MUCKAMORE ABBEY HOSPITAL INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF

THE POLICE SERVICE OF NORTHERN IRELAND

25th February 2025

1. The PSNI welcomes the opportunity to make a closing statement and would like to again commend the families of MAH patients, past and present, for their determination and dignity. The PSNI, in particular the SIO and dedicated officers of the Op Turnstone team, continue to value their open, transparent and supportive relationships with all those involved in the ongoing investigation as it enters a seventh year. In the PSNI opening remarks to this Inquiry on 8th June 2022, the PSNI began by acknowledging the patients and families being at the heart of the investigation into allegations of abuse at Muckamore Abbey Hospital. The PSNI's dedicated Op Turnstone team has continued to work closely with the families of Muckamore patients, past and present, as criminal proceedings progress.

2. This work has ranged from initial outreach and engagement by individual officers, primarily focused on next of kin of patients in PICU ward, to the subsequent understanding that a bespoke family liaison strategy would be required to manage and co-ordinate updates and communication to all affected family members. It has always been of utmost importance to the PSNI's Op Turnstone team that family members are updated in a consistent, timely and compassionate manner. Each family has a named officer to update them and act as point of contact to answer any questions they may have. As the Op Turnstone Investigation enters its seventh year our Family Liaison Officer ("FLO") strategy has proven effective and beneficial, with many families continuing to reach out to their PSNI contacts for information and support even after their loved ones have successfully been resettled in the community.

3. For many of the families who are affected by the allegations of abuse in MAH, criminal proceedings can be difficult, confusing and overwhelming to navigate with many families having had no prior experience of criminal courts whatsoever. All the members of the Op Turnstone team have gone to considerable lengths to support the families in Court. The two dedicated Op Turnstone Detective Sergeants have attended every Court hearing and mention alongside the family members and are always on hand to explain proceedings, due to the unprecedented size and complexity of the investigation.

4. The PSNI would like to acknowledge, and thank, the small team of experienced Social Work professionals who have concurrently been working as Family

Liaisons appointed by the Trust. The PSNI has formed a very positive working relationship with this group, based on our respective and complementary goals of achieving the best possible criminal justice outcomes for those affected by alleged abuse in MAH, and supporting the patients and their loved ones in understanding and recovering from their experiences with MAH. The Inquiry has heard evidence from several of these dedicated and compassionate professionals, and the PSNI would wish to acknowledge the legacy of compassion and advocacy left by the late Geraldine O'Hagan, who will not be forgotten by the PSNI officers who had the privilege of working with her.

5. It will be no surprise to the Inquiry, the Core Participants and the public, to hear that the PSNI faces an unprecedented resourcing crisis. Notwithstanding this crisis, the PSNI has sought to engage to the fullest degree with the Inquiry providing assistance, information and investigative material on a continuous basis since early 2022 in tandem with the demands of the largest safeguarding investigation in the UK. Conversely, all evidence gathered by the Inquiry to be heard in the public hearings has been shared with PSNI in advance of oral evidence sessions, in order to ensure that any evidence, which has the potential to prejudice ongoing criminal proceedings, can be subject to an application to the Chair for a Reporting Restriction Order. To this end officers from the PSNI's Op Turnstone team have reviewed many thousands of pages of evidence, often within limited timeframes, whilst continuing to progress the investigation, submit investigations to the PPS, and assist and support the PPS with the administrative tasks associated with preparing for criminal trials. As a small

team within PSNI's Public Protection Branch, Op Turnstone officers are frequently required to assist colleagues with real-time operational incidents whilst, simultaneously, ensuring that progress on Operation Turnstone has continued steadily. At one point, twenty officers were dedicated to the investigation, eight of those officers solely tasked with the initial viewing of CCTV. Currently, having completed the viewing of all footage, the team is comprised of 10 officers.

6. At all times, PSNI has sought to ensure that the balance between transparency, safeguarding responsibilities, and the need to preserve the efficacy and confidentiality of the largest safeguarding investigation in the UK, has been maintained. As alluded to above, significant amounts of information gathered during the PSNI's investigation into alleged abuse at MAH has been shared with the Inquiry, demonstrating the PSNI's commitment to transparency and genuine desire to assist the Inquiry. It should be noted, however, that it is highly unusual for an Inquiry to run concurrent with a police investigation given the challenges this presents in preserving confidentiality, procedural fairness, and compliance with PACE and the Criminal Procedure and Investigations Act 1996 (CPIA).

7. The Memorandum of Understanding between the Inquiry, Public Prosecution Service and PSNI has required regular review and amendment to ensure robust protection of the investigation whilst providing the Inquiry with the data required to fulfil its remit. The PSNI's role is to investigate, prevent and deter

crime, with the underlying aim of ensuring the safety of the people of Northern Ireland.

8. It will be evident to Core Participants and the public alike, that the catalyst for the PSNI investigation was the discovery, and subsequent viewing, of CCTV from PICU ward in August 2017, following a report of an assault on a non-verbal patient. As outlined in PSNI evidence to the Inquiry, historically there have been very limited numbers of successful prosecutions in the field of Adult Safeguarding, at least in part due to the challenges in obtaining first-hand accounts from complainants with learning disabilities. The presence of CCTV affords additional protections for such complainants and ensures that they have a voice and equal access to the criminal justice system and therefore the PSNI welcomes and encourages the use of CCTV in these contexts. **It is the PSNI's strong view that the presence of CCTV in care settings can only serve to enhance the safety of patients. The PSNI is disappointed that there is no provision within the Draft Adult Protection Bill for the mandatory installation of CCTV in settings where care is delivered to those with severe learning disability or mental health needs and trusts that the Inquiry will consider this important issue when making their recommendations**.

9. The PSNI has noted the position of the families in relation to CCTV. PSNI recognises that the goal of the families is that CCTV is mandatory. PSNI wholeheartedly supports that position as it gives protection to those without a

voice who are unable to engage with the criminal justice system in the same way as persons with no learning or mental health disabilities.

10. It is the view of the PSNI that, without the CCTV evidence, there would be no police investigation, no prosecutions, no public knowledge of the issues uncovered in MAH, no public inquiry, no scrutiny and no safe place for those subjected to abuse. It would only mean that the circumstances giving rise to allegations of abuse continued.

11. A final point that the PSNI would wish to address on the issue of patient safety is the suspension of MAH staff throughout the duration of the PSNI's Op Turnstone investigation. The PSNI would like to comment on the issue of patient safeguarding. In the PSNI opening remarks to the Inquiry almost three years ago, the PSNI called upon the Inquiry and all Core Participants to protect the integrity of the police investigation and criminal proceedings.

12. It has been suggested during evidence heard by the Inquiry that within the context of Operation Turnstone in particular, Trust colleagues tasked with the supervision of MAH staff members under investigation were not given sufficient information to allow for effective supervision and safeguarding. With respect, the PSNI refutes this suggestion. During the initial period of PICU CCTV viewing, it has been established at length that viewing was first carried out by BHSCT staff and this has been reinforced by evidence provided to the Inquiry by Trust personnel. On this basis, the BHSCT staff were in possession of the CCTV, viewing logs and associated records pertaining to their staff and

therefore, it is the position of the PSNI that BHSCT was in possession of all the information necessary to ensure appropriate safeguarding of patients. In addition to the benefit of having the specific footage of incidents, the trust had their own policies to apply, and ought to have advised their supervisors of what was expected.

13. Moreover, the alleged offending for which all MAH staff have been investigated falls within four discrete categories or offence types; namely Wilful Neglect, Ill Treatment, False Imprisonment and Fraud/Forgery in respect of medical reports. BHSCT supervising colleagues from a professional background within the Trust should have no difficulty in identifying actions that amount to Ill-treatment or Wilful Neglect of a patient, nor any difficulty in identifying inaccurate or misleading entries or records. It is also reasonable to expect a supervising member of staff to ensure adherence to the BHSCT's own policy on seclusion without the need for PSNI instruction.

14. It has also been suggested that large numbers of suspensions in 2020/21 as the police investigation progressed led to unsafe staffing levels within MAH, placing patients at further risk. Whilst the PSNI is not blind to the resourcing challenges brought about by staff suspensions, once CCTV has been viewed and a staff member is suspected, based on the viewing, of criminal behaviour towards a patient it would present an untenable risk to allow the staff member

continued access to patients. The staffing levels are not a matter for police, they are a matter for the Trust.

15. The alternative would be to permit those suspected of offences to continue working with vulnerable patients. This would obviously compromise the safety of patients. Safe staffing levels is a Trust responsibility and DOH responsibility, not the responsibility of law enforcement. The Inquiry and Core Participants have had access to written evidence from Dr Cathy Jack, Chief Executive of the BHSCT, reaffirming responsibility for staffing at Muckamore and assuring the DoH that safe staffing levels were and would be maintained. In evidence given to the Inquiry on 16th October, at paragraph 262 of the transcript of Dr Jack's evidence she states that it would be indefensible from a Trust position to keep staff on the wards who were seen to be abusing staff and she further confirms that issues with staffing in MAH went beyond Op Turnstone related suspensions.

16. On 10th June 2024 Professor Maxwell asked a BHSCT Witness at paragraph 204, line 27 of the transcript of evidence of Gillian Traub, whether the police investigation took precedence over the protection of patients. With respect, this question fundamentally misunderstands the PSNI position on safeguarding. The PSNI investigation serves to protect patients by ensuring they are not in the care of staff members who are suspected of mistreating them. Had staff suspected of abusing patients not been suspended, the only recourse open to PSNI would have been the arrest and release on police bail of hundreds of staff

members who would then have been subject to protective bail conditions for the entirety of the investigation. Any such bail conditions would have rendered employment at MAH in a patient facing role problematic to say the least. It is also worth noting that all the versions of the Joint Protocol, it is the local Health Trust which is charged with taking the lead on safeguarding whilst PSNI takes the lead on the investigation, in accordance with the skill sets of both agencies. Safe staffing levels can also be considered by the RQIA, who have conducted regular inspections at MAH during the lifespan of the investigation.

17. The PSNI's evidence to the Inquiry given by Detective Chief Superintendent Fisher has detailed the challenges both in identifying and investigating Adult Safeguarding offences in Northern Ireland over the last two decades. There can be no doubt that historically, significant barriers existed to the successful detection and prosecution of offending against the most vulnerable members of society. The PSNI have provided the inquiry with an overview of improvements in the regional Joint Protocol, collaboration with the Department of Justice to implement and promote the use of Registered Intermediaries, and ongoing work with Department of Heath on the new Adult Safeguarding Bill, all with the aim of making Northern Ireland a safer place for members of the community with learning or mental health disabilities. The introduction of twelve dedicated adult safeguarding officers within Public Protection Branch and the additional training to all uniform and student officers to recognise and respond to Adult Safeguarding incidents and concerns

have resulted in steadily increasing positive criminal justice outcomes as detailed in the evidence of Detective Superintendent Fisher.

18. Moreover, within PSNI's Public Protection Branch there now exists a dedicated Adult Safeguarding (AS) Policy role, in recognition of the importance of skills development, training and consistency across Northern Irelands five Trust areas. The Adult Safeguarding Policy Sergeant also plays a key role in supporting the PSNI's AS lead in the development of Northern Ireland's first AS Bill, and other related workstreams such as the review of Adult Safeguarding Joint Protocol.

Conclusion

19. In conclusion, the PSNI has devoted significant resources towards the assistance of the Inquiry alongside the criminal proceedings. PSNI has to date triaged 274 members of MAH staff, interviewed 97 members of MAH staff, submitted 68 files to the PPS with two further files awaiting submission at the time of writing. The first eight staff members to be charged have been committed for Trial at the Crown Court in Laganside, and a further eight await committal to the Crown Court in the coming weeks. Whilst subject to minor amendments, the Indictment in the upcoming Trial extends to over four hundred counts and currently a Court of Appeal judgement is awaited to determine the PPS's application to split the Indictment into two parts. The PSNI evidence from Detective Chief Inspector Duffie and Detective Sergeant Porter has sought to assist the Inquiry in understanding the steps taken to secure vital

CCTV evidence and the approach taken to the safeguarding arrangements developed between PSNI and BHSCT.

20. In preparing evidence for the Inquiry, the PSNI has taken the opportunity to reflect on the learning from over two decades of adult safeguarding and is committed to embedding that learning in the implementation of the new Joint Protocol and Adult Protection Bill. The PSNI welcomes any recommendations from the Inquiry that will enable the PSNI to continue learning and improving our ability to keep people safe.

21. Op Turnstone has reinforced the support for the family position on CCTV as an essential tool for safeguarding.

22. The PSNI has sought to act with transparency, accountability and cooperation at every stage of this process in the context of its safeguarding responsibilities, and the need to preserve the efficacy and confidentiality of the ongoing investigative actions.

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