable for its performance and for ensuring that appropriate assurance mechanisms were in place.

This obligation rested with the Trust's board of directors. It was the responsibility of the Trust Board to manage local performance and to manage emerging issues in the first instance. Trust Boards remain presently responsible for performance management and assurance in respect of all of the Trust's activities. 14:15

Prior to the Health and Social Care Act Northern Ireland 2022, Trusts were accountable to the Board for the availability, quality and efficiency of services they provided against agreed resource allocations. 14:15 They were also accountable to the Minister through the Department and the Board for performance against ministerial targets, including compliance with any statutory obligations.

14:15

The 2002 Act makes a number of significant changes to the landscape of health and social care within Northern Ireland. Whilst this is on its face outside the Terms of Reference of this Inquiry, it is likely to be of relevance to the Inquiry in terms of its consideration 14:16 of the legal and regulatory framework and any recommendations the Inquiry might make.

The 2002 Act was introduced to strengthen the system,

to remove complex and bureaucratic structures, to ensure clarity in relation to accountability and decision-making.

The effect of the 2002 Act was to dissolve the Board and to transfer its powers, duties and responsibilities, including commissioning, performance management and resource management to the Department. Responsibility for oversight and performance management is now placed within the Department under the new Strategic Planning and Performance Group, the acronym for which is SPPG. 14:16

The Health and Social Care Trusts are now directly responsible and accountable in respect of their delivery of health and social care functions to the Department. 14:16

If I might now turn to the Department's operational structures that were in place. 14:17

In due course the Inquiry will no doubt seek detailed written evidence around the governance structure within the Department. However, at this stage it may be useful to provide an outline of this. Some of the relevant groups within the Department that reported to the Permanent Secretary, and through him to the Minister, which this Inquiry will consider are: Firstly, the Social Services Policy Group. This is 14:17

headed by the chief social work officer. It is responsible for policy, legislation, for professional advice in relation to social work and social care services. It is responsible for services for families and children, older people, and importantly to this Inquiry, people with disabilities.

Within this group sits the disability and older persons directorate, and within this directorate sits at present the Muckamore Abbey Review Team. This review team was set up in 2019 after the allegations of abuse came to light and it is responsible for overseeing the implementation within the health and social care sector of actions and recommendations which are found in the Muckamore Health and Social Care Action Plan, and I'm going to refer to that as the action plan.

This Muckamore Abbey Review Team also provide support for the Muckamore Development Assurance Group. Finally, it is responsible for supporting the Department's response to this Inquiry.

The next relevant group that I might turn to is the Chief Nursing Officer group. This is led by the chief nursing officer, and this group is responsible for leading the nursing, midwifery, and allied health professionals, contributing to the development and implementation of the health and social care policy.

We also have the chief medical officer group. This is led by the chief medical officer and this group has three main areas of responsibility.

Firstly, it provides professional medical and environmental health advice to ministers and departments to help inform policy decisions throughout the Department. Secondly, it provides public health policy, including health promotion, disease prevention, emergency planning, health protection and environmental health. And, thirdly, safety and quality policy, including standards and guidelines, professional regulation and adverse incident reporting and learning. 14:18 14:19

The strategic planning performance group, which I've referred to already today, has been incorporated into the Department following the dissolution of the Board. This is responsible for planning, improving and overseeing the delivery of effective high quality and safe health and social care services for the people of Northern Ireland. 14:19 14:19

Finally, the resources and performance management group is responsible for policy and governance arrangements and in respect of the allocation of finance. 14:19

Of course those aren't all of the groups within the Department, but they're certainly the ones that it seems to us are relevant to bring to your attention at

this stage.

The Minister and Permanent Secretary are supported by the Departmental Board and by the top management group. The Departmental Board's role is to scrutinise the governance and performance of ALBs and the implementation of the ALBs assurance and accountability arrangements within the Department. 14:20

An additional level of scrutiny is provided by the Department's audit and risk assurance committee, who advise the Permanent Secretary as the Departmental accounting officer through the Departmental Board, on the quality of assurances they receive about strategic processes for risk management, governance, internal control and the integrity of financial statements. 14:20

Importantly, this committee includes a number of members external to and independent from the Department. 14:20

Whilst ALBs are sponsored by the Department as a whole, individual branches within the Department conduct those sponsorship responsibilities. These branches engage specifically with the arm's length body and are their everyday points of contact. For example, the Regulation Quality and Improvement branch within the chief medical officer's group carries out the day-to-day sponsorship work of the RQIA. 14:21

Policy are professional leads within the Department, to varying extents, are responsible for ensuring arrangements are in place to monitor and to report on policy and strategy within the areas of responsibility. 14:21
They take the lead on issues of assurance with regard to professional disciplines and otherwise engaging with monitoring and contributing to ALB governance.

Along with the ongoing engagement with ALBs, those 14:21
bodies are required to submit bi-annual assurance statements to the Department to assist in ensuring the continuing robustness of internal governance. Annual governance statements are also required. These statements are reviewed to determine if the information 14:21
provided was in line with the Department's knowledge of the body and any risks it was facing. Mid and end year accountability reviews of arm's length bodies ensure both the robustness of the assurance is provided and hold ALBs to account for their performance against 14:22
organisational and service delivery priorities.

The Inquiry should be aware that exceptionally there was a suspension of the assurance calendar for a period during the Covid-19 pandemic. This was as a result of 14:22
departmental resources being re-prioritised to deal with the exceptional issues caused by the Coronavirus pandemic.

Given the Department did not have a direct operational role in Muckamore, and its governance, it is likely that the Inquiry will want to consider how information flowed upwards to the Department from the relevant arm's length bodies - including the Belfast Trust, the Board, the RQIA - the Inquiry is likely to want to consider the extent to which the assurance mechanism between the Department and other bodies was sufficiently robust, and insofar as relevant information was not being provided to the Department, was this as a result of the system not working as it was designed or more systemic flaws? 14:22 14:22

Turning to the Departmental response to allegations of abuse now, sir. 14:23

As can be seen from what has been already said, it is for the Department to implement the Minister's strategic vision and priorities for health and social care. The vision itself provides an overarching direction of travel that should reflect already well-established policies and strategies. 14:23

I want to say something within this chapter about the policy direction, and it's clear that the policy direction from the 1990s - and as touched upon yesterday by Mr. Doran - has been a clear and consistent commitment that no one should be required to live in long-stay institutions and that people with 14:23

learning disabilities should be adequately supported to live independently within a community setting. They should be provided with opportunity and support to enable them to maximise their potential to fully engage with the communities and with wider society. 14:23

The defining principle is that resettlement should be offered where it is clinically appropriate, meets the patient's needs, has the potential to better the life of the patient, and is in line with the wishes of the 14:24 patient and their family where this is appropriate.

This policy direction has been reflected in a number of policy documents, to include the second report of the Bamford Review in 2005, entitled "Equal Lives". This 14:24 report sought, amongst other things, to identify the needs of people with learning disabilities and to develop appropriate policies for promoting their health and quality of life. The Equal Lives Report was the second report from the Bamford Review. This review was 14:24 set up in 2002 as an independent review of the law, policy and provision affecting people with mental health needs or a learning disability within Northern Ireland. It was overseen by a steering committee comprising representatives from professional and other 14:24 interested groups in the mental health and learning disability fields. This report sets out a vision for services for people with a learning disability. It identified a series of objectives and then provided a

jigsaw of recommendations to provide a coherent framework for guiding the delivery of a programme of change.

The Transforming Your Care Report 2011, restated the commitment to ensuring that no one should be required to live in long stay institutions and supporting those with learning disabilities within the community. Substantial steps have been taken to date to comply with the policy direction, and inpatient numbers in Muckamore are 38 as of 27th April of this year, and have been reduced to 37, as updated by Mr. Doran yesterday. This is from a figure of 318 in 2005. The resettlement of those patients who remain within Muckamore is highly complex, requiring significant community infrastructure, and it has been hampered by the impact of Covid-19 and by the necessity to protect these extremely vulnerable patients. 14:25 14:25 14:25

It is against this general policy background that the allegations of abuse by a member of staff on a patient came to light initially in 2017. This was brought to the attention of the Department, and the existence of CCTV recording of the incident emerged. The Department raised concerns with the Belfast Trust about the handling and reporting of the allegations, and further concerns emerged following retrospective viewing of the CCTV footage. 14:26 14:26

The Belfast Trust commissioned an independent Level 3 Serious Adverse Incident Review - that's an SAI - of safeguarding arrangements, which was completed in December 2018, with a "way to go" report.

14:26

In response to this report, the Permanent Secretary and senior departmental officials, including the chief social work officer and the chief nursing officer, attended a meeting in December 2018 with a number of families whose relatives had been affected by the abuse allegations, to brief them on the finding of the SAI review. As the Department is the body ultimately responsible for health and social care, and in circumstances where no Minister was in post as a result of the absence of a Northern Ireland Executive, the Permanent Secretary apologised to families of Muckamore patients at this meeting for what had happened to their loved ones whilst in the care of the Hospital. He was appalled and angered that vulnerable people were let down. At the same time he identified the need for urgent action by the health and social care system as a whole in response to the recommendations of the report. Consequently, in January 2019, the Permanent Secretary wrote to the Chief Executive of the Board to the five Health and Social Care Trusts and the RQIA, inviting them to attend a meeting at the end of January to formulate a plan to implement the review recommendations and its commitments to the families. At that meeting he set out expectations for the

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delivery of his commitments and the development of a health and social care action plan and appropriate associated governance arrangements.

A Muckamore health and social care action plan, or the action plan, was developed. Progress on this plan is monitored by the Muckamore Departmental Assurance Group established in August 2019. The objectives of that assurance group are, firstly, to ensure that the services being delivered at Muckamore continue to be safe, effective and fully human rights compliant; secondly, to ensure that the commitment given by the Permanent Secretary to resettle patients is met and the issue of delayed discharges is addressed; thirdly, to ensure that the team on site at Muckamore is given the support and resource necessary to achieve their and these goals; and, fourthly, to ensure that the lessons learnt from Muckamore, to include those identified in the SAI report, and the more recent report, are put into practice consistently on a regional basis in line with wider policy for services for people with learning difficulties and also to inform the work underway to transform learning disability services within each Trust. 14:27 14:28 14:28 14:28 14:29

This group is jointly chaired by the chief social work officer and the deputy chief nursing officer, and is made up of representatives from the health and social care organisations and other key stakeholders.

Importantly, this includes representatives of families of patients. This group meets regularly, initially monthly and latterly bimonthly, although there were some interruptions to the schedule of these meetings due to the Coronavirus pandemic. Minutes from the group's meeting have been published on the Department's website since September 2020. 14:29

The Muckamore Departmental Assurance Group are provided with the report at each meeting. This provides a summary of arrangements to ensure patient safety at the Hospital. It must be acknowledged at this stage that to ensure the services currently being provided by the Hospital are safe, a range of measures have been put in place by Belfast Trust. These include restructuring and enhancement of the Trust's senior management team, installation of CCTV in all wards, day care and the swimming pool. There is contemporaneous viewing of footage selected at random and viewed by an independent group of staff. The provision of seclusion practices has resulted in a significant reduction in the number of seclusion episodes and numbers of patients requiring seclusion. 14:29 14:29 14:30

A weekly report on patient safety is prepared. This is viewed by the senior management team in Muckamore and is shared with the multidisciplinary team. There is also a weekly live governance call for all clinical areas to feed back on the previous weeks incidents and 14:30

any other governance issues.

In addition, the Permanent Secretary chaired a number of meetings with the senior executives in Belfast Trust, the Board, the Public Health Agency during 2019, 14:30
to discuss options for the future of Muckamore and any necessary interim measures to ensure the safety and stability of the Hospital.

RQIA continued to carry out unannounced inspections of 14:30
the Hospital, and the Department has also held regular meetings with both the RQIA and the Belfast Trust outside of the assurance group to seek assurances about the safety and stability of services at the Hospital.
14:31

Further to the findings of the SAA report, the Department considered that this report had not explored leadership and governance arrangements at Muckamore or the Belfast Trust sufficiently. Consequently, it directed the Board and the Public Health Agency to 14:31
commission an independent review of the Trust leadership and governance arrangements at the relevant time.

The independent review panel's report was published on 14:31
the Department's website on 5th August 2020, after a briefing event on its findings was held for families. This review panel were very clear that there were failures of care at Muckamore which resulted in harm to

patients, albeit it recognised the efforts made by Belfast Trust to promote and monitor a safe person centred environment at Muckamore. The review identified a number of issues with governance, a matter this Inquiry will no doubt investigate in much greater detail. 14:32

Ultimately, given the leadership and governance failings identified by this review, the Minister announced this Public Inquiry on 8th September 2020. He also accepted all of the 12 recommendations made by the independent review panel, these have been included in the action plan, along with the 42 recommendations from SAA Report, with their implementation overseen by the Muckamore Departmental Assurance Group. I can tell the Inquiry to date 27 of the 54 actions contained in the action plan have been rated as green and are now completed. 14:32 14:32

Whilst it does not seek to gainsay any police investigation or the work of this Inquiry, the Department wish to take this opportunity to once again publicly apologise for the appalling behaviours identified in the two reports to date, and to accept that the findings of the reports reflected practices that fell well short of what is acceptable. 14:32 14:32

At the same time, it is important to recognise those within the health and social care system who work

tirelessly to deliver high quality and safe services to people with learning disability and to recognise the dedication, determination and support of those family members who provide an invaluable support to their loved ones.

Now, turning to the Department's engagement with this Inquiry.

In anticipation of this Inquiry, the chief social work officer and the then chief nursing officer wrote to all health and social care organisations and to staff in the Department on 5th February 2020, to ask that all necessary steps were taken to identify and preserve any documents, records and other relevant material relating to Muckamore, and to ensure that they were not subject to schedule disposal. Minister Swan announced on 8th September 2020, his intention to hold an Independent Public Inquiry into the events of Muckamore. In December 2020, the Department's director of corporate services reiterated the message of the February 2020 letter, and as advised earlier the Muckamore Abbey Review Team was set up in 2019. It is responsible for overseeing the implementation of the sector-wide actions and recommendations in the action plan and providing support for the Muckamore Departmental Assurance Group. It is also responsible for supporting the Department's response to this Inquiry and additional resources have been allocated to deliver on

this role.

In August 2021, further correspondence was sent by the Department to senior staff around the identification, collation and forwarding of any material of potential relevance for the Public Inquiry into Muckamore. Following the publishing of the Inquiry's terms of reference in October 2021, and engagement with the Inquiry on 23rd November 2021, a further e-mail was issued at the end of November, on the 29th, by the Director of Disability and Older People Directorate, which sought nominated contact points and deputies for each of the command groups with the Department. They would be responsible for the receipt and action of requests for that group. 14:34 14:35 14:35

The Department has engaged in extensive searches of its records, both electronic and hard copy, held both on and off site and within the public records office. These have been catalogued and to date in the region of 72,000 documents have been identified as of potential relevance to this Inquiry's terms of reference and they've been catalogued. 14:35

A total of approximately 4,500 documents have been identified in response to the initial request by the Inquiry, and these have been uploaded to the Inquiry's system. Some continuing work is ongoing to identify a small number of hard files and a further direction has 14:35

been issued. The Department recognises the importance of the Inquiry having all relevant documents and is engaging in a quality assurance process to ensure that no stone has been left unturned. Albeit the Department is confident that its process has been robust and reflects its serious and diligent approach to its duty to this Inquiry. 14:36

Final on this topic, the Department wants to welcome the constructive approach of the Inquiry team to all engagements to date and to recognise the clear benefits of this collaborative approach. 14:36

In conclusion, I should like to conclude by welcoming on behalf of the Department this opportunity to provide an opening statement. It is hoped that this overview of health and social care structures has assisted in setting the scene for this Inquiry, albeit it's anticipated that the Inquiry will hear much more around the acronyms and the structures. The Department reiterates that it stands ready to cooperate with and assist the Inquiry in any way that it can, in particular given the important task of this Inquiry the Department welcomes the difficult questions which are likely to come and recognises that these will be essential to ensure fulsome answers and recommendations are produced by the Inquiry. 14:36 14:37

As we enter this stage of the process, it is recognised

that in due course the Department will be no doubt providing a closing a statement at the end of the oral hearings. It is anticipated that at that stage the Department will be in a more informed position to provide details around any failures and any missed opportunities, which no doubt will form the basis of learning and your recommendations.

Finally, the Department wishes to repeat what was said by Minister Swann when he announced this Inquiry. He suggested:

"I want to take this opportunity to once again put on record my apologies on behalf of the health and social care system to patients and families who have been let down by a failure to protect patients from abuse. But families want more than apologies. They want and need and deserve answers as to why this happened and how it was allowed to happen."

He also reflected on how this had been a sad chapter in the history of health and social care services in Northern Ireland, in particular for the Belfast Trust and Muckamore Abbey Hospital. He reflected upon their failure both in respect of their duty to protect patients and to family members and vowed that this abuse should never have happened and that he would do all he could to make sure that it never happens again.

The Department maintains this pledge to do all that it can to ensure this abuse never happens again.

Thank you, Chair and panel, for your time and consideration. 14:38

CHAIRMAN: Mr. McGuinness, thank you very much indeed. Thank you.

MR. McGUINNESS: Thank you, sir.

END OF SUBMISSION BY MR. McGUINNESS 14:38

CHAIRMAN: I think what we'll do is we'll take a short break. It is warmer this afternoon than it was yesterday for some reason. If we can just take ten minutes and then we look forward to hearing from 14:39 Mr. Robinson on behalf of the PSNI. Thank you.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

14:42

CHAIRMAN: Just give me a moment. (Short pause). Could I just, before we hear from Mr. Robinson, could I just ask everybody to make sure their sound is off on their computers because we're getting quite a lot of dinging coming through the feed as people receive 14:52 messages. So, sound off please. Mr. Robinson.

MR. ROBINSON: I'm obliged, Mr. Chairman, members of the Panel.

SUBMISSION BY MR. ROBINSON:

MR. ROBINSON: I appear on behalf of the PSNI. I'm senior counsel and I'm instructed by PSNI Legal Services Branch. I'm grateful for the opportunity on behalf of the PSNI to make opening submissions at the start of the public hearings. 14:52

First and foremost, Mr. Chairman, the PSNI wishes to acknowledge those at the heart of this Public Inquiry, and they are the family and the patients of Muckamore Abbey Hospital. The PSNI wish to commend the dignity and fortitude of the families and the patients in both seeking the establishment of this Inquiry, but also their continued engagement with the PSNI to continue their investigations. 14:52 14:53

The commencement of the Inquiry marks a significant milestone in the State's response to the allegations of abuse at the Hospital. The PSNI fully recognises the duty upon this Inquiry to fully investigate this matter and to develop a thorough Inquiry to find out what took place, why it took place, how it took place, and also to establish the steps that are required to ensure that this does not happen again in both this establishment and in any other establishment. 14:53 14:53

We wish to convey the PSNI's full commitment to the Inquiry to discharge that public duty. This recognises

both the importance of the work of the Inquiry and also the complexity of the tasks ahead.

There are two aspects for the PSNI as a Core Participant in this Inquiry. The first, we say, is the 14:54
live and current ongoing investigation under Detective Chief Inspector Jill Duffie, and I'll return to that in a brief moment.

A second limb, sir, is the pre-investigation, the pre- 14:54
Op Turnstone investigative materials. They will relate to previous responses to complaints and previous investigations.

It I may address the current and live operation, that's 14:54
Op Turnstone. Mr. Doran very helpfully has outlined a significant amount of detail that the PSNI wish to convey to the Panel and to the public about the investigation yesterday in his opening, and I'm grateful to him for that. I'll try not to repeat any 14:55
of that and simply add to what the Inquiry has already heard.

The public protection branch of the PSNI is dealing with the largest adult safeguarding investigation in 14:55
the United Kingdom. It has put together a dedicated team who is continuing to review significant volumes of CCTV. They're continuing to triage incidents and also interview suspects. And that's being conducted

expeditiously.

The timeframe being examined by Op Turnstone runs from March 2017 through to November 2017, and not only is that investigation ongoing, the PSNI is also engaging with other bodies, for example, the NMC and the GMC, highlighting any safeguarding issues they spot or identify as the investigation unfolds. Quite similar to how the Inquiry has indicated, it wishes to look forward to preventing further incidents as it goes through its Inquiry. 14:55 14:56

The criminal aspect, the criminal process has commenced, and we heard yesterday the progress that has been made. Evidentially, the police have recovered some 300,000 hours of CCTV evidence, and the rough calculation, sir, that equates to 34.2 years of footage. Now, the police continue to examine that footage and it's estimated that that exercise will continue through this year and into 2023. 14:56 14:56

As mentioned yesterday, there were four files submitted to the PPS involving a total of 38 members of staff. Eight members of staff in the first file submitted to the PPS are being prosecuted through the courts by way of indictment in respect of multiple alleged offences of ill-treatment and wilful neglect of patients in the Psychiatric Intensive Care Unit, contrary to the Mental Health Northern Ireland Order 1986 and other related 14:57

offences, including false imprisonment and common assault.

I can say, Mr. Chairman, that the eight defendant staff members are due to appear for a preliminary enquiry on Tuesday, 14th June 2022, which is next week. Decisions from the PPS, in relation to the second, third and fourth files concerning the remaining 30 staff members are expected in due course. 14:57

The police are also conducting criminal interviews in relation to staff from the other four wards that are being examined in this matter, and those interviews will continue from '22 into '23. That's all I wish to say about the Turnstone Operation. 14:58

Turning to the second limb, as I identified earlier, the pre-Turnstone material. That material will touch upon the issue of previous complaints and previous investigations. Searches are ongoing and the collation of that material remains ongoing, and that will be provided to the Inquiry as soon as possible. 14:58

If I can just make some brief comments then on the Memorandum of Understanding, and Mr. Doran very helpfully set out that yesterday, and I don't intend to reopen any of the provisions, but just to set the memorandum into context. 14:58

In much the same way as the Inquiry has the statutory obligation to investigate, so, too, does the PSNI under Section 32 of the Police Northern Ireland Act 2000, and where an offence has been detected they are under a duty to take measures to bring that offender to justice. That has brought about the necessity of that memorandum. And I can say that the PSNI, the PPS and your team have worked collaboratively and productively in compiling the provisions of that memorandum. The PSNI will continue to fully engage with the Inquiry and your team to ensure that the obligations under that memorandum are satisfied. 14:59 14:59

The Inquiry's task is to look to accountability through its investigation, and accountability is not only seen through your report, but it's also seen through the criminal justice system, and as highlighted on Monday, the Inquiry does not have any power to make any civil or criminal liability findings, so the only route to individual criminal accountability is through that criminal justice system. We say that it's incumbent upon all Core Participants, not least the PSNI, but also the Inquiry, to remain resolute in ensuring that there's no risk to that criminal justice process. The PSNI will continue to support the Inquiry as much as it can, whilst ensuring the sanctity of that criminal justice investigation. 14:59 15:00 15:00

We must all generously guard against any risk to that

criminal justice process because if we don't do that it may rob the patients, the families and the public of that individual criminal justice accountability exercise.

That's all I intend to say this afternoon, sir. Unless there's anything further that the Inquiry wish to me to address, those are the submissions on behalf of the PSNI.

CHAIRMAN: Thank you very much indeed, Mr. Robinson. Thank you. 15:01

MR. ROBINSON: I am obliged.

END OF SUBMISSION BY MR. ROBINSON

CHAIRMAN: All right. I think tomorrow, first up will be Mr. Aiken for the BHSCT, and then we'll be hearing from Mr. Neeson for the RQIA. And then at two o'clock we'll be hearing from Mr. Maguire, I think it is, for Group 3, as we're loosely calling them. 15:01

So, that completes our work certainly in this room today. Can I just remind everybody, please, about mask wearing when you do get up from your seats and move around. I'm not very good at it myself, and I have occasional forgotten, but can I remind everybody, please do wear masks when you move around the building because of course we do have people here, either in this room for in Room B who may be particularly 15:01

susceptible to the virus. We'll also try and do something again about the heating in here, but I'm hoping by next week the fans will be working properly with the right filters that will also reduce the risk of transmission. Thank you everybody very much. I think it's ten o'clock tomorrow. 15:02

MR. DORAN: Thank you, Chair. It's 10:30.

CHAIRMAN: Is it 10:30 tomorrow?

MR. DORAN: Yes.

CHAIRMAN: Yes. All right. In normal circumstances when we're hearing evidence we're going to aim to sit at 10:00. 15:02

MR. DORAN: Yes. Yes, I think we're moving to a 10:00 a.m. start on Monday morning.

CHAIRMAN: Fine. All right. Thank you very much. 15:03

MR. DORAN: Thank you, Chair.

THE INQUIRY WAS THEN ADJOURNED UNTIL THURSDAY, 9TH JUNE 2022 AT 10:30 A.M. 15:03