MUCKAMORE ABBEY HOSPITAL INQUIRY

# WRITTEN CLOSING SUBMISSION
# ON BEHALF OF THE BELFAST HEALTH AND SOCIAL CARE TRUST

## Introduction

1. This written closing submission is provided on behalf of the Belfast Health and Social Care Trust (the Belfast Trust).

2. The Muckamore Abbey Hospital Inquiry (the MAH Inquiry) has insisted[1] that written closing submissions are not more than 30 pages in length. The MAH Inquiry Terms of Reference document is itself 6 pages long, with substantive topics to be examined by the MAH Inquiry stretching across some 15 paragraphs. All of the issues set out in those paragraphs are to be examined across the primary time period of 21.5 years. The Belfast Trust (and its predecessor trust, the North and West Belfast Health and Social Services Trust, for whom it also must try to speak) had operational responsibility for Muckamore Abbey Hospital (MAH or the hospital) throughout that period. During that period the hospital cared for the conservative figure of over 740 patients, and, whilst it isn't presently possible to give a total individual staff figure across the 21.5 years, it can be reliably said that for a large period of time there were over 600 staff working in the hospital at any one time. In addition, on 12 September 2023[2], the Chairman of the MAH Inquiry announced 12 themes the MAH Inquiry was said to be addressing in detail arising from what the MAH Inquiry has described as the "patient experience" evidence that it had

[1] See the MAH Inquiry letters of 7 October 2024 and 11 November 2024
[2] https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-09/Chair%27s%20Statement%20for%2012%20September%202023.pdf

gathered. Whatever the limitations of the evidence gathered, the MAH Inquiry still disclosed 340 witness statements and held 120 days of oral hearings. Within the confines of 30 pages the Belfast Trust could obviously not make any comprehensive written closing submission to the MAH Inquiry, and certainly not a written closing submission that would properly and adequately address all the issues and themes that affects it, and which the MAH Inquiry was tasked with, or set itself to examine.

**What occurred?**

*Apology*

3. At the outset of the MAH Inquiry the Belfast Trust again apologised publicly to MAH patients who were abused at the hospital, and to their families. The apology was not confined to the 9-month period in 2017 for which CCTV from several hospital wards has been the subject of PSNI and Belfast Trust investigation.

4. The Belfast Trust will repeat and expand upon the apology during its oral closing submission.

*The abuse of patients at the hospital*

5. The MAH Inquiry has heard evidence, generally from family members on behalf of a limited number of patients, who explained their loved one was the subject of abuse at the hospital.

6. The Belfast Trust has wanted to provide the MAH Inquiry with all documentation that it has been able to find and has in its possession that relates to the abuse or alleged abuse of patients in its care at MAH falling within the time span of the MAH Inquiry Terms of Reference. This is so that the MAH Inquiry is aware of, and can take into account, abuse or alleged abuse of patients by staff who did not feature in any evidence from patients or families, or in the evidence of the limited number of MAH staff who gave evidence. It is also so that any findings of the MAH Inquiry can be based on a holistic understanding of the known position. The Belfast Trust

is distinctly uncomfortable with the MAH Inquiry not having all such material. The MAH Inquiry has sought and received material in this regard, but the MAH Inquiry has not been prepared to allow the Belfast Trust to provide it with all material of this type that the Belfast Trust has gathered.

7. In that context the Belfast Trust, in order to try to assist the MAH Inquiry, and as part of trying to be accountable for abuse said to have occurred at the hospital during the time period covered by the Terms of Reference, has itself tried to analyse the available material in its possession (some of which the MAH Inquiry has been prepared to receive, and some of which it has not). As part of so doing the Belfast Trust prepared a written submission summarising all known incidents of abuse, or alleged abuse, that it has been able to identify, and what, as far as can be ascertained, was done about them by the staff at the hospital and within the wider relevant Trust. The submission, albeit only a summary of known incidents, covered over 150 pages. A bundle of supporting material, containing the key documents in respect of each incident and what was done in response, was also prepared. The MAH Inquiry was not prepared to accept it[3].

8. It is not possible, in the space permitted, to analyse all the known incidents of abuse, or alleged abuse, at the hospital prior to 2017 so that there can be a comprehensive understanding of what is said to have occurred, and how the instances were responded to. Consequently, the evidential basis cannot be set out to ground the submissions made below. The Belfast Trust says that an analysis of the known material supports the following propositions:

    a. First, it demonstrates that, unfortunately, on occasions, prior to the abuse captured on CCTV from March to November 2017, MAH staff did abuse vulnerable patients in their care at MAH during the period covered by the MAH Inquiry Terms of Reference. That fact is why the public apology of the Belfast Trust, including the one made through Counsel before the MAH Inquiry on Day

[3] Belfast Trust letter of 16 August 2024, MAHI letter of 29 August 2024, Belfast Trust letter of 9 September 2024, MAHI letter of 20 September 2024, Belfast Trust letter of 21 October 2024, MAHI email of 21 October 2024 at 11.23, Belfast Trust letter of 23 January 2025 and MAHI letter of 28 January 2025.

4 of the public hearings, on 9 June 2022, is not confined to matters identified on CCTV from 2017.

b. Second, the material demonstrates that the principal system that did exist for identifying and reporting abuse when it occurred, did operate effectively in respect of known incidents, in that, primarily, a colleague or colleagues (of a member of a staff who mistreated a patient) reported that fact to a more senior colleague who then initiated action.

c. Third, the material demonstrates that the nature and extent of how matters were investigated changed over time. Further, the available investigative mechanisms and disciplinary processes, and learning mechanisms, also changed over time (which were generally regionally designed processes that had to be followed across the health and social care system). The processes can be said, generally speaking, to have, over time, become more detailed and generated more and more paperwork. Whether ultimately, on reflection, that also means they improved or were more effective may be a matter of debate.

d. Fourth, as with the consideration of almost any series of investigations conducted by a large organisation over a wide expanse of time (in this case almost 20 years), and in the context of an organisation whose primary function or expertise was not abuse investigations, it is likely to be possible to identify instances where investigations of incidents have fallen short.

9. However, there are a number of other important propositions that are also evidenced by a proper, thorough and fair consideration of the available material. They are:

a. Fifth, the various investigations of incidents appear to have been conducted in good faith with a genuine effort to try to establish what occurred against the appropriate standard required of such investigations, and to thereafter respond appropriately.

b. Sixth, where more senior staff could be satisfied that a member of staff had engaged in the abuse of a patient in their care, then the relevant staff member was dealt with robustly.

c. Seventh, there is considerable evidence available through the investigative material to indicate that those who ran MAH took extremely seriously any allegations that came to their attention that staff members at MAH had abused the patients in their care, and that it was not something that was either tolerated or acquiesced in.

d. Eighth, the material evidences, on any fair analysis, that those responsible for the operation of MAH (notwithstanding the toxicity surrounding events at MAH in 2017 and thereafter), did not have a "culture" (however one defines it) of tolerating MAH staff abusing their patients.

e. Ninth, the material indicates, when matters are considered in their proper context (taking into account the number of patients being cared for at the hospital, and the number of staff working there), that known incidences of MAH staff abusing patients in their care were, thankfully, rare. This is not to say that, because the incidents were rare, it somehow makes them acceptable. They were not, but it is important to acknowledge that these incidents do not appear to have been, prior to 2017, widespread in the context of the hospital as a whole at any point in time.

10. Most of the incidents reflected in the available material were not considered in evidence before the MAH Inquiry. In view of the page limit imposed by the MAH Inquiry, only some examples can be provided below to illustrate the type of incident that was said to have occurred, and what was done about them. It is also the case that a number of members of staff, who were either aware of, or regularly involved in, the investigation of known allegations of abuse reflected in the available material, were not asked about them by the MAH Inquiry.

*Illustrative example 1 – 28 August 2004 – Complaint made by the mother of a patient in Movilla A*

11. The first illustrative incident occurred in 2004. Records show that, on 15 February 2004, of the 345 beds then available at MAH, 293 were occupied by inpatients, and that was across 16 wards[4]. The staff figure at MAH in 2002 had been the wholetime equivalent of 638.41 persons, of which 421.21 were nurses or nursing assistants[5], and, in 2005 there was the wholetime equivalents of 622.82 members of staff working at MAH, of which 403.76 were nursing staff[6], so it can be said with some confidence that the likely staff complement during 2004 was in excess of 600 staff, of which in excess of 400 were involved in the provision of nursing care.

12. A complaint was received from the mother of a patient, P129[7], making an allegation against a MAH nursing assistant, BTS1[8] (the individual was not mentioned in evidence and does not have a MAH cypher) (BTS1 had been the subject of a previous allegation of verbal and physical abuse in 2002, which could not be substantiated[9]).

13. The mother of P129 alleged that on one occasion BTS1 threw water over the patient and, on another occasion, told the patient that if they mentioned their name again in a hostile way on a phone call, they would not be permitted another phone call. Specific dates or times of the allegations were not provided in the complaint.

14. H823, then a Senior Nurse Manager, investigated the allegations (as she did many other allegations made during her lengthy tenure at MAH). H823 was a nurse by

[4] BHSCT – DATA – 00696 – 2004 Yearly MAH Bed Occupancy (52 pages).pdf., disclosed 16 August 2024

[5] See the available 13 May 2002 MAH Hospital and Staff profile document prepared for the MHC visit of 18 June 2002

[6] See the available 4 August 2005 MAH Hospital and Staff profile document prepared for the MHC visit of 25 August 2005

[7] The brother of P129 provided a witness statement, MAHI-STM-152, that was read in on 20 September 2023. It is unclear if the MAH Inquiry has taken any steps to assess the veracity of any of the claims it contains. Belfast Trust has not found any material to support the claims it contains. Patient document requests from the MAH Inquiry only related to 33 patients, and did not include P129.

[8] See the Belfast Trust letter of 23 January 2025 and MAHI letter of 28 January 2025. "BTS" stands for Belfast Trust Staff. BTS1 is the cypher assigned to a nursing assistant whose name does not appear on the MAH Inquiry partial anonymity cypher list, as at 5 November 2024. The name can be provided to the MAH Inquiry and core participants should the MAH Inquiry so direct.

[9] The incident was said to have occurred on Movilla A on 11 January 2002. The complaint, made by the patient (the patient does not have an MAH Inquiry cypher), was that they had been verbally and physically abused. The matter was investigated by H77, then the Behavioural, Vocational and Therapeutic Service Manager (the BVTS Manager), who conducted many such investigations. H77 produced a detailed investigation report; staff and patients were interviewed, physical intervention forms reviewed, and a medical examination conducted. The medical examiner found there was no physical evidence of the patient being physically mistreated. Patient records indicated that during the relevant day the patient had been very unsettled and physical intervention had been required from several staff during the course of the day. The available material does indicate that, even in 2001/2, there was a Behaviour Nurse Therapist working with patients on the ward, the ward had a safety and seclusion room known as "The Green Room", and Physical Intervention Record forms were completed when it was considered necessary to lay hands on a patient. The complaint investigation report from H77 is available to be disclosed to the MAH Inquiry. When this report was identified the MAH Inquiry had already moved material of this type (based on the material of this type already disclosed by the Belfast Trust), into the category of material that the MAH Inquiry designated as for selective retrieval only.

profession and worked at MAH between 1972 and 2016. H823 interviewed the mother of the patient and a number of staff members. P129's medical and nursing file, the ward diary and allocation sheets were also reviewed.

15. H823 produced a report[10] which explained that the investigation found no evidence to uphold the allegation that water was thrown over the patient. On the occasion which could potentially have matched when this was said to have happened, an accompanying staff member was able to recollect how distressed the patient had been, their voluntary presence in the unlocked seclusion room, and their physical aggression towards staff.

16. However, evidence was found to suggest that BTS1 did, in a particular context, make a comment regarding the patient's use of phone calls. Staff witnesses explained to H823 that BTS1 had not spoken in a threatening manner, but to try to manage the behaviour that was occurring. H823 considered the issue could have been better managed in a different way.

17. H823 did not recommend that a disciplinary process be commenced, however H823 recommended the introduction of a protocol specific to the management of phone calls where staff were discussed in an abusive or threatening manner. The intention was to give staff clear direction as to how they should respond to such events, define what was expected of the individual patient, and allow relatives to understand why staff would intervene.

18. A detailed letter was written to the mother of the patient summarising the findings of the investigation. The letter included an apology for what had been said, and explained how similar matters would be responded to in future[11].

19. H823 worked at MAH for some 44 years, and in a variety of caring and management roles. On any level, H823 is a very important witness about the life of the hospital. H823 could have been provided with documentation in respect of

[10] The complaint investigation report from H823 is available to be disclosed to the MAH Inquiry. When this report was identified the MAH Inquiry had already moved material of this type (based on the material of this type already disclosed by the Belfast Trust), into the category of material that the MAH Inquiry designated as for selective retrieval only.

[11] See pages 73 and 74 of BHSCT - T - 00011 - MAH Complaints - Local - PART 11 - T-Z File (344 pages) - (00462).pdf. This document had been processed for disclosure before the MAH Inquiry moved material of this type into the category of material that the MAH Inquiry designated as for selective retrieval only.

the many incidents and investigations of abuse with which she was involved (including this illustrative example), most of which were not mentioned in evidence. H823 could have been asked to explain the prevalence of such incidents in the overall context of the hospital, and could have been asked about the approach, over time, as to how they were dealt with. H823 made a statement to the MAH Inquiry; see MAHI-STM-193 of 4 January 2024. H823 explained in her witness statement that she had, at times during her career, witnessed poorer care from some staff as compared to others, but she had not witnessed abuse at MAH during her extensive time there (see paragraph 44 of MAHI-STM-193-23). H823 explained in her witness statement that eventually, in her more senior role, she carried out investigations of staff conduct, such as that described above (see paragraphs 35 to 39 of MAHI-STM-193-17 to 19). H823 was not given any documentation by the MAH Inquiry, including relating to any investigation of abuse she did carry out at MAH. Instead, H823 herself gave some examples that she could remember. H823 was not asked to address the subject incident from 2004. The witness statement from H823 said she did not wish to give oral evidence to the MAH Inquiry[12]. The MAH Inquiry did not call H823 to give oral evidence (it may be H823 was not in a position to give oral evidence). H823's witness statement was read into the record on 6 February 2024.

*Illustrative Incident 2 – 3 January 2012 – Investigation into an incident in Killead ward*

20. The second illustrative example occurred in 2012. In 2012, there were the wholetime equivalents of 569.66 members of staff working at MAH, of which 361.76 were involved in nursing[13]. Records show that, as at 29 February 2012, there were 225 inpatients residing in MAH[14].

21. On 3 January 2012, an incident occurred whereby an alleged assault was perpetrated on a patient, P60, by H778[15], a nursing assistant, on Killead ward.

[12] MAHI-STM-193-40
[13] BHSCT – DATA – 00725, 2009 to 2023 MAH by Job Family WTE, disclosed 16 August 2024
[14] BHSCT – DATA – 00021, Yearly MHLD bed availability and occupancy 2010 – 2012, disclosed 29 March 2024
[15] H778 was not mentioned during the "patient experience" evidence but was spoken of by H823 in her evidence. Available material indicates that H778 had previously been given a verbal warning on 4 March 2007 when, while working on Fintona South, he had allowed a patient on Level 3 observations privacy in the bathroom, which resulted in the patient behaving inappropriately with another patient. The incident was investigated by H77 who produced an investigation report into the incident, which is available. H77, the then Behavioural, Vocational and Therapeutic Service Manager (the BVTS Manager), had commenced working in MAH in and around 1989, was a qualified nurse, and had been promoted to BVTS Manager in March 1998 (STM-271-

22. The incident was witnessed by members of staff who made statements about what occurred. The witnessing staff were H779[16], BTS2, BTS3 and BTS4[17].

23. H778 was placed on precautionary suspension on 3 January 2012.

24. The matter was reported to the PSNI and investigated as per the Safeguarding Vulnerable Adults Joint Protocol procedures. The RQIA was also notified of the incident.

25. H823 and H377 investigated the incident and produced a detailed 4-page report.[18]

26. A Disciplinary Hearing took place on 17 August 2012 and reconvened on 4 September 2012. The Disciplinary Hearing was presided over by H507, the then MAH Service Manager, and BTS5[19], a Senior HR Manager. A detailed 5-page outcome letter dated 11 September 2012 records what took place.[20]

27. The Disciplinary Panel, for the reasons that they gave, concluded that the allegation was proven and represented gross misconduct. H778 was dismissed with immediate effect.

28. The Belfast Trust advised the Independent Safeguarding Authority[21] of the Disciplinary Panel's decision.

29. On 25 September 2012, the PSNI administered a restorative caution to H778.

30. H778 appealed the decision of the Belfast Trust Disciplinary Panel. An Appeal Panel was convened and sat on 22 February, 26 February and 7 March 2013. The

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4). He retired in November 2018 in his then role of hospital services manager. The BVTS role included, amongst other things, the investigation of complaints which, at times, included allegations of "abuse" within the wide definition of the term in paragraph 5 of the Terms of Reference of the MAH Inquiry. H77 was involved with the investigation of many of the incidents of alleged physical mistreatment of patients by staff at MAH. H77 was not asked about the 2007 incident in his evidence.

[16] Mentioned by H823

[17] See the Belfast Trust letter of 23 January 2025 and MAHI letter of 28 January 2025. "BTS" stands for Belfast Trust Staff. BTS2, 3 and 4 are the cyphers assigned to nursing staff whose names do not appear on the MAH Inquiry partial anonymity cypher list, as at 5 November 2024. The names can be provided to the MAH Inquiry and core participants should the MAH Inquiry so direct.

[18] BHSCT – S – 00205 – [H778] Investigation Report Not Related to 2017 CCTV Investigations (4 pages) – (02578), disclosed 5 March 2024. The pdf file title has the actual surname.

[19] See the Belfast Trust letter of 23 January 2025 and MAHI letter of 28 January 2025. "BTS" stands for Belfast Trust Staff. BTS9 is the cypher assigned to a member of HR staff whose name does not appear on the MAH Inquiry partial anonymity cypher list, as at 5 November 2024. The name can be provided to the MAH Inquiry and core participants should the MAH Inquiry so direct.

[20] BHSCT – S – 00206 – [H778] Disciplinary Outcome Letter Not Related to 2017 CCTV Investigation (5 pages) – (02579), disclosed 5 March 2024. The pdf file title has the actual surname.

[21] Sean Holland erroneously claimed, in the context of suggesting the November 2012 Ennis Early Alert contained an error, that there was no such organisation (see Day 118 Transcript 21 October 2024 page 36); the ISA was the relevant predecessor body to what became the Disclosure and Barring Service on 1 December 2012.

Panel was chaired by a Belfast Trust Director and a Co-Director from outside Learning Disability. An 8-page outcome letter of 12 April 2013 records what took place[22]. Many staff members gave evidence and the Appeal Panel, for the reasons that they gave, upheld the decision of the Disciplinary Panel.

31. This incident was referred to in paragraph 17 of H377's witness statement dated 2 May 2024[23], disclosed on Thursday 30 May 2024 (H377 gave oral evidence 6 working days later, on 10 June 2024). Having identified that the incident about which H377 was speaking in paragraph 17 was this incident involving H778, the Belfast Trust wrote to the MAH Inquiry on Tuesday 4 June 2024 identifying the 18 pages of key material that spoke to the incident in question, setting out the locations where the material could be found in the Belfast Trust Disclosure, and indicating that the material had been disclosed to the MAH Inquiry on 5 March 2024.

32. In its 4 June 2024 letter the Belfast Trust submitted that the material demonstrated:

    a. The preparedness of at least the identified MAH staff to report the abuse of a patient when they witnessed it.
    b. The matter being taken extremely seriously by at least the senior staff at MAH involved with this incident, and the matter being dealt with appropriately.
    c. The zero-tolerance approach of senior staff from MAH and the Belfast Trust when aware that a patient had been mistreated.

33. In the same 4 June 2024 letter the Belfast Trust submitted that the material, and what it evidenced, also bore on the question of whether the same staff were aware that abuse was occurring on MAH wards in 2017 (at any time prior to what became apparent through the review of CCTV), and what their approach would have been to such activity had they been so aware. It was submitted:

    a. That the material should be provided to H377 in advance of his oral evidence.
    b. That H377 should be asked about the material during his oral evidence, and the themes that the Belfast Trust said the material evidenced.

[22] BHSCT – S – 00207 – [H778]_Disciplinary Appeal Outcome_Not Related to 2017 CCTV Investigation (8 pages) – (02580), disclosed 5 March 2024. The pdf file title has the actual surname.
[23] MAHI – STM – 243 dated 2 May 2024, paragraph 17.

c. The material should be considered by the Inquiry Panel.
d. The material should also be provided to H507, and she should also be asked about it during her oral evidence, and about the key themes the Belfast Trust submits the material evidenced, and whether this was the general approach taken to such matters.

34. There is insufficient space to fully address what thereafter occurred, and its effect on the quality of the evidence. The correspondence exchange should be read in its entirety[24], but the relevant material was not given to H377, and the Belfast Trust's application in respect of it was not heard or acceded to. The transcript of H377's evidence on Day 90 10 June 2024[25] reflects how H377 was then asked questions on two separate occasions about the incident, which he had to try to address purely from memory. Many of the questions would have been answered by the contemporaneous material that was not given to him[26].

35. H823 set out her recollections of her involvement as the investigating officer in respect of this incident at paragraph 37 of her witness statement dated 4 January 2024[27]. H823 was also not given any documents in respect of the incident. H823 did not give oral evidence. Her witness statement[28] was read into the record on 6 February 2024.

36. H507 referred to this incident briefly in her Ennis witness statement[29] and then during her Ennis oral evidence to the MAH Inquiry on 17 June 2024[30] H507 did so without being provided with any documents relating to it.

37. This incident also appears to be one of those that H507 is recorded as having discussed with representatives from the then Health and Social Care Board

[24] See the Belfast Trust letter of 4 June 2024, the Belfast Trust letter of 6 June 2024, the MAH Inquiry email of 6 June 2024 at 16.08, the Belfast Trust 7 June 2024 application to question the witness about the documents, the MAH Inquiry email of 7 June 2024 at 15.04, the Belfast Trust 7 June 2024 email at 16.08, the Belfast Trust email of 10 June 2024 at 09.15, the MAH Inquiry email of 10 June 2024 at 10.50 (during the evidence of H377)
[25] See Day 90 Transcript 10 June 2024 pages 27 to 31, pages 51 to 53
[26] There was a similar issue over documents in relation to the Ennis related incident referred to at paragraph 20 of the witness statement of H377 (only two of the identified documents were given to the witness), which included the no doubt unintended impression being given (see page 42 of the Day 90 Transcript) that the relevant documents had only recently been brought to the MAH Inquiry's attention and were still to be processed. The documents had been disclosed to the MAH Inquiry in September 2022 and June 2023.
[27] MAHI–STM–193 dated 4 January 2024, paragraph 37. The incident also appears to be being spoken of by P60's sister, but in a way that does not accord with what occurred as reflected in the available documentation; see MAHI-STM-146-5 paragraph 31.
[28] MAHI–STM–193
[29] MAHI-STM-229-2 paragraph 5
[30] Transcript Day 92 17 June 2024 page 18

(HSCB) and Public Health Agency (PHA) at the Ennis meeting on 15 November 2012.[31] H507 was not asked about this meeting with the PHA and HSCB in her evidence at any stage.

*Illustrative example 3 - 8 May 2012 – Investigation into an incident perpetrated by a staff member who had worked bank shifts on Ennis ward*

38. The third illustrative example also occurred in 2012. On 8 May 2012, an incident occurred whereby an alleged assault was perpetrated by a nursing assistant, BTS6[32] (member of staff not mentioned in evidence and does not have an MAH cypher), on a patient, P198[33], whilst in day care. It was alleged that BTS6 used foul language and raised her hand quickly before lowering and tapping P198 on the leg.

39. BTS6 was a longstanding Belfast Trust employee, had stayed on beyond her retirement age, and continued to work bank shifts as a nursing assistant at MAH.

40. Following the incident BTS6 was informed, on 8 May 2024, that she could not work bank shifts at MAH until further notice, and she was placed on precautionary suspension on 11 May 2012.

41. On 9 May 2012, the incident was referred to Adult Safeguarding and H92[34], senior social worker at MAH, was appointed Designated Officer. An Adult Safeguarding Case Discussion was held in Ennis ward on 11 May 2012. In attendance were Senior Nurse Managers, H823 and H377, an MAH doctor and a PSNI constable. It was agreed that a Joint Investigation with PSNI should be undertaken.

42. P198's next of kin were informed of the incident, and the RQIA was notified on 8 May 2012.

[31] MAHI – STM – 307 – 708 or MAHI – STM – 307 – 635
[32] See the Belfast Trust letter of 23 January 2025 and MAHI letter of 28 January 2025. "BTS" stands for Belfast Trust Staff. BTS6 is the cypher assigned to a nursing assistant whose name does not appear on the MAH Inquiry partial anonymity cypher list, as at 5 November 2024. The name can be provided to the MAH Inquiry and core participants should the MAH Inquiry so direct.
[33] P198 was not mentioned in evidence by anyone in the context of abuse. The MAH cypher arises from the benign content of exhibits attached to the Evidence Module 6 statement of Martin Dillon; see MAHI-STM-107-957 and following.
[34] H92, when providing the organisational module statement sought from him (MAHI-STM-222), was not given any documents by the MAH Inquiry, nor asked about any particular incident with which he was involved, how prevalent such incidents were, and how they were responded to.

43. H377 reported the incident to the PSNI and BTS6 provided a statement for the purposes of the criminal investigation. Witness statements obtained by the hospital from two daycare workers, BTS7 and BTS8, were also shared with the PSNI. On 30 August 2012 the PSNI advised that no action would be taken in respect of BTS6.

44. H823 and a colleague were appointed to conduct a disciplinary investigation into the allegations against BTS6. H823 and her colleague produced a detailed 3-page report recording how they conducted their investigation[35].

45. On 1 July 2012, before the investigation could be completed, BTS6 resigned from her position within the Belfast Trust. However, H823 and her colleague proceeded to try to meet with BTS6 following PSNI consent.

46. On 4 January 2013, H823 and her colleague concluded that, had BTS6 remained in employment, disciplinary action would have been instigated. BTS6 was informed of this outcome.

47. Whilst the disciplinary process could not be completed due to BTS6 no longer being an employee, the Belfast Trust made, in January 2013, a referral to the Disclosure and Barring Service in respect of the incident. The detailed submission to the Disclosure and Barring Service is available.

48. H823 was not asked to address this incident in her witness statement (MAHI – STM – 193). Her statement was read into the record on 6 February 2024.

49. It is likely that this incident was one of those being referred to by H507 at the Ennis meeting with officials from the HSCB and PHA[36] on 15 November 2012.[37] H507 was not asked to address the incident in her witness statement and was not asked about it in either of her oral evidence sessions.

50. It is also likely that it is this incident that was reviewed by H94 as part of the Ennis Vulnerable Adult/Adult Safeguarding investigation, as reflected in the minutes of

[35] The disciplinary investigation report from H823 is available to be disclosed to the MAH Inquiry. When this report was identified the MAH Inquiry had already moved material of this type (based on the material of this type already disclosed by the Belfast Trust) into the category of material that the MAH Inquiry designated as for selective retrieval only.
[36] The individuals involved from the PHA and HSCB do not appear to have provided any evidence to the MAH Inquiry.
[37] MAHI–STM–307-707 or MAHI – STM–307–634

the third vulnerable adult strategy meeting on 20 December 2012[38]. The case was reviewed by H94 as part of a consideration of any trends of abuse. H94 was not asked to address the incident in either witness statement or asked about it during her oral evidence[39].

51. The incident is also discussed in the report of the RQIA unannounced inspection of Ennis ward on the 13 November 2012[40]. The inspection followed notification of the initial allegations made by Bohill staff. Internal page 11 of the report[41] records that the MAH Registered Medical Officer, H50 (who met with RQIA along with the Senior Social Worker and Designated Officer for Safeguarding, the Senior Nurse Manager for the ward, the ward manager, the Operations Manager monitoring the hospital over the weekend, and the MAH Service Manager), explained to RQIA that there had been one previous allegation of abuse on the ward some 6 to 7 months previously. H50 was not asked about the incident during his evidence. The ward manager, who was not then asked about this incident when they gave oral evidence to the MAH Inquiry, explained to RQIA that the incident happened at day care, was reported by day care staff, and the staff member subsequently resigned. They explained that the incident was also notified to RQIA at the time.

52. In summary, it is submitted that the different types of illustrative incident provided do demonstrate the governance system operating properly; matters being reported by colleagues, matters being investigated, evidenced outcomes being reached, and, where a staff member was found to have abused a patient, the staff member being robustly dealt with. This approach is reflected across the incident material either in the possession of or available to the MAH Inquiry.

*November 2012 allegations of abuse on Ennis ward*

53. The MAH Inquiry placed particular focus on one aspect of the Belfast Trust response to allegations made in respect of initially 3 members of staff and their conduct towards 4 patients on one part of the then Ennis ward on 7 November 2012. At the time there were still over 200 patients resident in the hospital, and a

[38] MAHI-Ennis-1-44 paras 2 and 3
[39] MAHI-STM-113, MAHI-STM-198 and Day 91 Transcript 11 June 2024
[40] MAHI-Ennis-1-114
[41] MAHI-Ennis-1-124

staff complement of 570, of which nurses and nursing assistants made up some 375[42]. While, as indicated above, there were occasional incidents of MAH staff mistreating patients being reported and addressed both before and after November 2012, there was no basis, at the time of the Ennis allegations, to consider there was any widespread mistreatment of patients on wards at MAH. The available evidence, including the considerable steps taken to respond to the Ennis allegations, did not suggest (let alone evidence) there was any wider problem of abuse on the MAH site beyond the rare occasions of inappropriate behaviour that, when they occurred, were robustly dealt with. More will be said in respect of the Ennis issues in oral submissions, but the position of the Belfast Trust is that a proper consideration of all the evidence, much of which was not considered in any detail during the hearings, indicates that:

a. The allegations were taken extremely seriously by those Belfast Trust staff involved in addressing them[43].
b. The allegations were immediately reported to police[44].
c. The allegations were reported to the regulator, RQIA, who was involved throughout the allegations being addressed, both as part of the wider group overseeing the vulnerable adult process and separately as regulator conducting a number of inspections and requiring quality improvement plans.
d. The allegations were reported to the HSCB and the PHA[45] who remained involved in the consideration of them[46].
e. The allegations were reported to the department with ultimate responsibility for the hospital, the then Department of Health, Social Services and Public Safety, not just through the Early Alert mechanism[47], but also directly from the then MAH Services Manager contacting the department's Learning Disability unit[48].

[42] 569.66 WTE number of staff working at MAH, of which 361.76 WTE were nurses (BHSCT – DATA – 00725, 2009 to 2023 MAH by Job Family WTE, disclosed 16 August 2024). 196 patients as of 30 November 2012 (BHSCT – DATA – 00022, Yearly MHLD bed availability and occupancy 2012 – 2013, disclosed 29 March 2024)

[43] See MAHI-Ennis-1 to 800
[44] MAHI-Ennis-1-5
[45] MAHI–STM–307-706 or MAHI – STM–307–633
[46] MAHI-STM-307-16
[47] MAHI-Ennis-1-82/3
[48] MAHI- OM Additional Documents Bundle – 30. H507 was not asked about this.

f. Within 3 working days of the allegations being made they were specifically brought to the attention of the then Minister for Health, Social Services and Public Safety via a ministerial submission from senior officials[49].

g. The extensive and detailed Vulnerable Adult/Adult Safeguarding process was only one aspect of the response to the allegations[50].

h. Steps were taken to make sure that previous known instances of staff behaving inappropriately were known to those involved in the investigation, and taken into account in considering whether there was a wider problem[51].

i. The RQIA was very involved, both within the vulnerable adult process (which was focused on by the MAH Inquiry), and other parallel processes. RQIA wished to satisfy itself that there was not a wider problem at MAH, which it was specifically concerned about:

    i. RQIA conducted an unannounced inspection of Ennis ward on 13 November 2012, and provided a report, which resulted in a quality improvement plan being delivered by the Belfast Trust[52].

    ii. RQIA was engaged with the Learning Disability Governance Manager (who was not asked anything about Ennis in her evidence to the MAH Inquiry) about the hospital wide overall monitoring of the effectiveness of safeguarding arrangements[53].

    iii. RQIA, on 17 November 2012, updated the department about developments on Ennis ward at their liaison meeting[54].

    iv. The RQIA Director of Mental Health and Learning Disability and Social Care shared her 15 November 2012 letter to MAH's H507[55] with the HSCB[56].

    v. On 20 December 2012 RQIA conducted a further unannounced inspection of Ennis ward and provided a report, which resulted in a further Quality Improvement Plan[57].

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[49] MAHI- OM Additional Documents Bundle - 29
[50] MAHI-STM-107-11/12
[51] MAHI-Ennis-1-814
[52] MAHI-Ennis-1-114
[53] MAHI-Ennis-1-205
[54] MAHI-STM-249-171. This document was not available during the Ennis evidence, and witnesses from the RQIA and the Department were not asked about it. Minutes of the liaison meetings between the RQIA and the DHSSPS, where Ennis was discussed, have, as far as can be ascertained, not been disclosed.
[55] MAHI-Ennis-1-200
[56] MAHI-STM-249-171. The then RQIA Director of Mental Health and Learning Disability, who was heavily involved in the RQIA response to what occurred at Ennis and MAH, does not appear to have been asked to provide any evidence to the MAH Inquiry.
[57] MAHI-Ennis-1-145

vi. RQIA continued to engage with the Department of Health about the issues in January 2013[58].

vii. On 22 January 2013 the issues of staffing levels at MAH were being discussed between the RQIA Chief Executive, and the Department's Permanent Secretary and Chief Medical Officer[59].

viii. On 28 January 2013, RQIA remained not satisfied with the assurances provided by the Belfast Trust to that point, in respect of the checks and balances to prevent the events on Ennis ward happening again, and so RQIA decided to conduct a further unannounced inspection[60].

ix. On 29 January 2013 RQIA conducted that further unannounced inspection of Ennis ward, and provided a report, which resulted in a further Quality Improvement Plan[61].

x. On 31 January 2013[62], separate from the RQIA inspection process, the then RQIA Head of Programme for Mental Health and Learning Disability sought extensive documents from the then MAH Services Manager as part of steps being taken by the RQIA to assure itself. His letter was copied to the then Belfast Trust Director of Adult, Social and Primary Care and the Co-Director for Learning Disability at the Belfast Trust. A reply with the extensive documentation was provided on 8 February 2013[63].

xi. On 1 February 2013 the then RQIA Chief Executive wrote to the then Belfast Trust Chief Executive[64], pursuant to the RQIA escalation policy. The letter was copied to the then Chief Executive of the Health and Social Care Board, the then Chief Medical Officer[65], and the then Director of Mental Health and Learning Disability at the department[66].

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[58] MAHI-STM-249-215. This document was not available during the Ennis evidence, and witnesses from the RQIA and the Department were not asked about it.

[59] MAHI-STM-249-262. The document evidencing this meeting was in the possession of the MAH Inquiry but not disclosed at the time of the Ennis evidence, and not addressed with witnesses. The actual record of the meeting itself has not been disclosed.

[60] MAHI-STM-249-266

[61] MAHI-Ennis-1-163

[62] MAHI-249-300. This correspondence was in the possession of the MAH Inquiry, but not disclosed at the time of the Ennis evidence. No witness was asked about it. The then RQIA Head of Programme for Mental Health and Learning Disability does not appear to have been asked to provide any evidence to the MAH Inquiry.

[63] MAHI-249-319. This correspondence was in the possession of the MAH Inquiry, but not disclosed at the time of the Ennis evidence. No witness was asked about it.

[64] MAHI-Ennis-1-210

[65] MAHI-Ennis-1-213

[66] MAHI-STM-249-311

xii. On 4 February 2013[67] the then RQIA Director of Mental Health and Learning Disability and Social Care contacted the department to further express ongoing concerns about Ennis ward in MAH. Her discussion was circulated to the Permanent Secretary and the Chief Social Worker along with a series of other officials.

xiii. On 11 February 2013 the RQIA Director of Mental Health and Learning Disability and Social Care met with the Belfast Trust Learning Disability Co-Director, Learning Disability Clinical Director, and MAH Service Manager to discuss RQIA concerns[68].

xiv. On 21 February 2013[69] RQIA raised a medication issue arising from the 29 January 2013 unannounced inspection. A detailed response letter of explanation was provided on 26 February 2013 by the then Belfast Trust Learning Disability Clinical Director[70].

xv. RQIA had asked to be notified of any occasion when staffing fell beneath the intended level. One such notification was provided by the Belfast Trust on 8 March 2013[71].

xvi. On 13 March 2013[72] the RQIA separately inspected Oldstone, which then catered for 23 patients. The inspection included the use, as part of a pilot programme, of two "experts by experience", who themselves had experience of learning disability services. The inspection made various criticisms and restated various previous recommendations. It also received a complaint from one patient that they had been spoken to disrespectfully on one occasion by a staff member, which was referred to the vulnerable adult process. However, there was nothing from the inspection to suggest patients were being mistreated by staff at the hospital.

xvii. On 14 March 2013 the RQIA Chief Executive reported to the RQIA Board[73] about the issues on Ennis Ward, and about the steps being taken by the RQIA and the Belfast Trust to address them.

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[67] MAHI-STM-298-14
[68] MAHI-STM-249-215, 522. This document was in the possession of the MAH Inquiry, but not disclosed at the time of the Ennis evidence, and witnesses from the RQIA and the Belfast Trust were not asked about it, or the meeting it references.
[69] MAHI-STM-249-313
[70] MAHI-STM-249-315
[71] MAHI-STM-249-510
[72] BHSCT – R – 00028 - 2013.03.13 Oldstone Unit Inspection Report (30 Pages) – (00379).pdf
[73] MAHI-STM-249-521

xviii. On 9 May 2013, having received a 6-page police report recounting the evidence the police had gathered, and the recommendations for prosecution the PSNI had made[74], RQIA wrote to the Belfast Trust Co-Director for Learning Disability about the matters about which it wished to be reassured[75]. The Belfast Trust replied on 6 June 2013[76]. At the RQIA Board meeting, also on 9 May 2013, the Chief Executive provided an update about MAH[77].

xix. The RQIA provided information[78] to feed into the Ennis update submission to the Minister of Health of 21 May 2013[79].

xx. On 29 May 2013 RQIA conducted a further unannounced inspection of Ennis ward, provided a report, and a further Quality Improvement Plan was completed[80].

xxi. On 28 June 2013[81] the RQIA Director of Mental Health and Learning Disability and Social Care replied to the Belfast Trust Co-Director for Learning Disability, acknowledging, amongst other things, the considerable work undertaken by the Belfast Trust to address the issues raised.

xxii. On 1 July 2013[82] RQIA carried out an unannounced inspection of Cranfield PICU, then a 6 bedded mixed gender ward. While there were various criticisms and recommendations made, the patients spoken to expressed satisfaction with their care and treatment. There was nothing from the inspection to suggest patients were being mistreated by staff at the hospital.

xxiii. On 9 July 2013[83] RQIA inspected Cranfield Women's ward, then a 15-bed female unit with some 30 staff. The inspectors met 6 patients, and, on the whole, patient feedback was said to be positive. Three patients actually made disclosures that were referred to safeguarding. Staff reported the considerable level of physical and verbal aggression from

[74] MAHI-STM-249-536. This document was in the possession of the MAH Inquiry but not disclosed at the time of the Ennis evidence, and witnesses from the RQIA and the Belfast Trust were not asked about it.
[75] MAHI-Ennis-1-217
[76] MAHI-Ennis-1-219
[77] MAHI-STM-249-547
[78] MAHI-STM-249-553
[79] MAHI-STM-298-15
[80] MAHI-Ennis-1-183
[81] MAHI-STM-249-578
[82] BHSCT – R – 00030 - 2013.07.01 Cranfield ICU Inspection Report (26 Pages) – (00381).pdf
[83] BHSCT – R – 00031 - 2013.07.09 Cranfield Women's Ward Inspection Report (33 Pages) – (00382).pdf

patients, some of which was witnessed by the inspectors. Whilst there were various recommendations made for improved practice, there was nothing from the inspection to suggest patients were being mistreated by staff at the hospital.

xxiv. In November 2013[84] the RQIA, PHA and HSCB discussed the Ennis issues, the potential issue of "culture" leading to the situation, and whether it was an isolated case[85]. No witness was asked about these events[86].

xxv. On 20 January 2014[87] the RQIA conducted a further unannounced inspection of what was by then the Erne ward (Ennis, Erne and Mallow had amalgamated to form Erne ward in December 2013[88]). It was a largely positive report. RQIA have acknowledged that all the recommendations from the previous Ennis inspection had been addressed[89]. The inspector recorded the positive views expressed by patients and noted the dedication of staff towards the patients[90].

xxvi. The RQIA inspected virtually every other ward at MAH during 2013 and the early part of 2014[91], some more than once. All of those detailed RQIA reports are available to the MAH Inquiry. In addition to the Belfast Trust's own evidence, there was no suggestion from any of those inspections, or the different inspectors who conducted them, that the issues that RQIA was concerned about arising from Ennis were being replicated on any other ward in MAH.

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[84] There is a record of a bi-monthly meeting between RQIA and DHSSPS of 8 October 2013 (STM-249-595). The content is inconsistent with surrounding events at that time, as recorded in other documentation, and the Belfast Trust considers that the interpretation of the record at STM-219-20 is unlikely to be accurate. The Belfast Trust considers that the entry is unlikely relate to Ennis ward.

[85] MAHI-STM-249-692

[86] The MAHI called Ms Long on Day 94, 19 June 2024, but did not disclose her third statement of 7 May 2024 (STM-249), and the over 400 pages of further Ennis related documentation it exhibited, until 24 October 2024. It was said on 19 June 2024 that "A significant number of those documents had, in fact, already been included within the Ennis Bundle that had been compiled by the Inquiry team." Evidently over 400 pages of material had not. It was also said, as a justification for not having disclosed the material at the time Ms Long was giving evidence, that "there are also many documents that are not considered necessary for the purpose of the Inquiry's analysis of Ennis, having regard to the Inquiry's approach to this matter as I've already outlined." It remains entirely unclear to the Belfast Trust how documents that speak to what actually happened in respect of steps taken to respond to the allegations on Ennis ward could ever be said to be unnecessary to address the issues the MAH Inquiry says it was focusing on.

[87] MAHI-STM-249-699.

[88] MAHI-STM-249-704

[89] MAHI-STM-219-22 paragraph 88

[90] MAHI-STM-249-713

[91] Transcript Day 94 page 112; BHSCT – R – 00035 - 2013.11.18 Cranfield Male Ward Inspection Report (16 Pages) – (00386).pdf; BHSCT – R – 00033 - 2013.09.16 Donegore Ward Inspection Report (19 Pages) – (00384).pdf; BHSCT – R – 00036 - 2013.11.20 Moylena Ward Patient Experience Interviews Report (9 Pages) – (00387).pdf; BHSCT – R – 00032 - 2013.07.22 Oldstone Ward Inspection Report (12 Pages) – (00383).pdf; BHSCT – R – 00034 - 2013.10.29 Sixmile Ward Inspection Report (18 Pages) – (00385).pdf

xxvii. The RQIA witness asked by the MAH Inquiry to address matters connected to Ennis confirmed that the RQIA did not have a concern about a culture of abuse on the ward after the conclusion of the Ennis Adult Safeguarding investigation[92].

j. The RQIA received the Ennis Adult Safeguarding report[93].

k. The South Eastern Trust received the Ennis Adult Safeguarding report[94].

l. The Northern Trust received the Ennis Adult Safeguarding report[95].

m. The PSNI received the Ennis Adult Safeguarding report[96].

n. While the MAH Inquiry was interested in who the Ennis Adult Safeguarding report was provided to (beyond the likes of the police and the RQIA), it did not actually ask the author of the report at any stage who she provided the report to and why. Nor was the author asked why she did not make specific reference to the report in the Learning Disability section of the Delegated Statutory Functions report that she authored.

o. Everyone who needed to know about the allegations from Ennis ward, knew about them.

p. Everyone who should have been involved in the investigations into the allegations from Ennis ward, was involved.

q. On any level of analysis, an extensive range of steps were taken to try to properly respond to the allegations.

r. The individuals who made the allegations about some staff on Ennis ward themselves confirmed that they had seen no evidence of similar issues in any of the other wards they were on in the hospital[97].

s. Whatever view is taken about the correct classification of what was said to have occurred on Ennis ward, there was no basis to suggest that there was a similar problem on some other ward or wards in MAH in November 2012. Aside from the evidence of all those involved with the vulnerable adult investigation

[92] Day 94 Transcript 19 June 2024 page 173. Ms Long did not herself have any involvement with RQIA's response to Ennis, and was merely reading the records and expressing a view from doing so. It is unclear why the MAH Inquiry did not ask RQIA 5 (the then RQIA Director of Mental Health and Leaning Disability, who was directly involved in the Ennis investigation, including liaising with the Belfast Trust and the Department of Health, Social Services and Public Safety) for evidence of her actual involvement, as well as her view of the effectiveness of the approach adopted to the issues arising; whether the matter ought to have been dealt with differently; the lessons to be learned; and whether the issues arising in Ennis should have prompted a wider examination of conduct and practice within the Hospital at that time.

[93] MAHI-Ennis-1-67, 71

[94] MAHI-Ennis-1-67, 71

[95] MAHI-Ennis-1-67, 71

[96] MAHI-Ennis-1-67, 71

[97] MAHI-Ennis-1-45

and RQIA inspections (as well as those managing the steps arising therefrom) that this was the position, the MAH Inquiry has no other evidence of any kind to suggest there was any form of widespread problem on any other ward or wards at that time. It is pure speculation that conducting some exercise on some other ward or wards in late 2012 and early 2013 would have revealed some wider problem of MAH staff mistreating patients.

54. As previously indicated, between 2012 and 2017 there continued to be some thankfully rare occasions when a staff member of MAH was alleged to have or did mistreat a patient in their care. It is submitted that the material available to the MAH Inquiry shows those incidents being responded to seriously and robustly.

*The abuse seen on the 2017 March to November CCTV*

55. While the Terms of Reference of the MAH Inquiry span much wider than the events found on the 2017 March to November MAH CCTV from some wards, the abuse recorded on the MAH CCTV system was a principal reason for the decision of the Minister for Health to institute a public inquiry.

56. The MAH Inquiry panel viewed 2017 MAH CCTV footage said to show abuse, in conjunction with the PSNI. The Belfast Trust still does not know what CCTV footage the panel viewed. It is noted that whatever footage was viewed, it was not the subject of any questioning of any witness.

57. The MAH Inquiry did not hear from members of staff who were identified on MAH CCTV as having abused patients in their care at the hospital, in order to understand (if they would provide a reason or reasons) why they behaved as they did.

58. The MAH Inquiry has not heard from members of staff who were identified on MAH CCTV walking by while other staff abused patients in their care at the hospital, and failed to report the behaviour of their colleagues, in order to understand (if they would provide a reason or reasons) why they behaved as they did.

59. The limited evidence the MAH Inquiry has gathered demonstrates that staff at the hospital, and within the Belfast Trust, who were not involved in the abuse of

patients (or walking by that abuse) captured on CCTV during March to November 2017, were not aware that it was occurring (and were appalled and distressed by it when they subsequently did learn of or view it). As they were not aware it was occurring, they did not turn a blind eye to the fact of it, acquiesce in it, or seek to cover it up. This submission will be augmented during the oral closing.

**Identifying and responding to concerns**

60. The principal method, albeit not the only method, for communicating concerns about the behaviour of staff towards patients, beyond a report from the person abused, is the professional responsibility of a colleague or colleagues who witnessed what occurred, and who were concerned by it, reporting it as they are obliged to do.

61. While there are many examples in the available material of this occurring (some are illustrated above), and consequently the governance system working as it should, the investigation of CCTV from the hospital relating to the period March to November 2017 indicates that the system did not, and was not, working in respect of the incidents captured on MAH CCTV where a colleague can be seen to have actually witnessed the abuse that was occurring. While each of those occasions are failures by the individuals concerned, and breaches of at least professional responsibility as a result, each time they occurred was also a systems failure of the governance systems of the Belfast Trust.

62. One means of addressing that systems failure, in addition to also being a check against potential staff abuse itself, is the use of CCTV. A mechanism that involves the relatively contemporaneous review of a sample of recorded CCTV was one of the mechanisms introduced by the Belfast Trust in response to what was found on the March to November 2017 CCTV. The Belfast Trust acknowledges that there can be debate about how best to conduct such reviews, but the Belfast Trust has found it to be a useful mechanism that it intends to continue. The Belfast Trust recognises, depending on the incident being identified, that there is the potential for unfairness in the absence of sound (the present CCTV systems in operation do not record audio), and in the absence of obtaining an account from the person or persons involved in the incident, and that these are issues that will need to be

considered further, particularly if the use of CCTV is going to become widespread and standard practice in settings involving vulnerable adults and children.

63. It is the case that many of the Belfast Trust responses, at the various levels within the Belfast Trust, to the extent of the concerns that began to emerge in late 2017 and into 2018 from MAH CCTV review, were not standard responses. The nature of those non-standard responses, which were attempts to properly and proportionately respond to what was known at the time they were each introduced or adopted, will be discussed further during the oral closing.

64. Whether the present regional mechanisms for responding to concerns in health and social care are in the best form that they could be is a matter the MAH Inquiry will no doubt wish to consider. The Department of Health is already in the process of overhauling[98], with the assistance of health and social care staff from across Northern Ireland, the regional Serious Adverse Incident mechanism through its "SAI Redesign Project". The intention of the new draft regional framework, which will go out to public consultation, is to better harness learning and improvement from patient safety incidents than is arising from the present SAI system.

65. It is clear, from the limited evidence the MAH Inquiry has received about the 2017 March to November review of CCTV conducted by both the Belfast Trust and the police, that the unfortunately lengthy processes have at times been difficult in terms of the operation of various aspects of adult safeguarding, protecting the integrity of the police investigation and, for instance, communicating with staff subject to protection plans, proceeding with necessary disciplinary processes, and the effect on continuing to try to operate the hospital and provide safe and high quality care for those patients who remain. More will be said about this during the oral closing. However, from the evidence that the MAH Inquiry has obtained there has also clearly been difficulty in some of the human relationships between those involved in the various processes. The Belfast Trust regrets that the behaviour of its staff on various wards at MAH in 2017 has caused such damage and hurt, to the patients mistreated and their families, but also subsequently to those who endeavoured to properly respond to what occurred. It will not be difficult for the MAH Inquiry, which

[98] MAHI-STM-307-5 para 20/21

has the benefit of hindsight, to identify occasions when, in one process or another, an alternative approach could have been taken, or a step taken at an alternative point. Nonetheless, what the evidence does show is that many people in the Belfast Trust were doing their very best, often under considerable stress and strain, to properly respond to the extent of the situation that was developing before their eyes, and for which they had no pre-existing manual as to how to respond.

**Staffing**

66. The Belfast Trust recognises that appropriate staffing is vital to its ability to provide safe and effective care. The Belfast Trust considers that its most valuable resource is its workforce. The Belfast Trust acknowledges that it has, across all its care areas, many wonderful staff who often go well beyond what could be reasonably expected of them in the care of their patients. Equally the Belfast Trust recognises that having the correct number of appropriately skilled staff can be a complex and multifaceted issue, over which it does not have full control, and that acute staffing difficulty in health and social care has been a longstanding problem across the United Kingdom.

67. The Belfast Trust acknowledges that staffing MAH has been particularly difficult. It has been affected by the additional problem of the competing interests of trying to safely run a large learning disability hospital while at the same time trying to resettle the remaining patients currently residing there who no longer need the services of a hospital. More particular acute problems, manifested by having to secure considerable numbers of expensive agency staff from outside the jurisdiction, have had to be managed post 2017.

68. Paragraph 9 of the MAH Inquiry Terms of Reference required the MAH Inquiry to *"examine the policies and practices relating to the recruitment, retention, training and support of staff and management at all levels within MAH (and, where necessary, within other facilities offering comparable services)."*

69. The Northern Ireland Department of Health (DoH, formerly DHSSPS) is responsible for strategic long-term workforce planning, including commissioning of

nursing training and post-registration programmes[99]. The core skill set in MAH is nursing, accounting for around two-thirds of the overall staff in MAH at any one time[100]. In 2009 the DHSSPS published a Workforce Review recording 397 vacancies in the nursing and midwifery group across Northern Ireland. By 2013 this had risen to 770 vacancies. By December 2019, the DoH registered 2,754 vacancies, reflecting an overall vacancy rate of 11.5%[101]. Data shows that between 2012 and 2019 the registered nursing workforce in Northern Ireland increased by 8.8%, but the Northern Ireland Audit Office estimated workforce levels should have grown by over 23% to match the increase in demand[102]. The Belfast Trust carried the greatest number of vacancies across the region's five health trusts, with nearly 1,200 nursing vacancies by 2019[103].

70. UK and international competition also draws upon newly qualified nurses from Northern Ireland, with the Royal College of Nursing estimating that between 20% and 30% of student nurses who qualify in Northern Ireland do not work in Northern Ireland[104]. Global shortages within the nursing profession are not a secret. In May 2024 the World Health Organisation estimated that by 2030 global nursing shortfall will exceed 4.5 million nurses[105].

71. Despite the vacancies, and anticipated increase in demand, between 2011-2012 and 2016-17 the commissioning of nursing training places in Northern Ireland, which was centrally controlled by the DHSSPS, appears to have reduced by 732[106].

72. In 2015 the Royal College of Nursing explained to the Health Committee of the Northern Ireland Assembly that Northern Ireland also faces geographic challenges "*I think that one of the things that we need to remember is that we are all fishing*

[99] MAHI-STM-089-074. Also noted in the Northern Ireland Audit Office report "Workforce Planning for Nurses and Midwives" (published 31 July 2020), exhibited to MAHI-STM-102-4251, internal page 11 at paragraph 1.5
[100] BHSCT – DATA – 00725, 2009 to 2023 MAH by Job Family WTE, disclosed 16 August 2024.
[101] Northern Ireland Audit Office report "Workforce Planning for Nurses and Midwives" (published 31 July 2020), exhibited (T02.53) to MAHI-STM-102-4256, internal page 16 at paragraph 2.8
[102] Ibid MAHI-STM-102-4256 internal page 16 at paragraph 2.7
[103] Ibid MAHI-STM-102-4257 internal page 17 at figure 5
[104] Evidence given by Mr Garrett Martin, Royal College of Nursing to the Committee for Health, Social Services and Public Safety on 22 April 2015 "Transforming Your Care – Review of Workforce Planning: Royal College of Nursing and Royal College of Midwives" – NI Assembly, Hansard minutes of evidence
[105] WHO Nursing and Midwifery press release 03 May 2024, quoting Boniol M, Kunjumen T, Nair TS, et al, *The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage?* BMJ Global Health 2022;7:e009316.
[106] MAHI-STM-102-4240 internal page 1

*from a very small pool…"*[107]*.* By 2018 Northern Ireland was carrying double the local vacancy rate of that seen in Scotland[108]. By 2019 analysis conducted by the DoH estimated a vacancy rate of almost 10% specifically in mental health and learning disability nursing[109].

73. The Chief Nursing Officer's programme "*Delivering Care: Nurse Staffing in Northern Ireland*" commenced in 2014. It is a workforce policy framework. By 2023 Phase 9, which related to workforce planning for Learning Disability, was still not complete. In September 2024 the DoH reported ongoing work on the LD Service Model and LD Workforce Review[110].

74. On Day 37 of the MAH Inquiry hearings, 26 April 2023, Professor Owen Barr[111] was asked by the MAH Inquiry, "*…can I ask if you know how many learning disability nurses Northern Ireland needs, or does anyone know that number?".* Professor Barr replied "*I don't know how many they need. There is work being undertaken in relation to Delivering Care which would attempt to estimate those numbers, but the learning disability part of that hasn't been done."*

75. It is against this global, national and regional backdrop that the Belfast Trust tried to recruit into, and retain staff within, a hospital that, pursuant to longstanding government policy, was itself trying to significantly contract[112]. While it may be difficult to be certain as to the individual reasons of prospective employees, the limited numbers qualifying into a profession for which there were many vacancies across the jurisdiction and beyond, are unlikely to have seen MAH, with its retracting but increasingly complex patient population, as the most attractive career choice. As Professor McClelland explained: "*The MAH Inquiry will no doubt want to consider the effect of trying to run a learning disability hospital whilst at the same*

[107] Evidence given by Ms Rita Devlin, Royal College of Nursing to the Committee for Health, Social Services and Public Safety on 22 April 2015 "Transforming Your Care – Review of Workforce Planning: Royal College of Nursing and Royal College of Midwives" – NI Assembly, Hansard minutes of evidence.
[108] MAHI-STM-102-4258 internal page 18 at figure 6
[109] MAHI-STM-102-4256 internal page 16 at paragraph 2.10
[110] Action 5 September 2024 update, MAHI-STM-333-044
[111] Head of the School of Nursing at Ulster University from 2007 to 2017, Day 37 Transcript, 26 April 2023, page 70 line 22
[112] In 2000 the outcome of the public consultation on the future of MAH proposed a number of ward closures to reduce capacity to 115-beds by 2002 (STM-083-1849). At that time the hospital still had 350 patients; BHSCT – DATA – 00694 – 2002 Yearly MAH Bed Occupancy (52 pages).pdf, disclosed 16 August 2024. In June 2001 the Mental Health Commission described MAH, amidst much positive commentary about the care being provided, as being essentially understaffed with some wards being overcrowded (STM-100-037). By 2022, when there were between approximately 42 and 34 patients in MAH over the course of the year, the DoH opened a public consultation on the closure of MAH; https://www.health-ni.gov.uk/consultations/public-consultation-future-muckamore-abbey-hospital#:~:text=Consultation%20opened%20on%2024%20October,Closing%20date%2024%20January%202023.

*time resettle from it the patients who reside in it…[and] the effect of the process of resettlement where the most complex patients are those that are left behind to be cared for in the learning disability hospital"*[113].

76. The evidence before the MAH Inquiry does indicate that various exceptional steps were taken to try to improve the availability of appropriate nursing staff to work in MAH. These included the likes of:

    a. Exceptional arrangements for rolling nursing job adverts and targeted recruitment across the UK[114].
    b. From around 2015, the Belfast Trust organised streamlined nursing recruitment events, leading to offering posts in reduced timeframes. Such events included "one stop shops" where attendees at a recruitment fair could walk in, apply and be interviewed on the same day[115]. From 2018, the Belfast Trust organised MAH specific recruitment events[116], an example of which was the MAH recruitment walk-in event on 24 March 2018. It included fast-tracking of shortlisted applicants, where Access NI, Occupational Health Checks and interviews were conducted on the same day[117]. The purpose was to get newly qualified staff first and fast.
    c. In 2019 the DoH authorised an exceptional 15% pay uplift for registered nurses working in MAH to assist stabilising the workforce. This remained in place until 2020. The uplift was reintroduced in July 2022 and remained in place until March 2023. That additional pay did not make a significant impact does not alter the laudable intent that lay behind it[118].
    d. 50 agency nurses were "block booked" via an agency based in England. The registrants were either RNLD, RNMH or dual qualified[119].

**The Board of the Belfast Trust and Trust governance systems**

[113] MAHI-STM-083-003, paragraph 12
[114] MAHI-STM-275-023, paragraph 82
[115] An example of such an event occurred on 6 June 2015; see BHSCT - KK - 00132 - 2015.05.15_Senior Nurse & Midwifery Team Meeting Minute (7 pages) - (02722).pdf, page 3, disclosed 27 March 2024; BHSCT - FF - 00059 - 2015.06.02_Adult Social and Primary Care Directorate Meeting Minute (5 pages) - (02245).pdf, page 4, disclosed 31 January 2024.
[116] MAHI-STM-301-046, paragraph 186
[117] BHSCT - H - 00021 - File 11 of 2020 Leadership & Governance Review materials - BHSCT L&GRFile11 v3 -Redacted (438 pages) - (01781).pdf, page 60, disclosed 11 October 2023. And see MAHI-STM-301-046, paragraph 186
[118] MAHI-STM-102-082, paragraph 209
[119] MAHI-STM-102-215, paragraph 551

77. There is not the scope to examine this issue in any depth in the written submissions, but it is submitted that the available voluminous material indicates that there were many strands and levels of governance operating in the Belfast Trust to try to make patient care as safe and effective as it could be. Much time and effort was spent trying to constantly develop and improve the systems. This does not mean the systems never failed, but it is submitted that it is not the case that the Belfast Trust was indifferent to trying to have effective governance mechanisms in place.

78. The MAH Inquiry has received evidence about the extent of the steps undertaken by the Belfast Trust to try to respond to what emerged over time from MAH from later 2017 onwards. The steps included the likes of:

    a. The December 2017 appointment of an Independent Assurance Team[120].
    b. The January 2018 appointment of independent Level 3 Serious Adverse Incident investigation team[121].
    c. The February 2019 introduction of MAH weekly safety reports[122].
    d. The February 2019 appointment of a Director purely dealing with MAH[123].
    e. The February 2019 appointment of an external critical friend in the form of the East London NHS Foundation Trust[124].
    f. The significant October 2019 management changes to try to respond to the receipt of the three RQIA Improvement Notices[125].
    g. The September 2019 appointment to MAH of an external professional nursing advisor who came from the Department of Health[126].
    h. The April 2021 Stakeholder Risk Summit[127].

79. The Trust Board itself sought and received regular written updates from the Directors involved in responding to what was occurring at MAH, and MAH itself was a regular item on the agenda of Trust Board from late 2017 onwards[128].

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[120] MAHI - STM - 107 - 1427
[121] MAHI-STM-107-1338
[122] MAHI-STM-287-242
[123] BHSCT-V-00093 - 2019.03.07_Minutes_Confidential Redacted Copy (9 pages)-(01054).pdf Page 4, disclosed 16 June 2023
[124] MAHI - STM - 107 – 1572
[125] MAHI-STM-287-36 paragraph 118
[126] MAHI-STM-102-11815, MAHI - STM - 279 - 37
[127] MAHI-STM-287-440
[128] MAHI-STM-302-24, MAHI-STM-302-29 to 31

80. There is a limit to what the Board and Executive Team of a large health and social care Trust can reasonably know. The system of appropriate escalation, which involves a subjective judgment, is unlikely to ever be perfect. However, the available material demonstrates that when concern about MAH was brought to the Executive Team and then the Trust Board in later 2017 the hospital thereafter remained a constant detailed feature at the highest level of the Belfast Trust. The extent of the attention that was given to MAH could not reasonably have been given to other services operated by the Belfast Trust. The Belfast Trust acknowledged contemporaneously[129] the internal and external failures in August and September 2017 in respect of its initial response to what was emerging from MAH. The Belfast Trust acknowledges that not all of its response thereafter may be found to be without fault. However, the Belfast Trust does say that the evidence before the MAH Inquiry demonstrates that many good people were doing their level best to try to manage an extremely difficult situation.

## Conclusion

81. The Belfast Trust has, by necessity, addressed a small number of matters falling within the Terms of Reference of the MAH Inquiry, each in a limited way, given the restrictions imposed by the MAH Inquiry on this written closing submission. During the Belfast Trust's oral closing submission the Belfast Trust will address some of these matters in further detail, and will endeavour to address other matters including the likes of the "patient experience" evidence, the themes being investigated by the MAH Inquiry, the quality of the evidence received, resettlement and the issue of recommendations.

**Joseph Aiken KC, Anna McLarnon, Laura King, Nicholas Compton, Sarah Sharman, Sarah Minford, Beth McMullan, Niall O'Neill, Sara Thabeth, all Counsel of the Bar of Northern Ireland, Bar Library, Belfast**

**John Johnston and Jane McManus, Solicitors, Directorate of Legal Services, Belfast**

[129] MAHI-STM-272-338