Core Participant Group 3 – Skeleton Closing Submissions

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A) Introduction:

1. These submissions are in skeleton form and are intended to be considered in the context of the full oral closing submissions to be made by Mr Maguire KC on 3rd March 2025.
2. Core participant group 3 (referred to as "CP3") consists of 17 clients relating to 13 patients/former patients at Muckamore Abbey Hospital ("MAH"). They suffered abuse at the hospital.
3. It has been a privilege to represent these core participants.
4. The group was initially described as being, "*patients and relatives of patients at Muckamore who are not affiliated to [Action for Muckamore and The Society of Parents and Friends of Muckamore Abbey] but nevertheless have a close interest in the events at Muckamore …*"[1].
5. In fact, our clients had more than just "*a close interest in events*", because the harm suffered was not just by a distant group of adults with learning disabilities ("LD") and mental health ("MH") issues who happened to be classed as patients at this hospital, but by beautiful, albeit vulnerable people, who were (and are) loved sons and daughters, brothers and sisters, uncles and aunts who have all been deeply affected by the ill-treatment, poor care, neglect and abuse suffered by their dearly beloved relative/s at MAH.
6. For ease, and consistent with the Terms of Reference ("ToR")[2], we use the term "abuse" to cover a range of improper conduct perpetrated by staff on patients at MAH but will refer to types more specifically where required. And it is much preferred to the term used by the Trust at Directorate level - "*accidents and incidents.*"[3]

[1] Chair's opening statement (transcript) p36 @ 7
[2] ToR @ par 5
[3] Catherine McNicholl's evidence (transcript) p62 @ 10

7. And so vulnerable were the patients, so deserving of wrap-around care were they, so special were they, they should have been provided with specialist care in a safe environment, and with an expectation, at the very least, of a hospital which didn't breach one of the most basic and fundamental principles of any healthcare service - first do no harm.
8. MAH was "*a place apart*". Even the location was problematic being geographically remote. And it was part of a service on the periphery of health care with LD and MH getting lost within a vast system of competing demands. A service that the Department of Health ("DoH") acknowledged was "*struggling to get attention.*"[4]
9. No vulnerable learning-disabled person or their family should be faced with the same situation that so traumatised our clients and their relatives. We are conscious, though, that among many continuing issues for our families, two still have a relative living in the hospital.
10. And as many of our clients and their families continue on the resettlement journey, whether at home or in residential care, they must not be forgotten about by the health and social care authorities.
11. All of our patient/relative CPs have a similar set of aims and objectives, and whilst we acknowledge the efforts made by AFM and SPFM to ensure, among other things, that this Inquiry was set up, and we thank them for it, it is important to say that the core participants in group 3 are being represented as individuals who are not aligned to, or affiliated with, these groups.
12. The Inquiry has heard much evidence about governance, structures, processes and procedures, and will report on these (and make recommendations in respect of them). The Panel has heard evidence from what, in societal terms, might be considered very important people - professors and doctors, managers and directors; we have heard from senior nurses and social workers; we have heard from permanent secretaries and chief executives.
13. The Panel was right to identify, at the very start of this process, that the patients and their families are to be at the "front and centre" of the Inquiry[5].

[4] Andrew McCormick's Evidence (transcript) p118 @ 1
[5] Chair's opening statement (transcript) p8 @ 8

14. What is clear, we say, is that no governance regime and none of the structures, processes or procedures in place over the time of the Inquiry's ToR and, in particular, up to the disclosure of abuse by examination of CCTV in or around August 2017, protected vulnerable adults from mistreatment, poor care, neglect or abuse there.
15. Sometimes that abuse or neglect resulted in physical injury and should have been obvious to a critical observer. In many incidents there was insidious goading behaviour by staff that included, for example, pulling loved soft toys from vulnerable patients to get a rise out them. Dr Cathy Jack, former Belfast Trust CEO, described in her evidence what she had viewed on CCTV footage. She said: "*In fact some of the items of abuse that I witnessed were deliberate acts of force or taunting to trigger vulnerable patients, and there is no place for that and there never will be*."[6]
16. This, tragically, is typical of the accounts relayed by our clients in evidence.
17. And there is a common view that, but for CCTV footage being uncovered, little of the abuse or neglect or mistreatment that was evidenced in this Inquiry would have come to light.

B) CP3 Clients:

18. CP3 witnesses were the first to give evidence at the Inquiry, some going back to June 2022 - nearly three years ago. They took time preparing their statements with the assistance of CFR Sols, through drafts and re-drafts, always keen to make sure the panel heard their family's full story in the most articulate and comprehensive way, with each of them hoping to play their part in ensuring the mistreatment, poor care, neglect and abuse at this "*place apart*" was exposed.
19. The Inquiry has also heard evidence from numerous academic and professional witnesses; important evidence about governance and regulation and structures and processes. But it is the testimony of the patients and their families that forms the very foundation of the Inquiry's business and, as Professor Murphy sensitively but astutely put it: "*Culture means a lot of things obviously. But what I'm thinking about is the culture in relation to people with learning disabilities in*

[6] Dr Cathy Jack's evidence (transcript) p104 @ 4

MAH and the extent to which they were treated as human beings would want to be treated, that kind of culture."[7]

20. Our clients, along with other patient/relative witnesses, presented that human side. And, whilst the substance of the evidence they gave was often disturbing, giving us a window into the world of horrendous abuse and inhumane treatment suffered by patients at MAH, it was also tender and endearing and personal as we learned about these loved family members.
21. So, what was the reality for these vulnerable children and adults as patients in MAH? They were abused or provided with sub-standard care within that hospital environment, and, whilst, in most cases, at most times, hospital was not the proper place for care to be provided, it was a place, at least, in which they should have been safe and should have felt secure.
22. And such abuse, whatever its form, took place without reasonable or appropriate scrutiny being brought to bear. The patients and their families, as has been acknowledged now many times, were let down.
23. Yes, they were clearly let down by their abusers and those that neglected their caring responsibilities or managed the patients without dignity or respect. But they were also let down by those who bore the ultimate responsibility for their care, including the senior managers, directors and chief executives of the Belfast Trust, including the senior officials in the DoH, including those senior personnel in organisations tasked to assist with or oversee or regulate the provision of care.
24. Meanwhile, the patients themselves, by virtue of their disabilities and vulnerabilities, were often without a physical voice or the means to communicate, even to a caring third party about the abuse they suffered or were suffering. Loving relatives of these abused patients (our clients), when they brought issues to the fore, were frequently ignored or sidelined or humiliated, with devasting consequences for the patients and their families.

[7] Dr Cathy Jack's evidence (transcript)

25. Very early on in the process, as a legal team with the benefit of taking detailed instructions from our clients, we identified issues of concern that proved, unfortunately, to be the rule rather than the exception. And they related not only to adult safeguarding issues but to the lack of ordinary, decent, basic and humane care.
26. In broad terms we identified, and the Inquiry has heard evidence about a number of issues of concern at MAH including, for example, inadequate ratio of staff to patients, lack of trained carers, misuse of seclusion, ill treatment/manhandling of patients which, along with seclusion, was used as a punishment, inappropriate medication regimes and use of PRN.
27. The Inquiry also heard evidence from our clients on botched resettlements, and that two of our families have sons who are yet to be resettled into the community.
28. In addition, the Inquiry has heard evidence of the abuse and mistreatment perpetrated by staff on patients at MAH and you will make findings on the type of abuse that happened and the extent to which it occurred. The victims of that abuse were among the most vulnerable people in our society; they could not protect themselves; they could not speak for themselves, and they were deserving, as a minimum, of protection from harm.
29. The Inquiry has heard the human stories from families of patients.
30. The Inquiry has also heard from the family liaison social workers ("FLSWs") that advocated for the families both in their fight for services and in their engagement with this Inquiry. Sadly, Geraldine O'Hagan passed away last year, and, despite being gravely ill, she gave powerful testimony on behalf of the patients and their families. We have already acknowledged that without Geraldine's support a number of our clients simply would not have engaged with this process.
31. She spoke so eloquently but humbly about her role, saying, "*I came into my FLSW post to speak up for the voiceless and to support the families on this difficult journey.*"[8] She also spoke about the CCTV footage she viewed and gave an insight, from a professional perspective, into the world of the Trust.

[8] Geraldine O'Hagan's evidence (transcript)

32. And now, we give voice again to those patients, and their families, at the core of these closing submissions. Here is a short reflection of their lived experience of MAH and LD and MH services:

C) **Patient/Relative Evidence** (unrestricted)

33. **P1 –** known to Inquiry as Martin was a patient in MAH between 1990 and 2015. His sister, Antoinette, gave evidence on 28th June 2022, and was the first witness to do so[9].
34. Antoinette reflected a view, consistent with evidence of other our clients, that, but for CCTV footage being uncovered in August 2017, the regime that caused so much pain and suffering to patients would have continued.
35. Antionette gave powerful evidence, not only of the circumstances of Martin as a patient in MAH, but also of the impact this has had on her (and Martin's) family, especially their elderly parents.
36. What of the abuse? Antionette recounted that, "*a lot of things happened to Martin and a lot of things we had probably forgotten and suppressed probably.*" She then evidenced that within a couple of months of admission to MAH Martin had "*lost an awful lot of weight.*" She said, "*He moved into Conicar when he was 16 … he was a healthy weight and then … by the Christmas… he had dropped to five stone.*" Martin's rapid physical deterioration was laid bare in the photographs shared by Antoinette.
37. We must pause and reflect that this was under the care of a hospital, staffed with nurses and doctors, and overseen by managers and directors.
38. Antionette said her parents expressed concerns about this, but they were dismissed. Unfortunately, the dismissal by staff and senior personnel of the views and opinions of relatives of patients was a feature of the evidence of our clients, and this, we say, on every such (frequent) occasion, was to the patient's grave detriment.
39. Martin is a much-loved son and brother who is a highly vulnerable young man with no speech. Mentally, Antoinette said, he was "*like a baby*". He engaged in self-injurious behaviour. This has always been carefully managed by his

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[9] Antionette's evidence (transcript) P1's sister

family when he is in their care however whilst under professional care at MAH his self-injurious behaviour led to his face becoming deformed.

40. Antionette described the regime at MAH as "*a Victorian model of care that was … only making him worse.*"

41. There were many issues about Martin's time as a patient at MAH including (i) assaults, (ii) mis-management of medication, (iii) suffering injuries, (iv) being regularly restrained in his wheelchair which was not cleaned, (v) being moved to the Erne ward which was described as "*very cold and uncomfortable … absolutely appalling [and] not fit for human habitation*"; A ward about which H112 said in 2017 "*… felt like the forgotten ward.*"

42. And we must remember this was not just a ward in a hospital; it was Martin's home. Antionette described how this impacted on Martin. She said that when left back by her parents to the ward "*… he would lie down on the sofa and he'd turn his back to us, and he would cry…. it was just appalling.*"

43. Who knew what about Martin's case? Antionette's parents wrote to senior Belfast Trust personnel in late 2014 and early 2015 about their concerns over the abuse that Martin was suffering (the letters were exhibited to Antionette's statement)[10]. In her view, having received responses from Catherine McNicholl (*Director of Adult Social & Primary* Care) obo Professor Sir Michael McBride, then the Deputy CE of the Belfast Trust, the Trust knew of the abuse suffered by her brother and her concerns more generally about MAH.

P16

44. P16, who has Downs syndrome and was educated at a special school, was first admitted to MAH (Iveagh) as a 13-year-old. He spent two periods as a child there for 5 months from late 2011 and 10 months from mid-2015 and experienced a series of failed resettlements.

45. P16 was represented at the Inquiry by his mother who gave evidence on 20th Sept 2022[11].

[10] Antionette's statement (exhibits) exhibits 9, 10, 16 and 17

[11] P16's mother's transcript

46. On his 18th birthday P16 moved to a care home. It soon became clear to his mother that it was doomed to fail. His mum described that" there *was a lack of support for the young people and their needs.*"

47. His mother gave a straightforward summary of what she felt P16 needed to transition smoothly: *"…preparation… a social story for some time, maybe months in advance so that* P16 *knew what to expect.*" But this did not happen and P16 experienced, to his detriment, botched move after botched move.

48. In 2016 P16 was moved to MAH as a detained patient. His mother's description of Moyola ward was disturbing. She said, "*It was badly run down … It was horrible, with old corridors and carpet … It was filthy. P16 was sitting at the very end of the building … naked. P16 only takes off all his clothes when he is really distressed and agitated.*"

49. When returning to MAH after home visits P16 often became agitated, and it was clear at such times that he did not want to go back there. In light of what we learned from the CCTV footage (in August 2017) and from the evidence of other core participants, P16's mum questions herself. She said, "*… I feel guilty … now I think there was a reason for it, and he was trying to tell me something.*"

50. In October 2019 P16, a young man who needed 1-1 care, experienced a further failed resettlement when he was moved to a placement staffed by agency workers where he was expected to manage a degree of independent living which was obviously beyond him. He was placed there despite the resettlement team – a specialist team – knowing he could "*not do anything for himself*" and at a time which coincided with serious staffing problems.

51. This facility, which was to be P16's new home, was described by his mum as being "*filthy*" and at times smelled of faeces. She said, "*There was no management, and I just had to speak to whatever staff were on that day.*"

52. The placement only lasted for 10 weeks before his mother "*just lifted him and walked out.*" She regrets not taking him out sooner. P16s bed had been held open at MAH and he returned there.

53. Fortunately, P16's mum said he is now in a "*great placement"* close to his home where he has his own apartment with bedroom, bathroom, activity room and a private garden. There are lots of activities for him. The family is "*so happy*" about this after what P16's mum describes as "*such a hard road to get here*."

Ciaran (P57)

54. P57, known to the Inquiry as Ciaran, experienced MAH over an 18-year period (save for three years) between 1992 and 2010 when his mother, Patricia, who gave evidence on 20th October 2022[12], could take no more and removed him from the hospital to take him home.
55. She battled for resources to assist her and family to care for him but was let down and to this day manages him without outside assistance, save that a district nurse visits monthly to take his blood and Consultant Psychiatrist, H40, who Patricia commends, calls to their home every few months.
56. Patricia remains concerned that there is no still no social services or health services planning for a crisis that may happen.
57. Ciaran was a vulnerable 12-year-old child with severe learning disabilities yet, he was admitted to Conacre ward (an adult ward) where he slept in a dormitory.
58. Ciaran was described by his mother as "*a bright wee boy*" who, at the time of his admission to MAH, could read and write. After his admission Ciaran wrote about wanting to escape MAH which he described as a horrible place in which "*everywhere was locked and the staff walked around with keys*".
59. Ciaran was in Conacre adult ward for two years before moving to a children's ward. He moved again, aged 16 or 17, to ward M7A where he was abused and inappropriately touched by a patient a decade older than him.
60. This prompted his parents to remove him from MAH and he stayed with his family for the next three years until his behaviours became incapable of safe management at home.
61. Patricia said, "*The only option at the time was to agree for him to go back to MAH.* At around 20 years of age Ciaran was admitted to M7B, a locked ward.
62. In addition to suffering physical injuries Ciaran contracted dysentery and scabies on the ward, in the hospital, all whilst under the care of nurses and doctors.
63. Patricia described her and her family's pain at Ciaran's plight. She said, "*… I used to think to myself if I just keep driving over the ditch that would be the end of this for both of us. It was so devastating.*"

[12] Patricia's transcript

64. In 2010 Patricia and her husband removed Ciaran from MAH and he never returned.
65. Patricia referred to the contrast between Ciaran as a patient at MAH and then afterwards in her care. She showed a photograph taken in August 2008 and describes Ciaran as being gaunt and agitated. In stark contrast Ciaran is pictured looking happy and contented back home in his mother's care.
66. Patricia, like many other of our clients, pointed out that, unfortunately, there were no cameras at MAH when Ciaran was there so she will never know what exactly happened to her son. But Ciaran can, to a degree, fill in those blanks. Unlike many other patients at MAH, he is verbal and his heartbreaking response to any reference to MAH is telling. He repeats, "*You're not going back to this ward. You're not going to hurt me.''*

George (P18)

67. "George", with the cipher P18, was admitted to MAH in 2016 when he was 18 years old.
68. When his mum, Geraldine, gave evidence on 21st September 2022[13] George was still in MAH. George is part of a big loving family being one of five siblings. He is 6ft tall and a music lover with a passion for Elvis. He is a big gamer and is also a competent technician.
69. George has a diagnosis of autism and ADHD. He is verbal and can communicate however doesn't always understand what is going on. His mum said people think he has better degree of understanding than he does. He suffers from anxiety and can have physical outbursts.
70. George was able to come home most weekends from MAH and Geraldine felt it was clear he was "*relieved*" to be there. On four or more occasions George come home "*covered in bruises on the back of his arms and legs*" yet Geraldine never saw body charts or records relating to this.
71. Geraldine now believes being at home for long periods is what stopped him being hurt more.

[13] Geraldine's transcript

72. She, like many of our clients, had little opportunity to see George's home or living space at MAH, when collecting George she had to do so from a reception area.
73. She was in no doubt however about how George felt about the hospital, and she said: *Well, … he doesn't like Muckamore. He doesn't like being there. He's had water threw over him, coffee threw over him, which is lucky enough they give it at a certain temperature.*"
74. Geraldine wanted from MAH what society should expect of a hospital caring for learning disabled adults. She said, "*I never thought the staff at MAH would do anything like that to harm George ...*"
75. George should have a safe living environment that is not a hospital. Like many other patients he experienced a failed resettlement attempt in a facility where staff "*simply could not handle him*".
76. George is still a patient in MAH. He has home visits and goes shopping with his mum but yearns for his new home. Geraldine fears MAH will close before he is resettled, and George may have to be moved to yet another hospital environment.
77. Geraldine, told the Inquiry back in September 2022 about what George wanted - *"a forever home and a girlfriend."* And as for what Geraldine wants for George, she summarised it simply but effectively when she said, "*all I want for George is to come away from there and have his own wee place.*"

Daniel "Danny" (P28)

78. P28, Danny (a twin), one of four children, was in MAH from January 2017 to February 2019. He was then settled into the community.
79. Danny's mum and dad, Helen and Robert, gave evidence on 28th September 2022[14]. She talked about how Danny loved music and singing and he would go to bed with his favourite toys including Barney and Tigger and sing the Barney song. He liked animals.
80. Danny, who has a mental age of an 18-month-old child, had two years being cared for in a facility in Donaghadee. Sadly, the care he received there was

[14] Helen's transcript

poor, he suffered unexplained injuries, his medication was mismanaged, and his basic care needs were neglected.

81. Helen described that she raised the issues with social services "*but they were brushed aside, and we were not listened to.*"
82. Helen didn't want Danny to be admitted to MAH, but he was detained there under the MHO. Danny's beloved Barney and Tigger toys were left with him however Danny's parents said they cried all the way home feeling they had abandoned him.
83. Helen said Cranfield ward "*felt alien and intimidating … more like a prison*".
84. Danny was supposed to be in MAH for 6 – 8 weeks but this "*prison sentence*" lasted for two years during which, *inter alia*, he became more and more withdrawn, his epilepsy medication was mismanaged, his beloved Barney was stolen, he lost significant weight to the extent that *'his trousers were falling off him',* his basic needs were neglected and he was often dirty and "*smelt of strong body odour and urine.*"
85. Unexplained bruising was dismissed by staff as having been caused by Danny himself or otherwise explained away.
86. On the abuse allegations Helen said, "*I know in my heart that Danny was ill-treated and neglected and that was never addressed … Our worst fears were realised when news broke of the abuse cases in MAH … You can imagine our horror.*"
87. Before Danny's "*release*" from MAH his mum described that "*He was looking frail and his face was grey and his eyes sunken. He no longer sang; he was no longer happy. The joy had simply been switched off.*"
88. When he had left MAH, Danny's parents were informed that CCTV footage had shown "*at least seventeen incidents involving Danny being mistreated.*"
89. The impact on Danny and his family, as with other patients and their relatives, cannot be overstated. Helen said, "*I trusted them. MAH said it was the best place for Danny but it was the worst place for him … This has crushed our family. I feel that we have been failed and our most vulnerable families have been failed.*" And speaking of the Inquiry she said, "*It has been a very painful experience to do this but I just don't want this to happen to anyone else.*"

Re: - Gregory "Greg" (P13)

90. P13, known to his family and to the Inquiry in evidence as "Greg" was represented by his sister Nicola who gave evidence on 5th July 2022[15].

91. Greg, who has a learning disability and challenging behavioural issues, is described by his sister as a "*loving brother*" who loves to listen to music and with a particular fondness for Elvis and Daniel O'Donnell.

92. Greg was in MAH at various times over a 40-year period. He has no sense of danger and his behaviour can be challenging. He was 9 years old when first admitted to MAH as he could not be cared for at home.

93. Nicola said of MAH, "*We felt that [it] was best suited to his needs and had appropriate nursing care, routine and activities that he enjoyed. [He] never complained to us about his care at MAH.*"

94. However, there were numerous failed resettlement attempts over a 35-year period (between 1983 to 2018). Without appropriate facilities, and home care not being viable for Greg, he spent an eight-year period in MAH (between 1990 and 1998) albeit he went home for the weekends. He was described as being "*always happy to go back [to MAH]*"

95. In 1999, after a short-lived resettlement attempt, Greg went back into MAH and remained there until 2006. Again, no concerns were noted.

96. After a further failed resettlement attempt Greg then spent another 11 years in MAH (from 2007 to 2018). Again, he appeared to be happy there and had day care and good activity provision. Nicola described that outbursts and challenging behaviour "*seemed to be managed much better by the staff at MAH as opposed to the community placement staff.*"

97. Despite being happy with Greg's care at MAH Nicola and her family were left shocked and upset when they heard in July 2020 from their FLSW (Geraldine O'Hagan) that July/August 2017 CCTV footage showed two incidents involving Greg.

98. By the time the CCTV abuse allegations came to light Greg had already been discharged from MAH.

99. In respect of allegations of abuse at MAH Nicola said (*per* statement and transcript), "*This came as a huge shock to me and my family and I find it hard to believe that this was allowed to happen to vulnerable adults in the care of*

[15] Nicola's transcript

MAH. It was wrong that my brother, and other vulnerable adults had to go through this horrible ordeal and I believe that the people involved need to be held accountable for their actions."

P97

100. P97 is now 59 years old. He is non-verbal. He was a patient in MAH between 1982 and 2000. His sister made a statement which was read to Inquiry on 13th September 2023[16].
101. As a child and growing up as part of a family of five brothers and sisters P97, despite having special needs (and being autistic), was described as being "*affable*". P97's sister said, "*[He] was fun loving and enjoyed a good, warm relationship with me and the rest of our family.*"
102. P97's family lived in rural Fermanagh and there was little community or social services support for them.
103. In line with other witnesses, including professional witnesses, P97's sister commented on how "*isolated and lonesome*" MAH was. It was a place, geographically at least, apart. P97's sister described that her parents could visit only rarely although about twice each year MAH arranged transport for P97 to visit his parents on a one-day visit. When P97 and her siblings were older and either working or at university in Belfast they visited regularly. She said, starkly, "*Visits in those early days were bleak and depressing for me. I felt powerless; seeing [P97] so unhappy.*"
104. P97's depression worsened over time, he was increasingly confined to bed and he became overweight.
105. P97's sister presented a mixed view about staff at MAH some of which, she said, "*got on like they were prison staff or bouncers and that they were there should strong people be needed to intervene with patients.*"
106. P97's head became deformed during the time he spent at MAH and his sister believes this was due to him banging his head against things (the floor or the walls) when he was unsettled.
107. P97's sister said, "*In retrospect, I never enquired what measures MAH staff were taking to minimise the damage that [P97] was inflicting upon himself when*

[16] P97's sister's transcript

he was banging his head on the floor or wall. [P97] still does this, albeit staff now provide him with a mat. This is used instead of restraining measures and prevents [P97] from injuring himself."

108. P97, who was a detained patient at MAH, was initially resettled into a facility catering for autistic adults. She described that although the "*resettlement was well handled … it broke down because of the competing needs of residents.*" He then had a successful placement in supported living where, P97 said, "*he is supported to live as independently as possible*."
109. P97 is able to socialise with his siblings and "*enjoys going to restaurants*" and being taken out at the weekends. He is described as continuing "*to thrive within the supported housing framework [which is] well suited to [his] needs.*"
110. As a result of this Inquiry P97's sister reflected on her family's experience of MAH. She concluded: "*MAH caused both [P97] and our family to adapt to an institutionalised approach … I feel that [P97] has been deprived of a large part of his youth, family life with his parents and siblings, freedom and a lot of happiness … I do not think that MAH was appropriate for [P97].*"

Kirsty (P4)

111. Kirsty (P4), who is now sadly deceased, was a patient in MAH over a two-year period up to 2018. She was a loving daughter and sister.
112. Her mother gave evidence on the first day of the Inquiry's hearings and was the second witness to present her testimony[17]. Initially she did not want to give evidence and when asked, by Inquiry counsel, why she had changed her mind she said simply, *"… because I wanted Kirsty's story to be told, the way she was treated, because she is not here to do it herself …"*
113. Kirsty did not have a learning disability but, after leaving school at 16, it was clear she was a troubled young woman. She did get jobs but couldn't hold them down given her alcohol and drugs problems. She needed help. Her mother, who had two much younger children, needed help. But neither got that help.
114. Kirsty was initially admitted to a hospital unit (Mater Hospital) then went, as a detained patient, to a mental health unit (Knockbracken). She was diagnosed with paranoid psychosis and a personality disorder.

[17] Kirsty's mum's evidence

115. Kirsty remained in this unit for a number of years before, without any consultation with Kirsty or her mother, she was moved to MAH. Kirsty's mum said, "*I got a phone call from Kirsty to say that she waiting on an ambulance and was being taken to MAH. To this day, I do not know why she transferred or who transferred her.*"
116. She went on to say, "*Kirsty did not like it from the start. It was not the right place for her and I feel that the care team and the system failed her.*"
117. How? Kirsty's mum gave evidence that, "*Kirsty had mental health issues with addiction to drugs and alcohol. She heard voices and did not like to be on her own. She did not get any treatment for these issues at MAH. There was nothing for her to do, no recreation, no walks, no gym or exercise. When Kirsty went into MAH she was a size 10 … when she left MAH she was a size 20. Kirsty looked and was a completely different person after MAH.*" This is a common refrain.
118. Kirsty's mum said she had "*very little communication with the staff and they didn't let me know what was happening with [her] treatment or care. They said she was an adult and I was never informed about things like medication changes. I would ask for family meetings but I never got an answer.*"
119. Kirsty expressed her view of MAH to her mother. In simple terms Kirsty's mum recalled that she said. "*Mummy, this is a terrible here.*" In her mum's words, "*She hated it in MAH.*"
120. Kirsty was not learning disabled; she was vocal; but she was not listened to.
121. Kirsty's mum regularly noticed marks and bruising on Kirsty's upper arms and each time Kirsty told her they held her down to put her in seclusion where, she said, Kirsty could be held for hours on her own. Kirsty's mum described this as being "*physical and mental abuse.*"
122. Kirsty's mum gave evidence that her daughter became increasingly more drowsy and sleepy on her visits, being "*doped up*" and she became "*very bloated and overweight*" which made her very depressed.
123. In 2018 Kirsty was discharged into a community placement which soon broke down and her belongings were sent to her mother's house in bin bags.
124. Another placement failed because Kirsty could not cope on her own and she was placed in a central Belfast hostel where, one week later, she was found dead, aged 31, on 2nd September 2020.

125. Kirsty's mum concluded her evidence saying," I *would like to see some justice for Kirsty. She suffered mental and physical abuse at MAH and was failed by the system when she was released into the community with the proper support or help that she needed … I am still grieving for my daughter and it is very difficult but I want to tell the Inquiry what happened in MAH for Kirsty.*"

126. And what could life have been like for Kirsty? Her mum said, "*I would … have liked to have seen, if Kirsty had … got the proper help, where she would have been with her life now and what she would be doing, if she had … been put into the proper place*."

P113

127. P113''s mum and dad gave evidence 26th September 2023[18]. He was admitted to MAH on 13th April 2017 aged 20 and has a diagnosis, among other things of severe learning disability and autism. He is middle of three sons. He speaks but has a limited vocabulary.

128. P113's mum said about her son, "*When P113's in good form, he's smiley, he laughs very heartily. He loves eating. He has to have a magazine, he lives around his magazine deliveries … he just loves being home with us.*"

129. His admission to MAH came at a time of crisis, borne out of P113's distress and challenging behaviours and a lack of appropriate community support. P113's mum felt, "*every door seemed to close."*

130. After a short emergency respite placement P113's parents were called and told P113 was being driven to MAH handcuffed to a police officer. P113's dad described feeling '*distraught*' about his son's admission.

131. The decision to admit P113 (initially to PICU then to Cranfield) was out of their hands and they "*trusted the professionals*", and P113's dad said he felt reassured they could help P113 who had been admitted as a detained patient for assessment. He said he thought, "*… that [P113] would stay in MAH for a short period and did not imagine that he would still be there almost six and half years later.*"

[18] P113's mum's evidence (transcript)

132. During this time the parents noted times when he was "*over-medicated*" and "*lethargic*". P113's mum described P113 presenting as if he was in a trance, stumbling and dribbling with glazed eyes.

133. P113's parents visited him regularly. On their arrival P113 was often either not dressed or he was wearing "*old worn clothes*", not those they bought and labelled for him. This was a common theme in our clients' evidence. Good and sometimes very expensive clothes and trainers would disappear or be seen on other patients. P113's mum gave evidence that sometimes he would be sitting in soiled clothing and she would have to wash him.

134. P113 was the subject of a number of resettlements which failed due to "*lack of planning and staff training.*"

135. In May 2018 P113's mother, when on a day out with her son, received a phone call from a social worker during which she was told P113 had been abused. P113's parents were shocked that their son had been abused and were shocked to have been told about it in this way. She said, "*I felt completely numb and sick.*"

136. In September 2018 (14th) PSNI officers met with P113's parents in their home about police review of CCTV footage. P113's dad said police were "*sympathetic and tried to assure us that justice will be served.*"

137. P113's dad concluded his evidence stating, "*It makes me angry when I think about how my son has suffered … I feel let down by MAH as I trusted that my son would be looked after in a safe and secure environment.*"

D) ACCOUNTABILITY:

138. There is no doubt, we say, that despite the many good, decent, well-intentioned staff, tasked to care for and treat and manage LD patients at MAH (some of whom bravely whistle-blew), there were other staff who perpetrated abuse, mismanaged care, neglected patients and their families or even simply treated them without dignity or respect. There were also staff, we say, who did not fall into this category but who witnessed what was happening to these vulnerable patients and did nothing, or who knew, or suspected, there was abuse and failed to act. This has been referred to in evidence as the first line of defence[19].

[19] Mr Peter McNaney's evidence (transcript) p72 @ 22 (quoting statement)

139. But responsibility, where abuse was so widespread, lies beyond this so called "first line".

140. Having examined the issue of abuse of patients at MAH as a core objective of the ToR, the Inquiry will not only "*determine why the abuse happened*" but also, *"the range of circumstances that allowed it to happen*", and "*ensure that such abuse does not occur again at MAH or any other institution providing similar services in Northern Ireland.*"[20]

141. In opening remarks the Chair said, "*What an Inquiry is not allowed to do is to rule on or to determine anybody's civil or criminal liability. Now, that doesn't prevent the panel forming and publishing conclusions which may lay blame at an individual or organisational door.*"[21]

142. And that view was reinforced by Senior Counsel to the Inquiry in his opening address. He said, "… *an Inquiry Panel is not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes. This provision underpins the inquisitorial nature of the Inquiry.*"[22]

143. If there is blame to be laid, we urge the panel, on behalf of our clients and their loved ones, to do so. The families deserve no less.

144. The ToR dictate that, "*The Inquiry will examine the primary and secondary causes of such abuse and will address the question of whether the abuse resulted from systemic failings within MAH or the wider health care system in Northern Ireland.*"[23] The question we ask, therefore, is, "*How did a persistent culture of abuse develop where it was happening on many wards across a vast hospital estate and over decades?*".

145. In the top tier, and ultimately responsible for the region's health is the DoH, and, in the case of MAH, at least from 2007, the Belfast Trust was responsible for delivering care.

146. There is little doubt, we say, that the system for provision of safe, effective and appropriate care for vulnerable LD adults - within the timeframe of the Inquiry's ToR - was inadequate and deficient. We know this from the opening

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[20] ToR @ par 1
[21] Chair's opening statement (transcript) p8 @ 26
[22] Senior counsel's opening statement (transcript) P63 @ 10
[23] ToR @ par 8

submissions of, among others, the DoH and the Belfast Trust; we know this from the evidence of the patient/relative witnesses; we know this from the apologies of senior Department officials and Trust personnel and from those corporately responsible for delivering that care.

147. We have heard apologies from chief executives and permanent secretaries; from chief medical, nursing and social work officers; from senior Trust directors and managers.

148. On 22nd October 2024 Professor Sir Michael McBride gave an "*unreserved*" apology as CMO (in the DoH) and former CE of the Belfast Trust, for "… *the systematic failings that occurred, the abuse that occurred … It was fundamentally wrong and it should never, ever have happened.*"[24]

149. For those of our clients who have followed this Inquiry and have read or heard the numerous apologies, only they can speak to their view of how sincere they believe the apologies were.

150. But the common view among them is that the pain of their experience at "*Muckamore*" has not eased or dissipated by the apologies.

151. So, setting the apologies aside, how and why was this inadequate and deficient care system for LD permitted and sustained? How and why was a culture of abuse allowed to develop and be maintained at MAH? Prior to CCTV footage being viewed in mid-2017 who, in senior positions, knew about the abuse – even if not the extent of it – and what measures did they take, or fail to take, to stop it? And if they didn't know about the abuse, were they curious enough or critical enough? Did they scrutinise enough?

152. We say the only conclusion to be reached on the evidence is "*no*".

153. What of the Department of Health - at the top end of the governance pyramid?

154. Mr Andrew McCormick was permanent secretary between 2005 and 2014. Whilst it was a common view among senior Belfast Trust witnesses that the size of the organisation was not an excuse for failure to ensure patients at MAH were safe, Mr McCormick, referring to his time in the DoH acknowledged that, "*getting a governance structure and organisational structure that was going to be effective was a challenge.*" And he concluded, "*But I think it's undeniable*

[24] Professor Sir Michael McBride's evidence (transcript) P185 @ 3

that it leaves Mental Health and Learning Disability … struggling to get attention, I think that's, you know, a simple fact."[25]

155. Mairead Mitchell (Head of LD Services from December 2016 to 2019) put it in starker terms. She said, *"So Muckamore and Learning Disability Services, I felt, and a lot of staff felt, were at the bottom of the pile and it wouldn't have been seen as a priority."*[26]

156. We know, however, from Mr McCormick's evidence, that significant concerns about MAH were known about by the Department as early as 2007. In January of that year Mr McCormick was interviewed on a local BBC radio station about issues at the hospital. In that interview he said, vulnerable people at MAH were not being "*forgotten about*". Although he acknowledged, "*It's an immensely challenging agenda ... There's a lot to do here.*" Talking about, among other things, delayed discharge, he said "*the particular issue of people, people being in a totally inappropriate environment is something we only knew about in the last few days*." But he declared that the Department was "*committed to … making a difference.*" And, he said, "*Things are getting better.*"[27]

157. We now know, things did not get better. Indeed, we say, and the panel my conclude, having heard the evidence, that things got worse; a lot worse!!

158. Mr McCormick also agreed with the interviewer that certain patients in MAH were "*the least likely to stick up for themselves*", saying "*these people need advocacy. They need support*."[28]

159. Mr Richard Pengelly, who was permanent secretary at the DoH between 2014 and 2022, led it through the CCTV allegations in mid-2017, and, because there was no assembly and no regional government, issued a formal apology to the patient victims of abuse and their families.

160. In evidence he, too, confirmed the Department's view that the size of the Belfast Trust, didn't cause difficulty in terms of the oversight function, and, he said there was *"no evidence during my time in post to indicate these oversight arrangements were not effective."*[29]

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[25] Andrew McCormick's Evidence (transcript) p117 @ 26
[26] Mairead Mitchell's evidence (transcript) p174 @ 16
[27] Andrew McCormick's statement @ exhibit 3 - Transcript of interview on the BBC Nolan Show on 18th January 2007 pp27 - 33
[28] Ibid. @ p33
[29] Richard Pengelly's evidence (transcript) p59 @ 10 (quoting statement)

161. The responsibility to escalate concerns and the effectiveness of arrangements, according to Mr Pengelly, "*is dependent on all stakeholders recognising their obligations ....*"[30] He said, "*… but maybe the practical application of that was less than it should have been.*"[31]

162. He repeated this view when asked about abuse disclosed in CCTV footage and whether that, "*[brought] into question dramatically the effectiveness of the oversight arrangements*". Mr Pengelly answered, "*Absolutely, clearly and unequivocally …*"[32].

163. Is it possible that for any governance or oversight system to work effectively one can differentiate between the arrangements *per se* and the application of those arrangements? We say it is not. Because to do so is not only to delegate the arrangements but to delegate responsibility for those arrangements.

164. That something went wrong with the system between the Department at the top of the pyramid and the front-line staff at the lower end is undeniable. In essence, though, from the Department's perspective, it was the responsibility of others to practically apply the arrangements.

165. So, what of the Belfast Trust? Prior to CCTV footage being viewed in mid- 2017 who, in senior positions there, knew about the abuse, and what measures did they take, or fail to take, to stop it? And if they didn't know, where they curious enough or critical enough? Did they scrutinise enough?

166. Mr Peter McNaney, Chair of the Board of the Belfast Trust from 2014 to 2023, said of the Trust's system of governance, "… *I genuinely thought we had a decent governance system … But, you know, the bottom line is unacceptable abuse was happening, we didn't pick it up, the system that was there to prevent it didn't prevent it ... I regret that deeply.*"[33]

167. Dr Cathy Jack, most recent former CEO of the Belfast Trust (and long-standing Board member), said, albeit using a rather unusual analogy, "*I mean, you know, what we need in an organisation the size of Belfast is to get a sense, not just from the balcony, but also from the stairs and the dance floor.*"[34] She said, "*I mean, you know, you need to be able to go the mile deep as well as have the*

[30] Ibid. p59 @ 26 (quoting statement)
[31] Ibid. p60 @ 14
[32] Richard Pengelly's evidence (transcript) p60 @ 27
[33] Mr Peter McNaney's evidence (transcript) p67 @ 13
[34] Dr Cathy Jack's evidence (transcript) p83 @ 16

mile wide."[35] But it is others, she said, that had to go the mile deep. And, on the failure of others to escalate issues to Board level, she accepted the Trust Board "*should have been more curious*"[36].

168. We were given some insight into how they could or should have acted. Professor Charlotte McArdle said in evidence: "… *we have to use our data to do those deep dives to understand how we can improve services and not rely on inspection because it is only a moment in time it's on a day … We need a high level dashboard that gives us all the data that we can all use at whatever level to identify trends and analysis.*"[37]

169. Notably, Dr Jack also confirmed that MAH was only discussed three times at Board level between 2012 and September 2017 (when the abuse was uncovered in CCTV footage). Dr Jack said, "*It is the case that up until September 2017 MAH was not a place of concern for the Trust Board or the Executive Team.*"[38]

170. But it should have been. And, but for CCTV footage coming to light in mid-2017, we say it is likely to have remained the case that MAH was "*not a place of concern for the Trust Board or the Executive Team.*"

171. The previous CEO of Belfast Trust, Martin Dillon (between February 2017 and February 2020), talked about needing *"a robust system delegated and distributed leadership throughout the organisation"*[39] given its size. On accountability of the CEO he accepted that delegated leadership didn't diminish it and that he was responsible for ensuring "*the system of delegation … was effective.*"[40] In his view, however, prior to 2017 "*[he] had no reason to believe that the structures and processes for the management and oversight of Muckamore at directorate level were other than effective.*"[41]

172. Clearly, we say, they were not.

173. Mr Dillon said, "… *no system of governance is perfect, and any system of governance is only as strong as its weakest link, which is the staff who use it.*"[42]

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[35] Ibid. p98 @ 28
[36] Ibid. p181 @ 4
[37] Charlotte McArdle's evidence (transcript) @ p 45 - 46
[38] Dr Cathy Jack's evidence (transcript) p130 @ 4 (quoting statement)
[39] Martin Dillon's evidence (transcript) p63 @ 22
[40] Martin Dillon's evidence (transcript) p72 @ 18 -21 (question and answer)
[41] Ibid. p 169 @ 15
[42] Ibid. p 170 @ 9

And, "… *staff working together who collude together can defeat any system of governance.*"[43]

174. Dr Cathy Jack put it differently. She said that, "*Any governance system, no matter how well developed and comprehensive, relies on individuals doing the right thing*"[44]. This, we say, shows something of the Trust's mindset. It's back to the first line of defence. And, whilst an isolated incident involving a determined and secretive abuser, may not be readily detectable, the Inquiry should not accept, where there is widespread abuse as part of a culture, governance systems should not pick it up.

175. In unrestricted evidence Ms Esther Rafferty said of CCTV footage she watched, "*… Unfortunately what I was viewing on CCTV was instances of people abusing or staff abusing patients in full view of registrants and non-registrants and the disregard that I witnessed was unbelievable because it seemed to be in the open.*"[45]

176. Professor Sir Michael McBride, acting CEO of the Belfast Trust between 2014 and 2017, double-jobbing alongside his tenure as the DoH's CMO, also confirmed, *"The robustness of governance arrangements were dependent on matters that required Muckamore staff, clinical and managerial including at director level, to escalate concerns and to ensure appropriate intervention and action."*[46] Albeit the Professor accepted that good governance required the Board to apply "*downward curiosity.*"[47]

177. There was no evidence, we say, that the Trust Board or its senior executives applied any, let alone sufficient, downward curiosity to MAH such that abuse was detected or detectable. The facts, we say, speak for themselves. Until CCTV exposed abuse of patients by staff at MAH in August/September 2017 the Trust appeared to be ignorant of the abusive conduct and it appeared to be blind to the inadequacies of the circumstances that facilitated and sustained that abuse.

178. Professor McBride did acknowledge the Trust's failings. He said, "… *it is absolutely the fact that they did not detect the abuse and the systematic failings*

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[43] Ibid. p171 @ 17
[44] Dr Cathy Jack's evidence (statement) par 64
[45] Esther Rafferty's evidence (transcript) p 156 @ 14
[46] Professor Sir Michael McBride's evidence (transcript) p133 @ 7 (quoting statement)
[47] Ibid. p133 @ 19

that were clearly occurring within Muckamore Abbey Hospital, I mean, and that I deeply regret …"[48]

179. When pressed on whether any system of governance, no matter how good, could have detected the abuse at MAH, the Professor, said: "*one cannot conclude that the systems of governance and oversight were sufficient …"*[49]

180. We say, demonstrably, they were not – and with dire consequences for the patients and their families.

181. The Professor said, when asked by the Chair, whether he was sufficiently probing or challenging, "*… I don't think any of us at any level were and I think we are all diminished by that ....*".

182. But, for both the Trust and the DoH, prior to CCTV footage coming to light and subsequent reports, there were significant missed opportunities to identify and address concerns over abuse at the hospital. These included, (i) the EHSSB/NWBHSST Review of 2005 into safe-guarding at MAH[50] and (ii) the Ennis Investigation, which related to multiple allegations of abuse of a number of patients by staff – with a report produced in October 2013[51].

183. And it is at least conceivable, from evidence given to the Inquiry, that had the recommendations of the Bamford review been implemented those patients subsequently abused in MAH, would not even have been there, in that most inappropriate environment.

184. Professor Roy McClelland, giving evidence on 29th March 2023, said that if the proposals from the Bamford review had been implemented then MAH would not have existed in 2017 other than as a potentially small acute assessment and treatment facility.

185. In any event, and notwithstanding the lack of implementation of the Bamford recommendations, there were other non-MAH specific opportunities that should have alerted the leadership of the Trust and the DoH about, at the very least, the potential for abuse being an issue at MAH, including the review into abuse at Winterbourne View.

[48] Ibid. p135 @ 29
[49] Professor Sir Michael McBride's evidence (transcript) p138 @ 27
[50] EHSSB/NWBHSST Review December 2005
[51] Ennis Bundle

186. But there were other potential red flags when relatives of patients spoke with managers or wrote to directors. At a meeting in MAH in 2015 Antoinette (P1's sister) recalled her mother raising concerns at a multidisciplinary meeting that there was systemic abuse at MAH only to be told "*Ach, now, Come on now Mrs [redacted]*"[52] by the consultant psychiatrist. She said her family was *"brushed off at every turn*" and "*constantly being browbeaten.*"

187. Where the Department and Trust put leadership and governance structures in place for the safe running of MAH and LD services more generally, other agencies were there to provide external oversight, assistance and regulation. Yet abuse persisted.

188. Most significantly, the RQIA was an independent body set up to regulate and inspect the quality and availability of Northern Ireland's health and social care services. MAH was within its remit from 1st April 2009 when the functions of the former Mental Health Commission were transferred to it. Since that date, the RQIA has had a specific responsibility for keeping under review the care and treatment of patients with a mental disorder or learning disability.

189. Mr Ruck Keane KC told the Inquiry the RQIA is a "*hugely, hugely important role*"[53]. But, we say it just wasn't strong or effective enough, or, to adopt Mr McCormick's, terminology, it just wasn't "*scary*"[54] enough to adequately oversee care provision at MAH and uncover the widespread abuse that took place there.

190. Counsel for the Authority acknowledged that, "*The RQIA recognises failings in the oversight of the care provided to the patients in Muckamore and apologises to the victims and their families that it did not uncover the abuse they suffered.*"[55]

191. Despite the involvement of these agencies, though, until CCTV footage came to light in mid-2017, a culture of abuse, in all its forms, pervaded MAH.

E) CCTV:

192. The PSNI appreciated the import of CCTV footage both for safeguarding purposes and in identifying alleged perpetrators of abuse.

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[52] P1's sisters (Antoinette's) evidence (transcript) p93 @ 10
[53] Ruck Keane KC evidence (transcript) p83 @ 24
[54] Andrew McCormick's Evidence (transcript) p125 @ 6
[55] Opening statement for RQIA (Michael Neeson BL) p30 @ 23

193. DCI Jill Duffie, in charge of Operation Turnstone, said it was "*concerning to PSNI*" that from 18th December 2018 DAPOs where not permitted on site at MAH to carry out reviews of viewing sheets (par 6). She said, "*essentially, this meant there was a pause on safeguarding and the Trust were, therefore, arguably not fulfilling their statutory obligations in respect of safeguarding.*"[56]

194. DCI Duffie attended at MAH for a meeting at which it was confirmed, "*the Trust had not viewed as much CCTV as had been previously communicated to Police.*"[57] She said she seized the CCTV hard drives because she "*was unable to rely on the assurances from BHSCT that all footage had been viewed.*"

195. In a contemporaneous note DCI Duffie recorded, "*… I cannot have faith in the [T]rust viewing of the footage … To maintain public confidence in the investigation …*"[58]

196. In a sad indictment of the Belfast Trust a commonly held view among our clients was that it could not be trusted. Now we learn, even the PSNI, it seems, couldn't trust the Trust!

197. What was clear, though, was that CCTV was a game-changer. We say it was the **only** effective change that led to the uncovering of widespread abusive practices and ultimately led to further reports and to this Inquiry.

198. On that we agree with the observations of Professor Sir Michael McBride regarding the other arrangements. He admitted, "*they singularly failed to detect, to identify, to detect and escalate the abuse that was going on and that was a fundamental failure.*"[59]

199. All seem to agree, and the panel may, therefore, readily conclude, that but for CCTV widespread abusive practices most likely would have continued unabated at MAH.

F) CONCLUDING REMARKS:

200. The Inquiry has heard how the patients and their families, who we represent, have been traumatised by their experiences at MAH and how many still have a feeling of guilt for what happened to their loved ones there. And that evidence,

[56] DCI Jill Duffie statement par 6
[57] Ibid. @ par 8
[58] DCI Jill Duffie statement exhibit 2 @ pages 10 and 11
[59] Professor Sir Michael McBride's evidence (transcript) p136 @ 9

unlike in many public inquiries, was not about a single traumatic event or an experience over a short time. It was the lived experience of our clients' lives, before, during and after MAH. It was their journey battling, often alone, for their loved LD sons and daughters. It was their account, but this is our collective story because we, as a community, owe a duty of care to these vulnerable people and their families. And we entrusted our leaders – the government ministers and their permanent secretaries, the chief executives and board directors of the Belfast Trust - to ensure that was done.

201. It was not done right.

202. Whatever was the state of the health and social care services more generally, for LD and MH there was a broken system from top to bottom. And that broken system caused terrible damage for which, if justice is to be served, among recommendations to protect the interests of the LD and MH communities in the future, we say patients and their families should receive appropriate redress.

203. For MAH was not an environment in which our clients' loved but vulnerable LD relatives should have been placed for anything but specialist treatment.

204. All agree that a hospital should never have been their home. But, where it was their home, they should have been safe and well cared for. They weren't.

205. We reflect on the evidence of Mr Ruck Keene KC who provided a helpful analysis of the human rights model of disability, highlighting the basic principle that it is not the disability or impairment that is the problem, rather it is society's failure to respond to the impairment which creates the problem. We agree.

206. Our clients and their relatives have, too often, been viewed as the problem. Their common view is that there was little desire, within the walls of MAH or within the offices of the Trust or within the committee rooms of the DoH, to understand their loved ones and what lay behind their, at times, challenging behaviours. Rather, in keeping with the "patient as the problem" approach, which our clients say prevailed at MAH, there was a hasty, even immediate, move to the nuclear options, including PRN, seclusion and MAPA, to the grave detriment of patients and utter disregard for their basic human rights.

207. And, of course, patients were deliberately mistreated and abused.

208. We pause there to consider the approaches of the DoH and the Belfast Trust. If the Inquiry accepts the evidence, a summary of which we have just referenced, at least that evidence up to 2017, the DoH had sound governance

arrangements in place **but** relied on the Belfast Trust to carry them out. And the Belfast Trust had, they believed, effective structures and processes in place, **but** they "*were dependent on*" on management and staff. So, we're back to the first line of defence.

209. As professional witnesses have acknowledged, neither the Belfast Trust nor the DoH nor the RQIA were curious enough or scrutinised enough. And that, we say, is a grave indictment on the leaders and managers in those organisations. But it is also to oversimplify and understate the issue.

210. The reality, of course, was very different.

211. CCTV was a game-changer, and the Inquiry is aware of our view that but for it, it is likely abusive practices would not have been curtailed. But, whilst, we say, CCTV must be an integral part of the protective regime within any hospital or community placement, it is not a panacea. Because, whilst it might be a deterrent, of necessity it can only evidence abuse after the event. Instead, there must a system in place to ensure issues are identified and addressed before they become problematic. Sean Holland (chief social worker from 2010 – 2012) referenced this succinctly in concluding remarks of his evidence. He said, "*Systems that catch are no replacement for care that prevents.*" [60]

212. Looking to the future and consideration of recommendations, the LD and MH community needs to be embraced by a wraparound service with families being integral to decision making and being utilised as a valuable resource. LD and MH services must be properly resourced with a focus on assisting families to care for their LD relatives at home for as long as possible, and were that is not possible, they should be placed in well managed, but appropriate, community placements. All the time with a focus on the person for whom the service is required and their family.

213. Our clients and their loved ones, to whom they have given voice, have been at the front and centre of this Inquiry, and will be, we hope, as the panel considers its findings and makes recommendations. But what is a successful outcome for them?

214. Yes, it's about adequate and appropriate resources for LD and MH. Yes, it's about health and emotional well-being. Yes, it's about being safe and well-

[60] Sean Holland's evidence (transcript) p148 @ 4

cared for. But it's also about ensuring that in every decision relevant to their care the person is at the front and centre of their thinking. From the care-assistant to the social worker, from the nurse to the doctor, from the care-manager to the care-funder, from the director to the chief executive and from the permanent secretary to the minister. Only then will our clients feel their loved relatives are not "the problem". Only then will they truly feel their loved relatives are fully part of our community, where they belong. Anything less is not good enough.

Conor Maguire KC

Victoria Ross BL