

MUCKAMORE ABBEY HOSPITAL INQUIRY  
SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL  
ON, WEDNESDAY, 5TH MARCH 2025 - DAY 123

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I N D E X

P A G E

CLOSING SUBMISSION - MR JOSEPH AIKEN.....5

1 THE INQUIRY RESUMED ON WEDNESDAY, 5TH MARCH 2025, AS  
2 FOLLOWS:

3  
4 CHAIRPERSON: Good morning, thank you. We've received  
5 a notification and an apology from Mr McGuinness who 10:00  
6 wrongly attributed a quote yesterday to Sidney Decker,  
7 it was the quote that we may remember about the benefit  
8 of hindsight that almost no human action or decision  
9 that cannot be made to look more flawed or less  
10 sensible in the misleading light of hindsight. He 10:01  
11 wanted to correct it, it was actually Sir Anthony  
12 Hidden QC in the Clapham Rail Disaster and Mr Decker  
13 was re quoting.

14  
15 With that correction we can now start with Mr Aiken, 10:01  
16 thank you.

17  
18 CLOSING SUBMISSION OF MR AIKEN

19  
20 MR. AIKEN: I think you'll hear during the course of 10:01  
21 the morning, sir, how that correction comes about.

22  
23 Sir, members of the Panel good morning, I make these  
24 closing oral submissions on behalf of the Belfast  
25 Health and Social Care Trust which is responsible for 10:01  
26 the ongoing operation of Muckamore Abbey Hospital. As  
27 you heard from counsel for the Department of Health  
28 yesterday, 15 patients remain in the hospital today.  
29 I recognise on behalf of the Belfast Trust that on

1 Monday it was said to you that saying sorry was not  
2 sufficient. It may not be sufficient, but it is  
3 nonetheless important and appropriate that the health  
4 and social care organisation responsible for the  
5 hospital in which its patients were abused and the 10:02  
6 abuse was carried out by staff employed by the health  
7 and social care organisation, that the organisation  
8 does say sorry.

9  
10 During the initial public hearings of the MAH Inquiry 10:02  
11 on the 9th of June 2022, the Belfast Health and Social  
12 Care Trust which, as you're aware, is a very large and  
13 diverse organisation with some 21 and a half thousand  
14 staff, who in the vast majority of cases day in and day  
15 out, often under immense pressure and unreasonable 10:03  
16 circumstances, have provided and are providing the most  
17 remarkable service to the public.

18  
19 The Trust repeated its previous personal and public  
20 apologies to those MAH patients who had been abused at 10:03  
21 the hospital whilst in the care of the Belfast Trust,  
22 and to their families.

23  
24 The apology on the 9th of June, which was and has been  
25 repeated by a number of witnesses from the Belfast 10:03  
26 Trust that you've heard from, was not confined to those  
27 abused in 2017 as seen on CCTV. As the Belfast Trust  
28 acknowledged that 2017 was not the only time when staff  
29 conduct towards vulnerable patients in their care

1 unfortunately met the broad definition of abuse as set  
2 out in paragraph 5 of the MAH Inquiry's Terms of  
3 Reference. That is why the apology that was given on  
4 behalf of the Belfast Trust was to all patients and  
5 their families affected by abuse by staff at Muckamore 10:04  
6 at whatever point in time that abuse occurred.

7  
8 The Belfast Trust repeats that apology in these closing  
9 oral submissions. The Belfast Trust also apologised  
10 for the behaviour of some other staff, those who were 10:04  
11 staff of the Belfast Trust who, whilst not themselves  
12 directly abusing patients, allowed some of the direct  
13 abuse that occurred and which they witnessed to go  
14 unchallenged and unreported. As well as perpetrating  
15 abuse, walking past abuse, was and is not acceptable. 10:04

16  
17 The Belfast Trust repeats the apology in respect of  
18 those of its staff who walked past or failed to  
19 intervene to stop abuse that they saw occurring:  
20 Further, the Belfast Trust also acknowledged that the 10:05  
21 individual failings of the staff who abused patients,  
22 or of the staff who failed to report and escalate abuse  
23 that they witnessed, also meant that an important  
24 aspect of the governance system in place and operated  
25 by the Belfast Trust failed to prevent abuse, failed to 10:05  
26 detect abuse when it occurred, or when witnessed failed  
27 to escalate the fact that it had occurred. Each of  
28 those instances are themselves systems failures within  
29 the organisation and the Belfast Trust apologised for

1 the fact of those systems failures.

2  
3 It is a fact that governance systems, however well  
4 developed in principle rely on human beings, whether  
5 that's reporting up or checking down, there will be 10:06  
6 times when those systems do not function as designed  
7 and fail as a result. In this case that has resulted  
8 in harm to MAH patients and their affected families and  
9 the Belfast Trust apologises for that fact.

10 10:06  
11 It's also clear to the Belfast Trust that even, if, in  
12 some instances, the Inquiry has heard only one side of  
13 a story, the many efforts to try to address what  
14 occurred at MAH also suffered various systems failures  
15 and, indeed, in some cases hurt and damaged the very 10:06  
16 staff who were part of trying to address the problems:  
17 Some of whom were not even staff at Muckamore when  
18 abuse occurred in 2017. The Belfast Trust also  
19 apologises for that reality recognising as it does,  
20 that the deeply regrettable fallout from events at the 10:07  
21 hospital, particularly those from 2017, will continue  
22 for many years to come.

23  
24 It is a matter of deep regret for the Board of the  
25 Belfast Trust and its Executive Team that events at one 10:07  
26 of its hospitals, which in this case should have been  
27 providing high quality care for extremely vulnerable  
28 people, has resulted in such toxicity extending even to  
29 the very name of the hospital. The Department



1 recognised in material that you have that the hospital  
2 was seen as "a toxic brand even before the prosecutions  
3 commenced and this public Inquiry began." That  
4 toxicity has added to the ongoing difficulty in  
5 recruiting the desired staff to operate the hospital. 10:08

6  
7 It's also a matter of deep regret to the Belfast Trust  
8 that the vast majority of staff who served in Muckamore  
9 Abbey Hospital, many of whom devoted a significant  
10 amount of their lives to caring for MAH patients and 10:08  
11 who had no part in abusing any patient or in failing to  
12 report the abuse of others, have had their reputations  
13 tarnished by the behaviour of others. Some of those  
14 individuals who served their patients with distinction  
15 over a prolonged period, perhaps in some cases for an 10:08  
16 entire lifetime, or working lifetime, now feel a sense  
17 of shame that their efforts do not deserve.

18  
19 The Belfast Trust also recognises that what has  
20 occurred at Muckamore Abbey Hospital has contributed to 10:09  
21 an already highly damaging lack of Trust that exists  
22 between many families and health and social care  
23 professionals in the area of learning disability care.  
24 The Belfast Trust also apologises for the damage its  
25 failures connected to the hospital have had on that 10:09  
26 important issue of Trust between families and the  
27 necessary public service providers of care for their  
28 loved ones.

29

1 Having had a brief opportunity to consider the written  
2 closing submissions on behalf of the family groups and  
3 then to hear the oral closing submissions being  
4 delivered on their behalf, it's evident to the Belfast  
5 Trust that there is much work to be done in this area 10:09  
6 of Trust and that a way must be found to re-set those  
7 very damaged but vitally important relationships  
8 between families and those individuals who, by  
9 necessity, provide vital care for their loved ones.  
10 Its care that is not always easy to provide. There may 10:10  
11 well be failures that occur with it but in many cases,  
12 there will have to be a life-long relationship between  
13 staff in the health and social care system and in  
14 mental health and learning disability in particular and  
15 the families of their highly vulnerable loved ones that 10:10  
16 the health and social care system must care for.  
17  
18 whilst it's perhaps entirely understandable, given how  
19 let down those families feel, that they should at  
20 present see no good or nothing positive in the care 10:11  
21 provided to their loved ones by the health and social  
22 care system. It is a dreadful indictment.  
23  
24 It's our respectful submission that a way must be found  
25 to try to rebuild those vitally important relationships 10:11  
26 which must endure long after the public Inquiry has  
27 completed its work. Perhaps the MAH Inquiry will give  
28 consideration to what form of recommendations it could  
29 make that might facilitate trust-building mechanisms

1 where an ongoing relationship is not just a choice but  
2 a necessity.

3  
4 I should say that I'm attended today, not just by my  
5 instructing solicitor and some members of the legal 10:11  
6 team, but also by Ms Maureen Edwards, the present Chief  
7 Executive of the Belfast Trust. whilst the presence of  
8 Ms Edwards cannot cure the ongoing ills that may exist  
9 in the system, nor make good the failures that have  
10 occurred, it is hoped her presence will be seen as a 10:12  
11 representation of the commitment of the Belfast Trust  
12 regardless of how difficult it and many of its staff  
13 may have found the Inquiry process, to doing the best  
14 it can for its patients.

15 10:12  
16 The Belfast Trust hopes that in addition to whatever  
17 criticisms it is considered the evidence can properly  
18 bear, and that its fair and necessary to engage in, the  
19 Inquiry can also make a positive contribution with  
20 realistic workable recommendations that can help 10:12  
21 improve the provision of Learning Disability Services.

22  
23 The Belfast Trust will do what it can, no doubt with  
24 the assistance of others in the system, to respond  
25 appropriately to those recommendations and will 10:13  
26 continue to try to play its part with others to provide  
27 the best possible services that the health and social  
28 care system is in a position to provide.

1 whilst it is again understandable that when things go  
2 wrong in the health and social care system, calls are  
3 made for resignations and dismissals at all levels, it  
4 is hoped that the MAH Inquiry Panel, which includes  
5 professionals who have worked in health and social  
6 care, will appreciate and accept that most health and  
7 social care staff, including those involved in learning  
8 disability care, do not get up in the morning with the  
9 intention of making mistakes in their work or of  
10 letting down the people they care for or frustrating or  
11 upsetting the families of their patients.

10:13

10:14

12  
13 Further, that being accountable for failures that occur  
14 doesn't necessarily mean losing your job, it can mean  
15 rolling up your sleeves and trying to make things  
16 better.

10:14

17  
18 Also present from the Belfast Trust is Ms Templar, the  
19 Belfast Trust Service Manager in relation to the  
20 Inquiry. I know that Ms Templar will not thank me for  
21 saying so because she regards it simply as part of her  
22 public service, but over the course of the last three  
23 years often in the evenings and weekends, and during  
24 times when she was notionally on leave, Ms Templar and  
25 her team, along with my instructing solicitors and the  
26 Directorate of Legal Services and the counsel team, who  
27 as well as assisting many witnesses who found the  
28 Inquiry process unnecessarily difficult in their view  
29 and some tried to explain that to the Inquiry, have

10:14

10:14

1 worked tirelessly to process what is the now over  
2 425,000 pages of material plus 2,000 Excel spreadsheets  
3 disclosed directly to the MAH Inquiry, together with  
4 more than 200,000 pages of material dealt with through  
5 Court approved disclosure directly to core participant 10:15  
6 families so they could have the notes and records of  
7 their patient loved ones in order to be in a position  
8 to make their witness statements to the MAH Inquiry in  
9 the way that they wished. There is, as you may be  
10 aware, a legal difficulty with providing records to 10:15  
11 family members via subject access requests where the  
12 patient to whom the records relate lack capacity.

13  
14 Further, providing material via subject access requests  
15 involves extensive redaction work that has to be 10:16  
16 undertaken to comply with the legal obligations that  
17 are imposed on the document holder. Further, the MAH  
18 Inquiry has concurrently received over 45,000 pages of  
19 witness statements and accompanying exhibited material  
20 from the Belfast Trust. In addition to the individual 10:16  
21 witness statements, a consideration of the many  
22 corporate witness statements also indicates a very  
23 significant number of staff and former staff of the  
24 Belfast Trust who contributed to the extensive work  
25 that was required for their provision. All of that 10:16  
26 work which involved many different strands occurring at  
27 the same time was undertaken at what was a relentless  
28 and gruelling pace.

1 The Belfast Trust from the outset and throughout the  
2 Inquiry process has acknowledged that it will be  
3 criticised for various failings connected to its  
4 operation of Muckamore Abbey Hospital. It does not shy  
5 away from that reality. At the same time it asks that 10:17  
6 any criticism be based on facts established by  
7 considering not just what individuals had to say but  
8 what the contemporaneous documents record, particularly  
9 if what individuals have had to say, whoever they be,  
10 is inconsistent with what is contemporaneously recorded 10:17  
11 as having occurred. If criticism is based on an  
12 inaccurate or incorrect factual basis, then it cannot  
13 be fair.

14  
15 I want to briefly address some of the evidential issues 10:17  
16 that effect your deliberations and I acknowledge you  
17 may already be alive to them. The first is about the  
18 importance of properly contextualising the evidence  
19 that you have heard. The Terms of Reference of the MAH  
20 Inquiry tasked the Inquiry with investigating a very 10:18  
21 broad range of matters relating to Muckamore Abbey  
22 Hospital and beyond, and spanning the period 2nd  
23 December 1999 to the 14th June 2021, just over 21 and a  
24 half years.

25  
26 As you're aware between December '99 and the 1st of  
27 April 2007, MAH was the responsibility of the North and  
28 West Belfast Health and Social Services Trust. From  
29 the 1st of April 2007 when the Belfast Trust, which was

1 originally the Belfast Health and Social Services Trust  
2 became operational, following the merger of various  
3 legacy Trusts, MAH became the responsibility of Belfast  
4 Trust, it remains Belfast Trust's responsibility today.

5  
6 Across 21 and a half years Muckamore Abbey Hospital,  
7 given its size and extent, and perhaps like any other  
8 large hospital over such an extensive time period, was  
9 itself constantly changing. In MAH's case that  
10 included over time, although not at the pace hoped for  
11 as you have seen in the evidence, an ongoing reduction  
12 in the number of wards, patients and staff as part of  
13 the longstanding government policy to have individuals  
14 with a learning disability living and cared for in  
15 their communities rather than in long-stay hospitals.

16  
17 When reaching any conclusions about practices and  
18 approaches in the hospital over an extended period,  
19 such as 21 and a half years, it's obviously very  
20 important that the proper context of any particular  
21 aspect of evidence is established and clear and that  
22 any findings are, where necessary, appropriately  
23 caveated to take into account the particular context of  
24 the evidence on which they are based.

25  
26 If that isn't done, then there's a significant risk of  
27 generalised criticism being seen to attach to times and  
28 locations within the hospital and consequently the  
29 staff who worked in those locations at those times that

1 the evidence does not itself merit: It is with  
2 respect, and this is not said as a criticism of anyone,  
3 one of the difficulties with the nature of the  
4 submissions that you heard on Monday where there was,  
5 in our respectful submission, perhaps explained by the 10:20  
6 time bound nature of the submissions, meaning  
7 generalised summaries were being provided, an absence  
8 of overall context with the result that someone  
9 listening may have considered there was nothing at all  
10 positive about the hospital and the many hundreds of 10:21  
11 people who worked there at any time during the 21 and a  
12 half years spanned by the Terms of Reference and that  
13 is just not the position.

14  
15 Further, the Inquiry is asked to consider on what basis 10:21  
16 the extent of any evidence as to the practices on one  
17 ward can then reliably be said to be reflective of  
18 practices on some or every other ward at the hospital  
19 and at any given point in time. The Inquiry will, no  
20 doubt, be cognisant that during the 21 and a half years 10:21  
21 of the Terms of Reference, more than 740 patients  
22 stayed at the hospital for varying lengths of time.

23  
24 The Inquiry has received evidence about the patient  
25 experience, as it has been described, of 78 people, 78 10:22  
26 patients that stayed in Muckamore at some point during  
27 the time period of the Terms of Reference. That is  
28 just over 10% of the patients who stayed at the  
29 hospital during the 21 and a half year time period.



1 The fact the percentage of patients is at that level,  
2 is not to diminish the individual experience of any of  
3 those patients who you did hear about, but it is a fact  
4 that it's nonetheless the case that the Inquiry has  
5 evidence in relation to a small percentage of patients 10:22  
6 who resided in the hospital during the period spanned  
7 by the Terms of Reference. That fact is obviously  
8 relevant to the drawing of any general conclusions  
9 about practices at the hospital and over what period.

10  
11 Further, it can reliably be said that for a large  
12 period of the time spanned by the Terms of Reference  
13 there were over 600 staff working in the hospital at  
14 any one time. As not everyone who worked in the  
15 hospital did so for the entire period of the Terms of 10:23  
16 Reference, it will be obvious that the overall total  
17 number of staff who worked in MAH through the Terms of  
18 Reference period, is considerably higher.

19  
20 The MAH Inquiry has received evidence from 53 10:23  
21 individuals who themselves worked in the hospital  
22 during the 21 and a half years. It has also received  
23 evidence from other staff of the Belfast Trust who were  
24 involved in wider Belfast Trust management but not  
25 necessarily working directly in the hospital. So the 10:23  
26 Inquiry has received evidence from what is less than  
27 10% of the staff who worked in the hospital over the 21  
28 and a half years. And the likelihood is that the  
29 actual percentage figure is in reality considerably

1 lower than that.

2

3 Again, this fact is not to diminish the experience of  
4 any of those individual members of staff that you did  
5 receive evidence from, but it is a fact that it's 10:24  
6 nonetheless the case that the Inquiry has received  
7 evidence from a small percentage of staff who worked in  
8 the hospital during the period spanned by the Terms of  
9 Reference. That fact is also obviously relevant to the  
10 drawing of any general conclusions about practices at 10:24  
11 the hospital and in respect of what period.

12

13 I want to say something about the evidence not heard.  
14 In addition to the limitations of the evidence that has  
15 been heard, it's important that the evidence not 10:24  
16 obtained and not heard is acknowledged because that  
17 absence of evidence is important in the context of some  
18 of the important matters that the Inquiry is  
19 endeavouring to investigate. The Inquiry does not  
20 itself appear to have received evidence from any staff 10:24  
21 member who actually committed abuse at Muckamore in  
22 order to seek an explanation from them as to why they  
23 acted as they did. While some witnesses, not involved  
24 in abuse, were asked to give their inevitably  
25 speculative view on the causes of abuse, it's an 10:25  
26 unfortunate fact that no account has been obtained from  
27 those who actually abused in order to understand from  
28 them if any would be prepared to give an answer, what  
29 the factors were that caused them to act and consider

1 themselves free to act in the inappropriate way that  
2 they did and, by that means, contribute based on actual  
3 evidence to the knowledge base as to primary causes of  
4 abuse by staff involved in health and social care  
5 settings and learning disability care in particular. 10:25

6  
7 It is a regrettable fact, as evidenced by a series of  
8 further abuse scandals of vulnerable patients that have  
9 come to light post-2017 in Muckamore such as, and the  
10 Inquiry Panel may be aware of these; Yew Trees in 10:26  
11 Essex, Cawston Park in Norfolk to Corston in Cardiff,  
12 Whitefield School in London, if I have time I may be  
13 able to mention some more, that there appears to be a  
14 much more widespread problem than anyone involved in  
15 health and social care would have liked to believe 10:26  
16 possible.

17  
18 It is obviously difficult to say whether the problem is  
19 greater than in times past or there's just a greater  
20 awareness and detection of it now, whatever the answer, 10:26  
21 understanding from the people who choose to behave in  
22 this way and those who turn a blind eye to it, must be  
23 an important element in trying to design the best  
24 systems to minimise the risk of it occurring.

25  
26 As well as accepting whatever criticism is due, the  
27 Belfast Trust is also keen to learn as much as it can  
28 about the causes and what can best assist with the  
29 detection of this problem for the future. That's

1 something I'll hopefully return to later.

2  
3 Given the breadth of the primary time period of the  
4 Terms of Reference, how learning disability care was  
5 provided and what was regarded as best practice 10:27  
6 inevitably changed over time. Further, the  
7 investigative or learning processes themselves that may  
8 have been activated in response to an incident changed  
9 over time. For instance, were initially regional  
10 vulnerable adult processes gave way to regional adult 10:28  
11 safeguarding processes, the definitions applicable to  
12 and operation of the Regional Serious Adverse Incident  
13 Policy changed, the Belfast Trust's own disciplinary  
14 processes and processes were themselves changed over  
15 time. 10:28

16  
17 Respectfully it's obviously very important that the  
18 adequacy of the response to any incident is judged  
19 against what was actually known at the point in time  
20 the incident occurred and was being responded to and by 10:28  
21 applying the standards that existed at the time the  
22 incident occurred.

23  
24 Any consideration of the adequacy of the processes that  
25 were utilised in response have to be judged by the 10:28  
26 standards that applied at the time of the response.  
27 They should not be judged through the lens of the type  
28 of processes understanding or expectations that might  
29 exist today and certainly not taking into account

1 something that subsequently occurred or became known  
2 and which could not have been known by the individuals  
3 dealing with a particular incident at the time they  
4 were dealing with it.

5  
6 This is particularly important when considering events  
7 or incidents at Muckamore prior to 2017 and what has,  
8 through CCTV, subsequently become known to have  
9 occurred in 2017. It's an obvious fact as set out by  
10 Anthony Hidden QC as he was then, in his 1989 Inquiry  
11 report into the Clapham Rail Disaster that:

12  
13 "There is almost no human action or decision that  
14 cannot be made to look more flawed and less sensible in  
15 the misleading light of hindsight. It is essential  
16 that the critic should keep himself constantly aware of  
17 that fact."

18  
19 That is, we respectfully say, particularly important to  
20 bear in mind when identifying what are said to be  
21 missed opportunities or previous events that can be  
22 identified genuinely missed opportunities based on what  
23 was known at the time those events were being dealt  
24 with, or are they only a missed opportunity when viewed  
25 through the prism of subsequent events, the nature of  
26 which will always cause you to look for something  
27 previous that might have alerted you to or been seen to  
28 be a sign of things to come.

1 Further, in identifying missed opportunities there is  
2 the need, we respectfully say, to step on through and  
3 to ask, well if that opportunity had been taken, what  
4 can it realistically be said would have been the  
5 outcome of taking the opportunity that was said to have 10:31  
6 been missed? It is one thing to suggest there is a  
7 missed opportunity, it's something entirely different  
8 to be realistically able to say that had the  
9 opportunity not been missed then the position would  
10 have been or is likely to have been X or Y. It's 10:31  
11 respectfully very easy to say of something that more  
12 should have been done and not to do it was therefore a  
13 missed opportunity, but the appropriate question is:  
14 if more had been done, can it genuinely and  
15 realistically be said it would have changed the 10:32  
16 position in some way as opposed to a generalised  
17 speculative suggestion?

18  
19 In the Clapham Rail Disaster Report, Sir Anthony Hidden  
20 made what we respectfully submit was another very 10:32  
21 important observation of particular relevance to a  
22 public Inquiry with Terms of Reference that span a  
23 lengthy period of time. He said:

24  
25 "In my review I have attempted at all times to remind 10:32  
26 myself of the dangers of using the powerful beam of  
27 hindsight to illuminate the situation revealed in the  
28 evidence. The power of that beam has its  
29 disadvantages. Hindsight also possesses a lens which

1 can distort and can therefore present a misleading  
2 picture. It has to be avoided if fairness and accuracy  
3 of judgment is to be sought."

4  
5 Another evidential issue that we ask you to take into 10:33  
6 account is the differences in perception and emphasis  
7 that can occur between people dealing with the same  
8 event. Different people can and do perceive the same  
9 event or circumstances in entirely different ways. The  
10 Inquiry ought, we respectfully submit, to exercise 10:33  
11 caution in relation to making findings on any event  
12 where it has only heard one person's version of events  
13 as to what occurred. This caution should be heightened  
14 where the single version of events is provided entirely  
15 from memory and the longer in time it is since the 10:33  
16 event or incident that's being remembered occurred that  
17 raises the greater need for caution.

18  
19 I am going to illustrate the submission that I'm making  
20 about the differences in perception and emphasis by 10:34  
21 looking at one document that was included in the Ennis  
22 Bundle. I'm grateful to your electrical operators. I  
23 should say for the benefit of the stenographer, I am  
24 going to have to travel at quite some pace, I will be  
25 able to provide the speaking note in cleaned-up form to 10:34  
26 make life hopefully a little easier.

27  
28 If we can, please, begin at page 3 of the bundle and  
29 what I'm showing you, and if we can maximise that, and

1 I know you will work with me to scroll as we go, this  
2 document is the minute of the second vulnerable adult  
3 strategy meeting of the 15th November 2012, so about a  
4 week after the allegations were first made by a member  
5 of Bohill staff in respect of Ennis Ward. The minutes, 10:35  
6 as you will know or the evidence indicates, were  
7 prepared by Ms Morrison and they refer, in this  
8 particular minute to a visit to the Ennis Ward that she  
9 conducted along with H92 two days before.

10  
11 If we just can scroll down please. So this is -- if  
12 move down please to the next. If you can scroll down a  
13 little further until we find H92 marked on the page,  
14 just there, thank you.

15 10:35  
16 So, there are two versions of this minute that are in  
17 your Ennis Bundle. There is a shorter version of the  
18 minute and then this longer version, the longer version  
19 wasn't opened during the hearings. And what I'm  
20 drawing your attention to, H92 was a social worker at 10:36  
21 Muckamore Abbey between January 1989 and November 2016,  
22 you'll find information in statement 222, so some 27  
23 years. He was the senior social worker between August  
24 2009 and November 2016 at Muckamore, so for seven  
25 years. 10:36

26  
27 So by 2012 when these events are being dealt with, he  
28 had over 20 years experience working at Muckamore in  
29 his role and so, the earlier version, just for your



1 record, is in the Ennis Bundle at pages 27, 28, but  
2 this version provides much more detail about the visit  
3 that Ms Morrison and H92 had engaged in on the 13th of  
4 November 2012. You can see from the detail that Ms  
5 Morrison, while acknowledging that she was (a); there 10:37  
6 on a brief visit and (b); didn't have herself knowledge  
7 of the patient's needs and; (c) recognised that the  
8 Ward Manager may have been nervous about her presence,  
9 nonetheless listed three matters that she was concerned  
10 about during the visit. The paragraph however, and 10:37  
11 it's authored by Ms Morrison herself, finished with the  
12 statement that Ms Morrison:

13  
14 "Also noted that H92 had not noticed anything of  
15 concern from the same visit." 10:37

16  
17 I'm not drawing this example to your attention for the  
18 purposes of asking you to determine who was right in  
19 their assessment on the ward visit in November 2012,  
20 but to draw to your attention that two experienced 10:38  
21 social workers, experiencing the exact same events,  
22 both there in response to allegations of abuse of  
23 patients, had entirely different perceptions or views  
24 arising out of the same visit.

25  
26 It reinforces the submission that I'm making to you on  
27 behalf of the Belfast Trust which is, where you've only  
28 received one person's version of what is said to have  
29 occurred and when there are others who have an equally

1 valid perspective, and in some cases, perhaps a right  
2 to be heard in their own defence where they have been  
3 criticised by a colleague in respect of the same event,  
4 then you should exercise caution in relation to making  
5 any findings in relation to that event.

10:39

6  
7 I want to address the topic of the awareness of abuse  
8 generally and then in particular relating to the abuse  
9 that was subsequently found on CCTV from 2017. I want  
10 to be clear on behalf of the Belfast Trust, that in  
11 considering this topic, which is a difficult topic, the  
12 Belfast Trust is not seeking to minimise or excuse the  
13 abuse suffered by patients, nor any systems failures  
14 for which the Belfast Trust can be reasonably and  
15 legitimately criticised. The fact vulnerable patients  
16 could be abused by health and social care staff is a  
17 known longstanding problem, that it could occur  
18 notwithstanding the vocation and professional  
19 responsibilities of staff, was known to the North and  
20 West Belfast Health and Social Services Trust and later  
21 the Belfast Trust, it was known to the Mental Health  
22 Commission and later the Regulation and Quality  
23 Improvement Authority. It was known to the then Health  
24 and Social Care Board, the Public Health Agency and the  
25 Department of Health, Social Services and Public  
26 Safety, later the Department of Health.

10:39

10:39

10:40

10:40

27  
28 The fact it is a known potential problem is relevant to  
29 considering the events about which you are

1 investigating. The fact that it has been in the public  
2 consciousness in the United Kingdom since at least the  
3 late 1960s, if not before, following 1967 newspaper  
4 allegations about the abuse at Ely Hospital in Cardiff,  
5 those newspaper allegations led to the establishment of 10:41  
6 an Inquiry known as the "Committee of Inquiry and  
7 allegations of ill-treatment of patients and other  
8 irregularities at the Ely Hospital, Cardiff". It was  
9 chaired by Sir Geoffrey Howe QC as he was then. It  
10 reported in March 1969, and the report was debated in 10:41  
11 Parliament on the 27th March 1969, a known problem.  
12

13 That is also reflected in the fact that in addition to  
14 general criminal offences that may apply to abuse, the  
15 Mental Health Act 1983 in England and Wales and then 10:41  
16 The Mental Health Northern Ireland Order 1986 in  
17 Northern Ireland, provided a specific criminal offence  
18 in respect of the ill-treatment or willful neglect by  
19 hospital staff of those receiving treatment for mental  
20 disorder as it was framed in the legislation at the 10:42  
21 hospital.  
22

23 You have evidence that the abuse that came to light  
24 through a Panorama programme in May 2011 at  
25 Winterbourne View, a 24 bed two-ward hospital in South 10:42  
26 Gloucester and which led to 11 members of staff facing  
27 criminal charges, was a subject considered within  
28 learning disability within the Belfast Trust. You  
29 heard from counsel for the Department yesterday that it

1 was also a matter considered in the Department and  
2 various steps were taken in respect of it, a known  
3 problem.

4  
5 The Belfast Trust has disclosed material to the Inquiry 10:42  
6 demonstrating that on occasions prior to the abuse  
7 captured on CCTV from March to November 2017 some MAH  
8 staff did abuse vulnerable patients in their care at  
9 the hospital during the period covered by the Terms of  
10 Reference. I'm not going to through the written 10:43  
11 submissions as you know, but I will refer you to  
12 paragraph 8(a) of the written submission which is on  
13 page three. That is why the apology made by the  
14 Belfast Trust is not confined to the events in 2017.

15  
16 However, we respectfully say that the material also  
17 demonstrates that the principal system that did exist  
18 for identifying and reporting abuse when it occurred,  
19 did operate effectively in respect of known incidents,  
20 in that primarily a colleague or colleagues of a member 10:43  
21 of staff who mistreated a patient reported that fact to  
22 a more senior colleague who then initiated action.

23  
24 what it also means is that more senior staff at MAH to  
25 whom incidents were reported, and there is material 10:44  
26 evidencing many such incidents, and who were then  
27 required to conduct investigations, initiate  
28 disciplinary action and on occasions dismiss staff,  
29 were clearly aware of the potential for abuse by staff

1 to occur at Muckamore Abbey Hospital, i.e., they were  
2 on notice of it, as they were from time to time, having  
3 to deal with the reality of it. I'll come back to  
4 that.

5  
6 The material demonstrates that the nature and extent of  
7 how matters were investigated changed over time. The  
8 available investigative mechanisms and disciplinary  
9 processes and learning mechanisms also changed over  
10 time. They were generally regionally designed  
11 processes that had to be followed across the health and  
12 social care system. The processes can be said,  
13 generally speaking, to have over time become more  
14 detailed and generated more and more paperwork, whether  
15 ultimately on reflection that also means they improved  
16 or were more effective may be a matter of debate.

17  
18 That may speak to why, as you will probably be now  
19 aware, there are major changes to come in adult  
20 safeguarding, I'll hopefully say a little more about  
21 that later, that an overhaul of the SAI process is now  
22 well advanced. You heard counsel from the Department  
23 yesterday that the intention is to simplify that system  
24 which is supposed to be a learning tool. The Minister  
25 for Health has now indicated, which you also heard  
26 about yesterday, that there will be legislation brought  
27 forward, if time permits, in the mandate in respect of  
28 an organisational duty of candour within health and  
29 social care. So there will be much forthcoming change

1 in the health and social care system. It may be  
2 recommendations that the Panel have in mind can  
3 contribute to the shaping of those developments.  
4

5 As with the consideration of almost any series of 10:46  
6 investigations conducted by a large organisation over a  
7 wide expanse of time, in this case up to 2017, I'm  
8 talking about almost 20 years, and in the context of an  
9 organisation whose primary function or expertise was  
10 not abuse investigations, it's likely to be possible to 10:46  
11 identify instances where investigations of incidents  
12 have fallen short.

13  
14 However, the material also indicates that the various  
15 investigations of incidents appear to have been 10:46  
16 conducted in good faith, with a genuine effort to try  
17 to establish what occurred against the appropriate  
18 standard required of such investigations, and to  
19 thereafter respond appropriately.

20 10:47  
21 The Belfast Trust has not itself found any evidence of  
22 and the MAH Inquiry has not suggested to any witness or  
23 any member of staff that staff to whom allegations were  
24 reported by colleagues were somehow involved in efforts  
25 to minimise or play down or not deal appropriately with 10:47  
26 what was being reported. If anything, the material  
27 demonstrates that where more senior MAH staff could be  
28 satisfied that a member of staff had engaged in the  
29 abuse of a patient in their care, then the relevant

1 staff member was dealt with robustly. Two of the  
2 illustrative examples in the written submission  
3 evidence that occurring. There are many more in the  
4 available material.

5  
6 There is considerable evidence available through the  
7 investigative material to indicate that those who ran  
8 MAH took extremely seriously any allegations that came  
9 to their attention that staff members had abused the  
10 patients in their care and that it was not something  
11 that was either tolerated or acquiesced in.

12  
13 The material evidences, on any fair analysis, that  
14 those responsible for the operation of MAH,  
15 notwithstanding the toxicity surrounding events at the  
16 hospital in 2017 and thereafter, did not have a  
17 culture, however one defines it, of tolerating MAH  
18 staff abusing their patients.

19  
20 The material indicates when matters are considered in  
21 their proper context taking into account the number of  
22 patients being cared for at the hospital and the number  
23 of staff working there, that prior to 2017 known  
24 incidents of MAH staff of abusing care in their care  
25 were thankfully rare. That is not to say that because  
26 the incidents were rare it somehow makes the incidents  
27 acceptable, they were not, but it's important to  
28 acknowledge that these incidents do not appear to have  
29 been, prior to 2017, widespread in the context of the

1 hospital as a whole at any point in time.

2  
3 In its written submission, the Belfast Trust provided  
4 three illustrative examples of different types of  
5 incidents that had occurred at MAH, and they are only 10:49  
6 illustrative examples, and set out how they were each  
7 dealt with. But, as I've indicated, there were many  
8 more such incidents. By necessity, very few of them  
9 have been touched on to any extent in the evidence  
10 hearings. 10:50

11  
12 However, I wish to further draw on those illustrative  
13 examples and some others for the submission that I do  
14 wish to develop on behalf of the Belfast Trust. Again,  
15 I wish to make clear that what I am about to say is not 10:50  
16 seeking to minimise any abuse that was suffered by any  
17 patient. The submission is about the awareness of  
18 abuse occurring on some wards in 2017 which was  
19 captured on CCTV. It's a very important issue given  
20 that the health and social care system was filled with 10:50  
21 people, both employed by the Belfast Trust and external  
22 to it, who were on the relevant wards in MAH during the  
23 period when abuse has been subsequently seen to be  
24 occurring, who knew that a staff member abusing a  
25 patient was possible and nonetheless did not detect 10:50  
26 anything untoward was occurring which would be later  
27 revealed on CCTV review, that this juxtaposition can  
28 occur is something, in our respectful submission, from  
29 which there can be much learning.



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I make the submission recognising that, in fairness to the staff I mention shortly for illustrative purposes, there has been no evidence adduced nor suggestion put to any member of staff who gave evidence to the MAH Inquiry that they were actually aware that patients onwards at MAH were being abused in 2017 by the staff who were supposed to be caring for them.

10:51

It has been said that:

10:51

"Where there is a small group of devious staff who deliberately mislead both those engaged in inspection and regulation processes, as well as MDT members, advocates and carers, it is very difficult to detect their actions, especially when service users are very vulnerable and have limited communication skills."

10:52

If we can bring up page 67 of the bundle, that is a quote to be found on page 56 of Professor Murphy's 67-page, 18th of March '2020 initial report on the adequacy of the CQC inspections at Whorlton Hall in County Durham following a Panorama programme that reported on 38 days of undercover filming on a 17 bed unit. The undercover filming recorded abuse by staff at the facility. The independent review was asked to:

10:52

10:52

"Consider and report to the Board of the CQC on the regulation of Whorlton Hall between 2015 and May 2019

1 and form a view as to whether the abuse of patients  
2 that has been identified could have been recognised  
3 earlier by the regulatory or inspection process."  
4

5 The report bears careful reading in full in order to be 10:53  
6 able to understand what is said in the concluding  
7 section 10. If we can just scroll up so we get the  
8 start of section 10, please. That contains the  
9 quotation I have already referred to.

10  
11 while the question being asked and answered,  
12 specifically related to the regulatory or inspection  
13 process, the conclusion reached has, respectfully,  
14 arguably much wider import. The question is posed and  
15 the report says: 10:54

16  
17 "This question was central to the regulatory review  
18 conducted. It is clear from..."  
19

20 And it refers back to Section 9: 10:54

21  
22 "...that there are a number of improvements that are  
23 needed to the CQC process. However, given the  
24 inspection and regulatory process in place at the time,  
25 it may be that abuse could not have been recognised. 10:54  
26 None of the CQC Inspectors saw punitive or abusive  
27 behaviour by staff, though three did say they felt  
28 uncomfortable and uneasy in the service."  
29

1 I am going to ask you to bear that in mind when we come  
2 to look at some of the RQIA reports from 2017:

3  
4 "The MHA reviewer from CQC, whose job it was to liaise  
5 with service users also said she didn't have concerns 10:55  
6 about the service, moreover, a large number of  
7 professionals went to Whorlton Hall who were not  
8 employed by CQC, including the local GP,  
9 representatives of the local authority, the CCGs who  
10 were placing residents there. In all, the local CCG 10:55  
11 who had counted the visits over the previous nine  
12 months, found 37 visits had taken place, excluding GP  
13 visits and none of those professionals recognised that  
14 abusive behaviour was going on which resulted in many  
15 members of staff being charged with criminal offences, 10:55  
16 even though they spoke to staff and service users.

17  
18 In addition, there were two advocates who were  
19 regularly in Whorlton Hall one day per week over a  
20 period of years who had close contact with service 10:55  
21 users and yet did not see abusive and punitive  
22 practices in place.

23  
24 During inspections, service users generally said that  
25 they felt safe and they liked staff and it appeared 10:56  
26 that they were not able to describe the cruel behaviour  
27 of some staff.

28  
29 In hindsight, after the Panorama programme..."

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And it is important that we remember this is 2019:

"CQC began to consider the issue of a toxic culture and how to detect it, the then head of the CQC Mental Health at the time drew up a paper alerting inspectors to the characteristics of a toxic culture..." 10:56

That is exhibited at Appendix 3 of the report:

"He listed a series of aspects of services that could be considered red flags, including many of the characteristics of Whorlton Hall. Nevertheless, were inspectors aware of such red flags of a toxic culture, the question remains could they have detected abusive practices?" 10:57

Then there is the quotation that I have already given about the nature of the perpetrators of abuse. And the report goes on to say: 10:57

"In hindsight, unannounced visits, especially at evenings and weekends may have helped to detect failings in the service. More helpful still would be the use of CCTV or other covert surveillance method. Even then, abusive and punitive staff may work out ways to avoid being seen, as one staff member described on the Panorama programme. The interview of staff who left after short periods of working at..." 10:57

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In this case whorlton hall:

"...once they were no longer employed by the provider. Much more careful interviews with service users in conditions of privacy where they felt safe, preferably with the use of alternatives and augmentative communication tools, such as talking mats, more thorough interviews with all family carers; frequently inspectors were simply given the contact details for a small sample of chosen carers."

10:57

10:58

Interestingly, you may consider, as the section of the report that I've read from says, it was not until after May 2019 that the Regulator in England and Wales, through its Head of Mental Health, developed some specific guidance for inspectors to try to identify closed cultures which it was considered would have a greater risk of abuse occurring and going undetected.

10:58

Albeit the guidance indicated that the presence of one or more inherent risk factor is not proof that there is an abusive or punitive culture, but could be a sign that there is an increased chance of one developing.

10:58

10:59

Muckamore Abbey Hospital had many different professional people, some who were directly based at Muckamore or worked for the Belfast Trust, but others who were not employed by the Belfast Trust but who were

1 on the very same wards interacting with patients and  
2 staff, where CCTV would subsequently show patients  
3 being abused by some staff.  
4

5 The first group I want to deal with is patient 10:59  
6 advocates. From as early as 2005 Bryson House, an  
7 independent provider, was providing patient advocacy  
8 services at Muckamore. The advocacy service in 2017  
9 appears, and the evidence isn't entirely clear, but it  
10 appeared to be that the witness was explaining to have 11:00  
11 involved two advocates working at Muckamore on an  
12 almost full-time basis "in and around April 2016". So  
13 the year prior to the CCTV footage:

14  
15 "Bryson House's service provision had been extended and 11:00  
16 it began providing advocacy and representations  
17 services to a broader cohort of relatives and patients  
18 of NHS patients than it had done before. It was not  
19 any longer confined to patients who had been identified  
20 for resettlement. Thereafter, Bryson House advocates 11:00  
21 appeared to have provided 25 hours of advocacy services  
22 within Muckamore each week based on a 38 week year. "  
23

24 That equates to some 950 hours per year of patient  
25 advocates actually on the Muckamore premises. Bryson 11:00  
26 House has provided data as to the extensive attendance  
27 of staff on the site, for example, in the period from  
28 April '17 to March 2018 there were 222 sessions, 314  
29 hours of direct contact between patients and relatives

1 who engaged with Bryson House's advocacy and  
2 representative services. These were 222 separate  
3 appointments over the course of the year, all were face  
4 to face.

5  
6 Further, prior to the Covid-19 Pandemic, as I said, Ms  
7 Marley appeared to be explaining there were two  
8 advocates based almost exclusively at Muckamore.  
9 Obviously the evidence of those individuals was  
10 potentially very important because those are 11:01  
11 individuals who are not employees of the Belfast Trust  
12 and whose only role was to act in the best interests of  
13 the patients they were involved with at the hospital.

14  
15 The Inquiry heard from Ms Marley, who was the Director 11:02  
16 of Bryson House from 2003, but who was not herself  
17 regularly on-site at Muckamore, however, Ms Marley was  
18 asked in her oral evidence, and if we can look at page  
19 79 and 80 in the bundle, please. She was asked about  
20 awareness of Bryson House patient and family advocates 11:02  
21 who were in and out of Muckamore. If we just scroll  
22 down please to the part that begins "but in terms then  
23 specifically". Just at the bottom of the page, line  
24 75:

25  
26 "But in terms then specifically of the work that Bryson  
27 advocates were doing, engaging face to face with  
28 patients and potentially with relatives throughout the  
29 time of its service provision, I just want to be very

1 clear, are you saying that advocates, to the best of  
2 your knowledge, weren't made aware of any allegations  
3 of abuse?". "

4  
5 And the answer from Ms Marley, was "yes". And then 11:03  
6 there is a slight interruption over her but "genuinely,  
7 genuinely". Then the question:

8  
9 "Q: By those service users?

10 A: No, genuinely not and had there even been a whisper 11:03  
11 of it, a sense of it, then, you know, we would have  
12 escalated that immediately. So I'm content that staff,  
13 advocates that we would have had in Muckamore were  
14 totally unaware of anything that serious. "

15 11:03  
16 Now, the Belfast Trust asked the Inquiry to obtain  
17 evidence directly from the advocates who were regularly  
18 present at Muckamore. They could have been asked to  
19 explain how they interacted with patients, how they  
20 found being present on the wards, how they found the 11:03  
21 staff. They could have confirmed the evidence given on  
22 their behalf by Ms Marley which would have, in our  
23 submission, affirmed the analysis of Professor Murphy  
24 from her investigations into what occurred at Whorlton  
25 Hall. Professor Murphy had, as the Whorlton Hall 11:04  
26 report indicates, spoken to the advocates who worked  
27 there, you will find that on pages 12, 41 to 43 of the  
28 report.  
29



1 The MAH Inquiry didn't do that and the Belfast Trust  
2 must therefore rely on what Ms Marley had to say was  
3 the position of those patient and family advocates who  
4 were regularly in and out of the wards at Muckamore.  
5

6 The Belfast Trust asked the Inquiry also to obtain the  
7 patient files maintained by the Bryson House advocates  
8 for those patients whose time in MAH was being  
9 considered in evidence. Ms Marley acknowledged the  
10 existence of those files. The basis for that was 11:04  
11 because the relevant files would provide for the  
12 Inquiry contemporaneous evidence with some objectivity  
13 about the experience of those patients whose time in  
14 MAH was being considered in evidence and which could be  
15 set alongside the evidence given by family members and 11:05  
16 the notes and records maintained at the hospital on  
17 behalf of the patients. As far as the Belfast Trust is  
18 aware the Inquiry didn't obtain that material.  
19

20 The second group that I want to draw attention to, who 11:05  
21 are external to the Belfast Trust, is nursing students  
22 who worked at Muckamore. On Day 84, that was the 28th  
23 of May 2024, the MAH Inquiry also heard from Professor  
24 Donna Fitzsimmons, the present Head of the School of  
25 Nursing and Midwifery at the Queen's University 11:05  
26 Belfast. Professor Fitzsimmons explained the close  
27 monitoring of placement students undertaken by the  
28 university. The Professor confirmed that the  
29 university had not received any concerns from students

1 about the care being provided at Muckamore or any  
2 suggestion that any of the patients may be being  
3 abused.

4  
5 If we can look please at page 81 in the bundle and just 11:06  
6 from the very top of the page. I am going to look at a  
7 number of pages that arise as this exchange takes  
8 place:

9  
10 "Can I move on to paragraph 31 and focus in on some of 11:06  
11 the allegations of abuse and how they came to light,  
12 more so particularly with the university. What, if  
13 any, change has happened as a result of those? You  
14 tell us at paragraph 31 that the abuse allegations came  
15 to light in November 2021." 11:06

16  
17 I think that should read 2017 when you read the rest of  
18 the transcript:

19  
20 "... that you were made aware of and you refer to audits 11:07  
21 undertaken of each placement following that. Are those  
22 the same audits that you have just spoken about a short  
23 time ago or is that a different style of audit?

24 A: It's the same process but we updated those audits.  
25 Doctor Marsh was on-site within 24 hours of us being 11:07  
26 made aware of the allegations and each of the  
27 facilities was audited within five working days of  
28 that. So we also debriefed the students who had  
29 recently been in practice in the area. We met with

1 them in a very supportive environment. I met them  
2 myself.

3  
4 Q: You, sir, then asked, sorry when you say in the  
5 area do you mean in Muckamore? 11:07

6  
7 Q: In Muckamore yes.

8 A: And I met with them myself and members of the  
9 learning disability team met with them and had  
10 supportive conversations around that reflection on 11:07  
11 practice and their evaluation around how they could  
12 draw to our attention any concerns that they had."

13  
14 Dr Maxwell then asked:

15  
16 "Q: This was November 2017?

17 A: Yes, as soon as we came became aware of the  
18 situation. Prior to that we had no knowledge that  
19 there was any concerns.

20  
21 Q: And so, the students that you spoke to, debriefed,  
22 had been in placement in Muckamore in the second half  
23 of 2017?

24  
25 Professor Fitzsimons answered, "that's true". Dr 11:08  
26 Maxwell then asked:

27  
28 "Q: When you debriefed them, had they any concerns  
29 then?

1 A: There was not one single student and they had the  
2 opportunity to come to us in the group situation or  
3 independently and privately to raise concerns by  
4 whatever medium they chose do it, even anonymously, and  
5 we had nothing that indicated a problem and we took 11:08  
6 steps to review the practice assessment documentation  
7 on the portfolios that we had at the time to reassure  
8 ourselves and myself as a professional. I reviewed  
9 some of those documents and could find no evidence of  
10 any concern, either subtle or explicit." 11:09

11

12 Professor Fitzsimmons is then asked:

13

14 "Q: When you reviewed the documentation, when you  
15 spoke to the students, did you get any sense that the 11:09  
16 students themselves were somewhat surprised by the  
17 allegations or how did they..."

18

19 The answer cuts across:

20

21 "A: They had no knowledge that anything untoward was  
22 happening in practice and, you know, this wasn't a one  
23 off event."

24

25 That is the review, the engagement: 11:09

26

27 "...this was a process by which we built up, you know,  
28 obviously the teaching staff within the school and the  
29 academic staff have a trusting relationship with them,

1 but we all gave them plenty of time, including, I mean  
2 the Deputy Director of Nursing in the Belfast Trust at  
3 that time who is a colleague of mine, I know that she  
4 met with the students quite regularly and her door was  
5 always open should they have wished to raise any 11:09  
6 concerns with her. She has a background in counselling  
7 and, you know, we were very comfortable with the  
8 situation and the opportunities to raise concerns that  
9 the students were given at that point in time. And for  
10 that reason and under continuous evaluation, at that 11:10  
11 point we did not withdraw any students from the setting  
12 because we had no evidence to suggest from our students  
13 that there was any wrongdoing. "

14  
15 Professor Murphy then asked: 11:10

16  
17 "Q: Can I ask you to explain that discrepancy?  
18

19 And the answer that the Professor gave:  
20

21 "So I have reflected on that and I have asked myself  
22 that question as a Registrant on the NMC register. I  
23 think the only plausible explanation that I can come to  
24 is, like any other form of criminal activity, it is not  
25 something you do in sight of people who are not 11:10  
26 embedded in the environment. The students probably  
27 would have been regarded somewhat as outsiders, they  
28 would have been seen as people who may not have been  
29 indoctrinated into a system where this was normalised

1 and therefore, just with any other type of criminal  
2 behaviour this may not have been something that  
3 happened under the plain sight of our students."  
4

5 **Dr Maxwell the is recorded as saying:**

11:11

6  
7 "Q: I was just going say, were any of those students  
8 working as healthcare assistants on the bank, so were  
9 they in Muckamore on two roles?

10 A: I do not know that to be a fact, but it may well be 11:11  
11 the case. "

12  
13 **Professor Murphy asked:**

14  
15 "Sorry, I was just wondering, the students would work 11:11  
16 in all sorts of wards, so they weren't prevented  
17 because they were still in training from working on  
18 what we now know where the more difficult words. "

19  
20 **The answer from Professor Fitzsimons:**

11:11

21  
22 "A: No, they would have been supported in all of those  
23 environments. So if you think about it, this is an  
24 incremental journey through their clinical settings.  
25 It is the same for mental health facilities. So, by 11:11  
26 nature, the way placements are organised and structured  
27 they will have a practice supervisor, a link lecturer,  
28 they will have a professional lead for the area of  
29 nursing, as well as their own personal tutor, it goes

1 through the entire programme with them. So there is a  
2 range of different professional support systems that  
3 are in place."

4  
5 The Professor asks again:

11:12

6  
7 "they could have been on any wards. Could they have  
8 been there at any time of the week, so you know,  
9 possibly weekends would have been more difficult times  
10 but might they be there over weekends as well?."

11:12

11  
12 The answer:

13  
14 "So I genuinely wouldn't, there were small numbers of  
15 our students in Muckamore at any given time. You then  
16 sir, asked, that's what I wanted to ask how many  
17 students, you may have given the information somewhere.  
18 single figures at anyone placement."

11:12

19  
20 She describes five or six students possibly at a time  
21 but using a range of different facilities and over what  
22 sort of period? They were placements that were six or  
23 12 weeks. Dr Maxwell asked about whether they working  
24 shifts and the answer was:

11:12

25  
26 "They worked shifts right across the entire roster."

27  
28 scroll on further down, please. There is a discussion  
29 then about the extent of the duties, does it cover

1 night duty and the answer was yes:

2

3 "There is an opportunity to do night duty in the  
4 programme."

5

6 And then further down there is a question asked about:

7

8 "And as far as you recall none of the wards were  
9 excluded by the placement audit?"

10 A: No, none were deemed unsuitable."

11:13

11

12 And then Dr Maxwell asked a question:

13

14 "So they could have been on the Intensive Care PICU  
15 Ward?"

11:13

16

17 And the answer from Professor Fitzsimons was:

18

19 "So the audits that were conducted after the 1st  
20 November 2017 didn't indicate concerns in any of the  
21 placement areas, so that would have included the more  
22 acute facilities as well."

11:13

23

24 And then she refers to it being a conundrum that she  
25 does not perfectly understand herself. Then it goes on  
26 to explain, slightly further down, the discussions that  
27 were engaged in thereafter.

11:14

28

29 As far as we can tell, the Inquiry itself didn't



1 specifically identify and hear from any of the student  
2 nurses that were on the wards in Muckamore in 2017 on  
3 which, from CCTV review, has subsequently patients were  
4 being abused and who were, the students that were  
5 debriefed by Professor Fitzsimons and her colleagues. 11:14  
6 They obviously could have been asked to explain how  
7 they interacted with patients and how they found being  
8 present on the wards and how they found the staff  
9

10 The Belfast Trust therefore has to rely on what 11:14  
11 Professor Fitzsimons had to say and the evidence she  
12 gave about the rigour of the review process that she  
13 explained to you she undertook with the relevant  
14 students in and around November 2017.

15 11:15  
16 I mentioned previously in the context of looking at  
17 section 10 of the whorlton Hall report that I wanted  
18 you to keep that in mind when I was going to look then  
19 at the RQIA. There were other external groups visiting  
20 MAH wards in 2017, various different inspectors from 11:15  
21 the RQIA were on various different wards. I want to  
22 look briefly at some of those reports from the RQIA  
23 from 2017. You did hear from a couple of the  
24 inspectors who were involved in inspections in 2017.  
25 what they actually found and what they recorded in 11:15  
26 their reports wasn't open to you during the evidence.  
27 If we can go please to page 172.

28 CHAIRPERSON: I was just thinking about timing, sorry  
29 to interrupt you, I'm happy, only you know how long the

1 next section is going to take, but it is now a quarter  
2 past, you have been going an hour and a quarter as has  
3 the stenographer.

4 MR. AIKEN: I am totally focused on the stenographer.  
5 I am perfectly fine. I am going to have difficulty 11:16  
6 getting through in the time that's available, so be it.  
7 It's perfectly necessary for the stenographer to have a  
8 break.

9 CHAIRPERSON: I think it would be sensible to take our  
10 usual morning break now and then we'll see how we go. 11:16  
11 All right, thank you very much. Okay, so we'll take  
12 our 15 minute break now, we'll try and come back at  
13 11.30. Thank you very much.

14  
15 AFTER A SHORT BREAK THE INQUIRY RESUMED, AS FOLLOWS: 11:21

16  
17 CHAIRPERSON: Thank you. Yes.

18 MR. AIKEN: Thank you sir. Page 172 in the bundle. I  
19 had indicated I wanted to look at some of the RQIA  
20 reports from 2017. 11:34

21  
22 This first report, if we just scroll down a little  
23 please, you'll see is from an inspection of Six Mile  
24 ward which took place between the 31st of January and  
25 the 2nd February 2017, so before there's available CCTV 11:34  
26 footage that was reviewed. And if we scroll down to  
27 page 173, you'll see one of the inspectors you heard  
28 from. If we scroll up a little bit again please, thank  
29 you, you'll see the name of one of the inspectors that

1 you did hear from, although this report wasn't opened  
2 with him and if we just scroll down then please to page  
3 173, which is page two of the report. If we move down  
4 a little further so we can see the text. Thank you.  
5 Just a little further down, just there. You'll see the 11:35  
6 ward itself is separated into two units, it's a 15  
7 patient ward, five patients are receiving treatment and  
8 care in the assessment unit and 10 patients are being  
9 cared for in the treatment unit.

10  
11 You can see reference to patients on the ward being  
12 supported by, I'm just losing my screen, but maybe  
13 everybody else is okay.

14 CHAIRPERSON: Mine is all right, but you need yours.

15 MR. AIKEN: we'll keep going. Thank you, I'm sorry. 11:36

16 So there's reference to patients involved with the  
17 multidisciplinary team, including nursing staff and the  
18 consultant psychiatrist, the forensic psychologist,  
19 social worker, day services staff, the occupational  
20 therapist and the behavioural therapist. 11:36

21  
22 I had referenced back to the passage that we looked at  
23 from the whorlton Hall report and I want to look please  
24 at page 175 in the bundle where you will see the  
25 inspectors, if we just scroll down hopefully to the 11:36  
26 passage that we begins "patients views". If I can just  
27 ask you to scroll with me as we go through this  
28 passage. You can see that during the inspection  
29 inspectors met with 10 patients, so that's, it's a 15

1 bed unit, 10 patients, six patients completed a  
2 questionnaire. They were complimentary regarding the  
3 ward staff and the relationships with the MDT were  
4 described as informal, helpful and patient focused.  
5 The staff interactions observed by the inspectors 11:37  
6 evidenced staff being supportive, friendly and caring.  
7 Patients presented as relaxed and at ease in their  
8 surroundings. It was positive to note that each  
9 patient stated that they had felt better since being  
10 admitted to the ward. There were no concerns expressed 11:37  
11 by patients regarding their ability to meet with any  
12 member of the MDT.

13  
14 Two patients, and they discuss their particular  
15 concerns about change and their understanding of the 11:37  
16 ward and how the ward no longer facilitated continuous  
17 bus runs or an annual holiday, and that that had been  
18 their previous experience. The inspectors noted that  
19 both patients had been in the hospital for more than 20  
20 years and their admission pre-dated the commissioning 11:38  
21 and opening of Six Mile ward itself which was in, I  
22 think, 2006:

23  
24 "It is important to note that the discharge of both  
25 patients have been delayed. Inspectors had no concerns 11:38  
26 regarding the ward's activity schedule or the use of  
27 hospital transport to support patients. Patients  
28 reflected on changes within the ward staff team,  
29 including the appointment of a number of new nursing

1 staff and new Ward Manager. These changes were seen as  
2 positive and it was good to note that patients who met  
3 with the inspectors felt the changes had been well  
4 managed and the high quality of care provided in the  
5 ward had been maintained. Patients reported no  
6 concerns regarding the care and treatment they received  
7 in the ward. Patients also stated that when they had a  
8 concern or difficulty regarding their care they could  
9 discuss these with the MDT and/or their advocate and  
10 informed inspectors that they knew who to talk to if  
11 they were not happy or had a concern. It was positive  
12 to note that patients understood their rights and a  
13 number of patients had previously attended the mental  
14 health review tribunals."

11:38

11:39

15  
16 Then there is a series of quotations from the patients  
17 directly as recorded by the inspectors about their view  
18 of the staff of the ward and there's a complaint where  
19 it's recorded:

20  
21 "They stopped the hospital gardening programme without  
22 telling us."

23  
24 Someone else saying "I'm treated well":

25  
26 "Inspectors reviewed the change in the hospital's  
27 gardening programme. Inspectors evidenced that the  
28 programme had changed due to a number of factors  
29 including a desire to evaluate and update the

11:39

1 recreational and creative activity programme."

2  
3 I am going to deal with day care a little later:

4  
5 "Inspectors noticed that patients had been consulted 11:40  
6 prior to the changes. It was also positive to note  
7 that staff arranged further meetings with patients to  
8 discuss future programme developments."

9  
10 And what I'm drawing to the Panel's attention and 11:40  
11 asking the Panel to take into account is, avoiding  
12 hindsight, this is the report that's being provided by  
13 inspectors who are external to the Trust and that  
14 report is then coming in to the Trust. It comes in  
15 through the Chief Executive's office as you've heard 11:40  
16 and then it makes its way back down into Learning  
17 Disability Services and to the hospital and this is the  
18 content that is being read by the staff who work in the  
19 hospital, not necessarily the nurses and nursing  
20 assistants that might be being spoken of in the report, 11:41  
21 but that the management in the hospital is reviewing.

22  
23 The next report that I want to look at is from May  
24 2017, so that is a time when the CCTV recording is  
25 available for, and if we can move please to page 188, 11:41  
26 you can obviously read the report in full, I'm just  
27 drawing your attention to some aspects. And if we just  
28 scroll down a little further please, so you can see  
29 that this report, again, it involves one of the

1 inspectors that you did hear from, although the report  
2 itself wasn't opened with him. This relates to  
3 Cranfield 1, and it's an inspection that takes place on  
4 the 16th to the 18th of May. It's a 17-page report and  
5 I ask you to read it in its entirety. I'm not going to 11:42  
6 be able to go through all of it now. It was a 14 bed  
7 ward.

8  
9 I'm going to, if we scroll down please, just move  
10 through the report for me, thank you, down to the next 11:42  
11 section, section 2, just a little further down the page  
12 which gives the profile of the service and then it  
13 records who is there, who is on leave and then if we  
14 move down please to pages four and five. So if you  
15 just scroll slowly down so the Panel can see the 11:42  
16 content. Then we are going to begin at the bottom of  
17 page 191. There is an inspection summary that is  
18 visible at the moment. You can see, just pause there,  
19 please just scroll up a little, you can see:

20  
21 "Inspectors evidenced significant concerns in relation  
22 to the function of the ward and the challenges faced by  
23 11 patients whose discharge from the ward was delayed."

24  
25 And then you can see the care and treatment that was 11:43  
26 being provided to patients in accordance with the  
27 required standards:

28  
29 "The ward's atmosphere was positive. Patients stated

1 they felt supported and the care provided to them was  
2 good. "

3  
4 You will be able to read all of that in full. What I  
5 want to do is go down please to pages four and five 11:43  
6 which relate to the patients views and that begins at  
7 page 191 of the bundle just at the bottom of the page.  
8 You can see:

9  
10 "During the inspection Inspectors met with seven 11:44  
11 patients who each completed a questionnaire. Patients  
12 were positive about their relationships with staff and  
13 the care they received. All of the patients described  
14 the ward as being clean and tidy and it was positive to  
15 note that each patient felt that being in hospital was 11:44  
16 helping them. Two patients stated that there not  
17 always enough activities to keep them busy at nights  
18 and at weekends.

19  
20 Patient/Staff interactions observed by inspectors were 11:44  
21 positive. Patients remained relaxed and at ease  
22 throughout the inspection. Inspectors note staff to be  
23 supportive, friendly and caring. There were no  
24 concerns expressed by patients regarding their ability  
25 to meet with any member of the MDT. 11:44  
26

27 Three patients discussed their concerns and frustration  
28 in relation to their discharge from the ward being  
29 delayed. Each patient explained that they understood



1 why their discharge had been delayed and the reasons  
2 for it. Staff who met with the inspectors were also  
3 frustrated regarding the difficulties faced by patients  
4 awaiting discharge. It was good to note that patients  
5 were continually updated regarding their discharge 11:45  
6 plans. Positive to note that ward staff continued to  
7 prepare patients for discharge and to engage with  
8 community teams.

9  
10 Patients stated that when they had a concern or 11:45  
11 difficulty regarding their care they could discuss this  
12 with their named nurse. Patients told inspectors they  
13 knew who was involved in their care and who to talk to  
14 if they were not happy or they were upset. Inspector  
15 observations evidenced that patients actively engaged 11:45  
16 with staff. Patient care records detailed the  
17 involvement of all professionals within the MDT."

18  
19 And then, again, a section dealing with some quotations  
20 from the people who were spoken to by the inspectors: 11:46

21  
22 "Very good. Very caring and very good staff. Staff  
23 have been excellent with me."

24  
25 And then recognition of not enough activities at night. 11:46  
26 Someone explaining they were happy to be there, "10 out  
27 of 10". A complaint that it was "too noisy". Someone  
28 else saying "I feel very safe". There was then an  
29 interaction over the noise levels on the ward:

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

"It is important to note that the ward provided care and treatment to newly admitted patients who presented as very unwell. At the same time the ward also continued to care for patients who no longer required treatment."

11:46

So again, I'm drawing to your attention that that's a report that's coming in to the Belfast Trust and moving down to the management of the hospital as to what the patients were saying to the inspectors who are not there employed by the Belfast Trust.

11:47

The third one I want to look at, please, begins at page 205 of the bundle. It's also in May. So the report we were briefly looking at was the 16th to the 18th of May. This inspection is the 17th and 18th May, different inspectors, and it is, if we just scroll down please, it is the Donegore Ward, you did hear from one of those inspectors I believe, although this report wasn't opened with her.

11:47

11:47

If we move down please to page 207 and just the bottom half of the page on 207 you'll see, again, sorry, it is in the top half this time, the detail of the ward itself. It's a nine bedded ward. The purpose of the ward is to provide care and treatment to female patients with a learning disability who present with behaviours that challenge. There were nine patients

11:48

1 present on that day.

2  
3 The unannounced follow-up inspection took place over  
4 two days on the 17th and 18th of May. So this document  
5 relates to that unannounced follow-up and you can see 11:48  
6 it is said:

7  
8 "The inspection sought to assess progress with the  
9 findings for improvement raised from the most recent  
10 and previous unannounced inspection which was the year 11:48  
11 before in three days in June of 2016."

12  
13 And if we can look down please, on page 208, to the  
14 second paragraph. Maybe it's the third paragraph of  
15 208. It begins, "patients on the..." , yes, it's the 11:49  
16 third line of the top paragraph and you can see on the  
17 screen it begins:

18  
19 "Patients on the ward had access to an associate  
20 specialist and duty doctors. The Clinical Director 11:49  
21 confirmed that they were available if required.  
22 Patients can access an out-of-hours GP every evening  
23 and at weekends for physical health concerns."

24  
25 I draw your attention to:

26  
27 "Inspectors noted that prescribing and monitoring of  
28 medication in relation to polypharmacy had improved. A  
29 review of medication for all patients was completed in

1 July '16 and prescriptions were changed to reflect the  
2 review. It was noted there was no polypharmacy with  
3 regard to anti-psychotic medication."

4  
5 Then there was a discussion about staffing difficulty 11:50  
6 arising from two consultant psychiatrists who were ill  
7 and how that was being managed the situation being  
8 improved with the use of a speciality doctor and cover  
9 from the resettlement consultant psychiatrist.

10  
11 You can see it was agreed, if we can find, just the bit 11:50  
12 at the bottom of the screen, thank you:

13  
14 "It was agreed at the inspection feedback that the  
15 Trust will provide the RQIA with an update by an agreed 11:50  
16 day in relation to consultant psychiatrist cover."

17  
18 And it explains how decision-making was going to occur  
19 in that context.

20  
21 You can see the ward environment was clean and tidy 11:51  
22 during the inspection and staff were available in the  
23 communal areas. Staff were observed to encourage  
24 patients to participate inward based activities.  
25 During the inspection patients were out walking with 11:51  
26 staff around the grounds at the coffee shop and at day  
27 care. Inspectors observed staff supporting patients:

28  
29 "Considerate to the patients presenting needs and staff

1 were patient, kind and respectful. It was good to note  
2 that schedules were in place for patients and staff  
3 actively encouraged them to follow their schedule.  
4 Staff were observed to respond promptly to patients who  
5 required support. Inspectors noted that patients 11:51  
6 appeared comfortable in their surroundings and  
7 approached staff without hesitation.

8  
9 Patients who met with the Inspector all confirmed they  
10 were satisfied with their care and felt safe on the 11:52  
11 ward. Patients also said that staff were caring and  
12 they had adequate time with their primary nurse. Staff  
13 said it had been difficult at times due to the  
14 previously inconsistent medical input to the ward,  
15 however stated this issue should now be resolved due to 11:52  
16 the recommencement of the associate specialist to the  
17 ward.

18  
19 The findings of the report will provide the Trust with  
20 the necessary information to assist them to fulfil 11:52  
21 their responsibilities enhanced practice and service  
22 user experience."

23  
24 Obviously you will be able to consider the report in  
25 full. The final one that I want to look at with you is 11:52  
26 at page 218 of the bundle and if we just scroll down  
27 you will see the information. The timing of this  
28 report and the context that I'm going to show you to  
29 which it relates is important, this is the 13th of July

1 2017. It's on Cranfield ward, it's a seven page report  
2 because, as you will see as we scroll down, it is  
3 specifically in response to complaints from an  
4 anonymous caller. You did hear from this Inspector,  
5 but this report was not opened with him. If we scroll 11:53  
6 down please to the next section we'll see the context I  
7 think of the ward set out at section 2. It's similar  
8 to what we saw with the previous Cranfield report and  
9 then if we move down to page 221 please. If we scroll  
10 down a little further please we will see what the 11:54  
11 concern was. So pause there, thank you. So RQIA have  
12 received an anonymous concern and this report is  
13 arising from an inspection that took place specifically  
14 in response to that concern.

15  
16 So the Inspector is going on the working assumption, in  
17 my respectful submission, that there is something  
18 wrong, they are going in response, it's not in the  
19 natural cycle of going to the hospital, going to a ward  
20 to see what it's like. This is specifically in 11:54  
21 response to a suggestion that there is a problem. And  
22 you can see that the Inspector says he:

23  
24 "... examined the ward situation in relation to each of  
25 the concerns identified, including the allegations made 11:55  
26 by the anonymous caller."

27  
28 The nature of the concerns and allegations and the  
29 Inspector's findings are detailed below. The findings

1 reflect, as the necessary caveat, that the ward  
2 circumstances on the day of the inspection. So you can  
3 see the first concern that would have been expressed  
4 was that patients were unable to access Allied Health  
5 Professionals:

11:55

6  
7 "On the day of the inspection the Inspector spoke with  
8 four patients and five members of staff and reviewed  
9 three sets of patient care records.

10  
11 Patients told the Inspector they had no concerns  
12 regarding their ability to access services, including  
13 podiatry, speech and language services, social work, a  
14 dentist or an optician. Patient care records evidenced  
15 that patient needs were comprehensively assessed and a  
16 corresponding care and treatment plan had been agreed.  
17 The Inspector found no evidence that patients had been  
18 unable to access any professional that might be  
19 required to support their care and treatment.

11:56

20  
21 Staff who met with the Inspector demonstrated  
22 understanding of AHP within the hospital. This  
23 included referral pathways to AHPs and the Inspector  
24 reviewed the referral pathways with the Ward Manager  
25 and discussed contingency planning in circumstances  
26 where there might be a delay; for example, in accessing  
27 a podiatrist or an optician.

11:56

28  
29 The Ward Manager assured the Inspector that the

1 hospital podiatrist was available as required and each  
2 patient was referred to the services on admission. The  
3 Ward Manager also explained that should a patient  
4 require an optician this would be arranged quickly.  
5 The Inspector found no evidence to support the concern 11:57  
6 that patients could not access paramedical services."

7  
8 Then you can see that the second concern that caused  
9 the Inspector to be there was that patient care and  
10 treatment not being appropriately monitored. And you 11:57  
11 can see the Inspector records:

12  
13 "The ward, Cranfield Male Ward 1, provides care and  
14 treatment to patients who have a Learning disability  
15 and are experiencing an acute mental health problem. 11:57  
16 Unfortunately there are also seven patients on the ward  
17 whose discharge has been delayed due to the  
18 unavailability of community resources.

19  
20 Subsequently, these patients no longer require hospital 11:57  
21 based care and treatment. Given that 50% of the  
22 patients admitted to the ward no longer require  
23 hospital admission, staff have to balance the needs of  
24 these patients with the needs of patients who are  
25 acutely unwell. 11:58

26  
27 The Inspector reviewed three sets of patient care  
28 records, two sets of records related to patients whose  
29 discharged been delayed and one record related to a



1 patient who remained acutely unwell. Care records  
2 reviewed by the Inspector evidenced that the ward's  
3 multidisciplinary team continued to provide  
4 contemporaneous records of each patient's progress.  
5 Patient care plans, risk assessments, physical  
6 healthcare assessments were up-to-date. Nursing  
7 continuing care records evidenced that patients were  
8 closely monitored and their care and treatment patient  
9 centred.

11:58

10  
11 The Inspector found no evidence that patient care and  
12 treatment was not being appropriately monitored, found  
13 no evidence to support the concern that patient care  
14 and treatment..."

15  
16 I think that is a sentence repeated twice in the  
17 report. He goes on to deal with another concern that  
18 was more do with the physical environment of the ward.  
19 You can obviously read the report in its entirety.

20  
21 But, again, this is a report this time specifically  
22 about a concern that prompted the Inspector to go  
23 there. That report is then coming back in to the  
24 Belfast Trust and moving down to the relevant  
25 individuals who see it and that is the context of  
26 information as matters take a totally different turn as  
27 the CCTV review subsequently reveals.

11:59

11:59

28  
29 But those are, again, external individuals whose

1 specific role is to see if there are problems that need  
2 to be remedied and that is the content of their  
3 reports. It may be that I have missed some, but you'll  
4 have them all, those are the ones that appear to be  
5 from 2017 in the period leading up to the summer. 12:00

6  
7 Obviously you're aware and you will have material that  
8 may allow you to know how often different police  
9 officers for instance were in the ward, it's not  
10 information that the Belfast Trust necessarily is able 12:00  
11 to put before you, but, you know that because of  
12 incidents that occurred various police officers were in  
13 and out of the wards on occasions at MAH.

14  
15 And then the MAH staff themselves, I want to look and I 12:00  
16 want to be clear that I'm grounding this point giving  
17 you some illustrative examples. You will be able to  
18 look at all of the individuals who the submission that  
19 I'm making would relate to. I'm merely doing it using  
20 illustrative examples. There were many experienced 12:01  
21 senior staff of the Belfast Trust who did work at MAH,  
22 I'm not necessarily referring to people who may have  
23 come in for visits or to hand out awards, I'm talking  
24 about people who worked there day and daily, and who  
25 were regularly on wards in the time period when 12:01  
26 unfortunately CCTV has shown patients were being abused  
27 by some staff and that abuse was going unreported.

28  
29 You heard from Dr Milliken, highly experienced

1 consultant psychiatrist who worked at the hospital  
2 almost throughout the entire time period of the Terms  
3 of Reference. You have his statement at STM-312 and he  
4 was in the hospital between 2001 and 2022, 21 years.  
5 He was the Clinical Director of LD Services between, 12:02  
6 and there is two different dates, I'll have to get the  
7 right one for you, it was between either 2003 and 2005  
8 up to 2018, so either 13 years or 15 years. He  
9 explained to the Inquiry in his witness statement that  
10 he himself, and this is paragraph 29, it's at 12:02  
11 STM-312-10, so page 10 of the statement, at paragraph  
12 29, he himself had never witnessed poor care or abuse  
13 at MAH.

14  
15 That's different from him being aware of abuse taking 12:02  
16 place, and you'll see that he was involved in various  
17 incident responses, so he was aware of that, what he is  
18 talking about is what he himself witnessed. And he  
19 explains in his witness statement that when he became  
20 aware of the developing problem being revealed in 12:03  
21 September 2017 he informed Dr Jack, who was then his  
22 Medical Director and you'll see the right way of that  
23 at paragraph 62 of Dr Jack's statement which is  
24 STM-287-18. He explained that the viewing of CCTV had  
25 indicated that allegations of abuse were wider than had 12:03  
26 initially been reported in respect of the initial  
27 incident and he had mixed emotions. He explained he  
28 felt, and this is paragraph 30 of his statement:  
29

1 "Shock, anger and despair."

2  
3 He explained that his work in MAH relied on others  
4 having the right attitude and providing the right care.  
5 He explained that, and this again is paragraph 30 of  
6 his statement, that: 12:04

7  
8 "The abuse allegations have been the most difficult  
9 vent in my professional life."

10  
11 He also explained in the same paragraph his experience  
12 of the reaction of his colleagues to what was coming to  
13 light, colleagues who:

14  
15 "...who were as shocked as he was when the allegations 12:04  
16 came to light."

17  
18 Now, going back to a submission I made to you earlier,  
19 the Clinical Director, the possibility of staff abusing  
20 patients was known to the Clinical Director. He had 12:04  
21 been involved in the response to the allegations on  
22 Ennis Ward. He was aware of and was the person who  
23 told the RQIA at that time about the previous incident  
24 of physical assault that had occurred on the ward,  
25 which is one of the illustrative examples in the 12:05  
26 written submission. You'll find content that assists  
27 with the references for that at paragraph 51 of our  
28 written submission.  
29

1 And Dr Milliken himself was one of the people aware of  
2 Winterbourne and had been involved in discussions  
3 relating to that in Muckamore. And both in 2014, in  
4 November, and at the end of October 2017 when Dr Jack  
5 met then, the Medical Director, with the consultant 12:05  
6 psychiatrist working at Muckamore as the extent of this  
7 problem started slowly to emerge. And you'll find that  
8 at STM-287-449. It's recorded that:

9  
10 "The consultants had mentioned that in the aftermath of 12:06  
11 Winterbourne, the consultants at MAH had met as a group  
12 and discussed and considered the systems in place  
13 to protect the patients."

14  
15 So the Clinical Director was someone who knew that 12:06  
16 patients could be abused by staff. And if we look  
17 please at page 87 of the bundle then, this is Day 108  
18 on the 23rd of September 2024 and he was asked  
19 questions about this issue by you, sir, so it begins  
20 about line 6. You ask: 12:06

21  
22 "Could I just ask you more specifically, presumably,  
23 and I don't want you to name names for obvious reasons,  
24 but you must now be aware of the names of some of the  
25 patients who are said to have been badly treated?." 12:06

26  
27 And Dr Milliken said yes he was. You asked him:

28  
29 "Sir, were any of them under your direct care?."

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He replied:

"I believe now that they were, yes."

You asked then:

"Sir, how many of them do you know?."

He said:

12:07

"No, I don't. I can think of particular examples, but I couldn't say an exact number."

Sir, you then refer him to and the evidence given:

12:07

"You described your shock, but does it surprise you that actually you didn't pick up at any stage that your patients were being mistreated?."

And his answer to that is:

"Yes, it shocks me."

You then ask, Chairman:

12:07

"How do you think that could have happened? You were having weekly ward rounds, you were having consultations. Can you help the Inquiry at all as to

1 how that could have happened and it didn't filter  
2 through to you?."

3  
4 And I ask you to keep in mind the passage that we  
5 looked at from Whorlton Hall where similar evidence was 12:08  
6 being given and the answer that Dr Milliken gave was:

7  
8 "That's obviously something, Mr Chairman, that I have  
9 reflected at length about and I'm not sure that I can  
10 answer that. We were, you know, I was not in the ward 12:08  
11 all of the time, so the clinical work was 50% in the  
12 hospital on different wards. I'm not sure I can. I  
13 don't think I know the answer to that question."

14  
15 And then you, sir, are recorded as saying: 12:08

16  
17 "No no, all right, okay. Again, just so that I  
18 understand, your responsibility for an individual  
19 patient, would you have been the named consultant for  
20 those patients that you have just been talking about?" 12:08

21  
22 Dr Milliken answered:

23  
24 "Yes, in Six Mile, yes."

25  
26 And we looked at an RQIA report in relation to Six  
27 Mile. You then ask, sir:

28  
29 "So does that mean that if any member of staff has a

1 concern about that patient they should bring it to  
2 you?. "

3  
4 The answer is:

5  
6 "I would have expected so and initially with the Ward  
7 Manager, assuming it was a member of the ward staff or  
8 the nursing team, I would have expected the Ward  
9 Manager and me, yes. "

10  
11 You then ask, sir:

12  
13 "Because you're not in charge of the ward, as it were,  
14 but you were -- you certainly have a high degree of  
15 responsibility for each of your named patients, is that 12:09  
16 fair?. "

17  
18 Dr Milliken said "yes "it was." You then asked sir:

19  
20 "At no stage did anybody, any member of staff or any 12:09  
21 patient come to you and say 'this patient is being  
22 mistreated' ?

23  
24 Dr Milliken said "I don't believe so". And you then  
25 thanked him for dealing with your questions. 12:09

26  
27 Now, I respectfully say that that's important evidence  
28 because the contribution that this Inquiry can make to  
29 understanding about how good people, experienced



1 professional people, doing their jobs, as I said to you  
2 at the start, not getting up in the morning to get  
3 things wrong, to look after their patients, but yet not  
4 themselves seeing any evidence of what the CCTV system  
5 subsequently demonstrated. 12:10

6  
7 Almost at the other end of, and I'm not able in the  
8 time to go through all of the examples, you will be  
9 able to take them into account. I am going to give you  
10 one at the other end, as it were, of the experience, at 12:10  
11 least as far as Muckamore is concerned. H223. If you  
12 don't have access to who that is, I wonder can that  
13 just be written down so you have in your minds as I'm  
14 speaking?

15 CHAIRPERSON: Yes. 12:11

16 MR. AIKEN: And if we can bring up please page 89.  
17 Page 89, my apology.

18  
19 So, in contrast to a medical practitioner with lengthy  
20 experience of the hospital, H223 took up a position as 12:12  
21 an LD Consultant Psychiatrist at Muckamore in May 2017,  
22 so about the time of two of the RQIA reports that we  
23 looked at. He was asked in his oral evidence on day  
24 100, which was the 9th September 2024, had he ever  
25 witnessed any concerning behaviour by staff before he 12:12  
26 was informed in November 2017 that abuse of patients  
27 had been recorded occurring on CCTV.

28  
29 And I think if we just scroll down please, I'm just

1 going to draw your attention to on page 90, at line 12  
2 you'll see:

3

4 "So in relation to that..."

5

6 If we move it up a little bit so the answer is on the  
7 screen as well:

8

9 "So in relation to that were you ever concerned about  
10 staff treatment of patients before the 2017 allegations 12:13  
11 of abuse came to light?

12

13 And the answer that H223 gave to you was:

14

15 "No, bearing in mind I was only there for a very short 12:13  
16 time, I joined the staff in May 2017. "

17

18 So it is someone who is new to the hospital, on one  
19 view you might consider fresh eyes:

20

21 "...so it was a very short time before this came to  
22 light."

23

24 so if you like, a sixth month period before which H223  
25 is told that there is a problem being displayed on the 12:14  
26 CCTV of abuse:

27

28 "I had no -- nothing concerned me as to what I observed  
29 in the early days of my time in Muckamore."

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He was also asked and you will see this on, I think it's the same page or in the next page of the transcript:

"If any patients or relatives of patients had ever raised with him any concerns about abuse or mis-treatment."

And he said in answer to that, and if we scroll down please, I think it's at the next... It should be page 41 of the transcript and at line 25. Just scroll back up a little please, sorry. So he was asked if any patients or relatives of patients had ever raised with him any concerns about abuse or mis-treatment and he said the answer was no and that he had not himself seen any bad practice from colleagues. 12:14  
12:15

Now, the MAH Inquiry heard oral evidence from a number of individuals who worked at the hospital for a very prolonged period of time and who, because of the roles that they held, had experience of various occasions when staff were said to have and were found to have mistreated patients and investigations ensued. I'm not going to be able to go through all of them. I am going to give you an example of an experienced member of staff who indicated to you that when she took up her later role did have some concerns, not about abuse, but about practices in the hospital and so was alert to 12:15  
12:16

1 trying to address those. So Mairead Mitchell told you  
2 that she became the Head of Learning Disability  
3 Services in December 2016 and held that role until her  
4 retirement in 2019. You'll find this in STM-240.  
5 However, Ms Mitchell had actually been heavily involved 12:17  
6 with Muckamore from at least 1997, so 20 years back.  
7 In her roles as the Assistant Director of Quality and  
8 then Assistant Director for Service Improvement in what  
9 was the LD Directorate of the North-West Belfast Health  
10 and Social Services Trust. 12:17

11  
12 From the commencement of Belfast Trust in 2007 until  
13 she became the Head of Learning Disability Services in  
14 December 2016, Ms Mitchell was the senior manager of 12:17  
15 service improvement and modernisation in what was then  
16 the Adult Social and Primary Care Directorate,  
17 essentially the governance manager with responsibility  
18 for, amongst other things, governance in MAH along with  
19 the then Co-Director Mr Veitch.

20  
21 And it's not possible for me in the time available to  
22 go into it, but material that's available to you shows  
23 that Ms Mitchell, as Head of Learning Disability  
24 Services at the end of 2016 when she takes up that  
25 role, was clearly concerned about the leadership of the 12:18  
26 then MAH Services Manager in 2017 and she explained she  
27 was dealing with a number of complaints from different  
28 sources. But, and you'll find this at -- I think it's  
29 STM-240-12, it's paragraph 71 to 80 of Ms Mitchell's

1 witness statement. She was dealing with a number of  
2 complaints but she was not aware of any suggestion that  
3 staff may be abusing patients.  
4

5 In fact, when you look closely at the documents that Ms 12:19  
6 Mitchell has exhibited to her witness statement you  
7 will see that in May 2017 when CCTV would subsequently  
8 indicate that abuse was occurring, Ms Mitchell as Head  
9 of the LD Service and Ms Heaney as then Director of  
10 Adult Social and Primary Care, within which LD and 12:19  
11 Muckamore sat, specifically visited and engaged in a  
12 walk around arising from concerns, these anonymous  
13 concerns that had been raised about the Service  
14 Manager. And  
15

16 That included speaking to staff, it included visiting  
17 Erne wards and Cranfield wards. If we just look  
18 actually at page 92 of the bundle, if that's possible  
19 please? Yeah. We can see the two exhibits are two  
20 summary chronologies prepared by Ms Mitchell at 12:20  
21 different points in time and if we scroll down please  
22 we can see the first one which is I think from July  
23 2017. Yep. You can see, if you just move down through  
24 please so we can see the types of issues, and then you  
25 can see recorded the first visit in May 2017. 12:20  
26

27 Now I think in her evidence she explained to you that  
28 it wasn't the only time it occurred, but it is the  
29 specific visit along with the Director that she was

1 referring to doing a walk around in respect of and you  
2 can see the wards that she and the Director were  
3 walking around.

4  
5 And the various issues raised by staff are recorded. 12:21  
6 If we scroll on a little further down please. You can  
7 see, yeah, move down a little further please, thank  
8 you. Those were the issues that were being raised and  
9 recorded at that time. Neither Ms Mitchell nor Ms  
10 Heaney don't experience or become aware of anything to 12:21  
11 suggest what would subsequently turn out to be  
12 occurring as recorded on the CCTV. And it's important,  
13 we respectfully say to bear in mind what was known by  
14 Ms Mitchell, the author of the summaries at the time  
15 she was writing them, as opposed to what she would be 12:22  
16 in a position to subsequently learn from the extensive  
17 viewing of CCTV.

18  
19 And when asked to reflect, I don't have this bit of the  
20 transcript for you but I'll just tell you where it is, 12:22  
21 given various steps and measures that Ms Mitchell had  
22 explained were occurring at Muckamore in the first half  
23 of 2017, essentially on how she was asked essentially  
24 how the abuse may have been occurring without her being  
25 aware, and that's on Day 104, that's the 16th of 12:22  
26 September 2024 and it's at pages 156 and 157 of the  
27 transcript. I'm just going to read that to you:

28  
29 "And ultimately we know that it was more than just one

1 incident, you have referred to being informed of the  
2 first incident. "

3  
4 This is talking about the post-August 2017:

5  
6 "But ultimately we know that it was more than just one  
7 and you continued to be Head of Learning Disability  
8 Services until 2019 and you've described various  
9 measures that you implemented to try and address issues  
10 at Muckamore. "

12:23

11  
12 So that's referring back to the walk around and the  
13 issues being managed about the Service Manager:

14  
15 "But in becoming aware of the issues that were captured  
16 on CCTV, did you or have you since reflected on how  
17 that could have happened in a situation where you were  
18 implementing the measures that you have described to  
19 us?. "

20  
21 And the reply is:

22  
23 "How the incident could have happened?"

24 Q: Yes, how the number, the number of incidents and  
25 the level of abuse that took place at Muckamore?. "

12:23

26  
27 The answer is:

28  
29 "I mean all I can say is CCTV is a wonderful thing, you

1 know, you know you do walkabouts and you don't see any  
2 of this. You are told things and whatever, but I, from  
3 when I took up post in 2016, there were a series of  
4 things that alerted me that something wasn't right on  
5 the site and you have material to do with that, people 12:24  
6 complaining about the Service Manager. That started to  
7 alert me that something wasn't right on-site and I  
8 think I have given you that information and I never  
9 ever thought it would be what has transpired. I never  
10 would have thought that. Shocking." 12:24

11  
12 You have heard from, there are lots of other examples,  
13 I'm only going to refer to one more of a different type  
14 of staff member because it links in with a theme that  
15 hopefully I can get to about day care provision. But, 12:24  
16 we've already, in the written statement, drawn your  
17 attention to H823 in paragraph 19 of the written  
18 closing. It covers pages seven and eight. That was a  
19 member of staff of a very longstanding who was involved  
20 in investigations into various incidents, including 12:25  
21 mistreatment and abuse of patients, which resulted in  
22 members of staff being sacked over time.

23  
24 And in addition, the one that I'm going to turn to is  
25 Bert Lewis, who had worked as a nurse in various roles 12:25  
26 at the hospital for in excess of 30 years. He was  
27 asked to, in effect, speculate at the end of his oral  
28 evidence on Day 102. If we can show page 99 in the  
29 bundle please, about how abuse he had not himself



1 witnessed because he explained he had not, might have  
2 been able to occur. He explained, he himself had not  
3 witnessed incidents of abuse, but had highlighted and  
4 highlighted two occasions when abusive behaviour was  
5 reported to him and how it was then dealt with and 12:26  
6 that's at pages 88 and 89 of the transcript.

7  
8 You'll see if we just scroll down a little, I can't  
9 find it on the screen, I am going to read it to you and  
10 hopefully we will pick it up: 12:27

11  
12 "So you were a mentor to student nurses at Muckamore  
13 from the 1990s until your retirement in 2020, is that  
14 correct?

15 A: Yeah. 12:27

16  
17 Q: During that time as a mentor did a student nurse  
18 ever come to you and express concern about patient care  
19 or the conditions of wards or anything in relation to  
20 practices at Muckamore?. " 12:27

21  
22 And his answer was "no":

23  
24 "Q: Elsewhere in your statement you say, and you'll  
25 pull up paragraph 61, thank you, you're here, third 12:27  
26 line down?

27 A: I don't recall any incidents where I witnessed poor  
28 care. I would have felt confident to report anything I  
29 was uncomfortable with to my line managers, but I

1 cannot recall any specific occasion when I needed to.

2  
3 Q: So you didn't personally witness any incidents that  
4 you were uncomfortable with?

5 A: Yeah.

12:27

6  
7 I think, again, when the question was asked to me, the  
8 question was specifically, had I witnessed poor care,  
9 it wasn't 'was anything ever reported to me', so there  
10 would have been..."

12:28

11  
12 And he then recalls two incidents where things were  
13 reported to him and what he did about those. And then  
14 one incident was to do with his time working on Movilla  
15 and another was do with his time working on Cranfield  
16 in 2015 and he explains the various processes that were  
17 engaged in:

12:28

18  
19 "So those are two occasions when something was reported  
20 to me which you had to act on immediately like, the  
21 first one, you know, we didn't know whether it was  
22 believable or not, but you had to take it that it was  
23 and follow procedures.

12:28

24  
25 The second one was different where it was a member of  
26 staff reporting another member of staff and there was a  
27 second staff witness."

12:28

28  
29 Then he was asked not to go into detail about those:

1 "Q: But you were always clear about what your  
2 responsibilities were?

3 A: Yes, you know, you couldn't have something like  
4 that happening on your ward and if it did happen, it  
5 had to be reported." 12:29

6  
7 Then he is asked:

8  
9 "with the exception of the two examples that you have  
10 just provided, I think it would be fair to say that you 12:29  
11 in your evidence today and also in your statement have  
12 painted a somewhat positive or rosy picture of your  
13 time at Muckamore, would that be fair?

14  
15 And he then he said: 12:29

16  
17 "No, I don't know if rosy is the right word, but  
18 certainly I have had a long career there and on the  
19 whole it was positive.

20  
21 Q: You will be aware then of the Terms of Reference of  
22 the purpose of the Inquiry, it also heard in relation  
23 to varying standards of cleanliness, issues generally  
24 with wards, how do you think that abuse that has come  
25 to light happened." 12:29

26  
27 And he said:

28  
29 "I can't honestly said how. I am just flabbergasted

1 that it did happen and it happened in an environment  
2 close to where I worked. It was shocking to hear about  
3 it and for somebody who would have shouted from the  
4 rooftops how good a hospital it was and what the  
5 practice was like, you turn around and now you're 12:30  
6 embarrassed to say that you worked there like. So  
7 struggle, struggle to deal with that part of things,  
8 yeah. "

9  
10 There are lots of other examples, no less important 12:30  
11 than the ones that I have looked at briefly for  
12 illustrative purposes with you this morning. You'll  
13 presumably reflect on them. Respectfully, the evidence  
14 obtained by the MAH Inquiry is clear, abuse did occur  
15 at MAH before 2017. When it was identified it was 12:30  
16 dealt with robustly, that's evidenced in the material  
17 that you have received. The problem did not appear  
18 widespread.

19  
20 The abuse that was occurring on some wards in 2017, as 12:31  
21 indicated in CCTV, was not known to more senior staff  
22 of MAH or other individuals beyond the Belfast Trust  
23 regularly on the wards at that time. The various  
24 systems that were in place, predominantly the eyes and  
25 ears of other staff, individuals of various types and 12:31  
26 others, did not detect it.

27  
28 I want to turn briefly, and then I'll have to just try  
29 and move through this very quickly, about what help was

1 sought and I'm not going to be able to do this subject  
2 justice in the time that's available, but I want to say  
3 something briefly about the response to the developing  
4 and growing problem that was found on the CCTV review  
5 and the response that followed to it.

12:32

6  
7 The Belfast Trust has already acknowledged and  
8 apologised for various failures associated with its  
9 response to abuse at MAH. There are a number of truly  
10 dreadful ironies about these events, including the fact 12:32  
11 that the start of events was an actual report, though  
12 unacceptably delayed. It wasn't from CCTV, it was a  
13 report from another member of staff about an incident  
14 involving P96, it wasn't from CCTV viewing.

15  
16 Before CCTV was examined, towards the end of September  
17 2017, and there's lots of material explaining the  
18 chronology of that, the offending staff member had  
19 already been suspended, as had other staff involved in  
20 how the matter was subsequently handled. An Early 12:33  
21 Alert had already been filed and an SAI consideration  
22 was underway. That had all taken place before the  
23 error over the availability of CCTV was established and  
24 consideration of it began. What CCTV then subsequently  
25 revealed including in relation to P96, was a whole 12:33  
26 series of other problems on wards that, to the point of  
27 review on the CCTV, was unknown.

28  
29 A significant and extensive problem of abusive

1 behaviour by staff emerged from the process of review  
2 of CCTV as it progressed, a process, the reviewing,  
3 also very difficult for the staff involved in the doing  
4 of it. From the evidence you've heard it's clear that  
5 the CCTV review process itself, perhaps arising from 12:34  
6 its extent and its nature, was itself at times  
7 difficult.

8  
9 You've heard the views of some of those involved about  
10 the effectiveness of that process for which there was 12:34  
11 no pre-existing manual or precedent and, indeed, about  
12 the relationship difficulties that occurred between  
13 some involved in the process.

14  
15 In some cases, and we ask you to bear this in mind, you 12:34  
16 only hear one side of a story of a particular  
17 difficulty and it would obviously be unfair to form a  
18 view or make a finding about the conduct or motive of  
19 the person being complained about without first giving  
20 that person complained about the opportunity to tell 12:34  
21 their side of the story in evidence. Their evidence,  
22 had it been taken, may have set events in an entirely  
23 different light. It may have revealed that what the  
24 complaining witness had to say was not accurate or was  
25 otherwise unfair. 12:35

26  
27 what is clear is that as time passed staff of the  
28 Belfast Trust involved with responding to abuse  
29 identified on CCTV could see that it was at a level, in

1 terms of volume, that was most definitely not expected  
2 at the outset. The consequences of necessary steps  
3 that had to be taken in response to what was discovered  
4 had a detrimental effect on the running of the  
5 hospital.

12:35

6  
7 There's considerable evidence available to the Inquiry  
8 that between August 2017 and the end of the time period  
9 of the Terms of Reference of June 2021, the Belfast  
10 Trust did seek to utilise various means to try to  
11 address and properly respond to what was coming to  
12 light. Many of those responses were outside of what  
13 might be called the normal functions or the normal  
14 processes of the Trust.

12:36

15  
16 The evidence shows that the Belfast Trust did not seek  
17 to hide from outside agencies what was being  
18 discovered, nor did it shy away from seeking external  
19 assistance to try to appropriately respond to the  
20 extent of the developing problems.

12:36

12:36

21  
22 It will obviously be easily possible, with hindsight,  
23 to say that Step A should have been taken sooner or  
24 Step B should have been taken in a different way.  
25 Hindsight facilitates doing that. But it's submitted  
26 that the MAH Inquiry can find that there was a genuine  
27 effort made by large numbers of staff of the Belfast  
28 Trust involved in efforts to try to identify  
29 appropriate steps to take and to take them and to

12:37

1 manage difficult situations, even if they did not  
2 always produce any or sustained improvement in the  
3 situation that was being addressed. And in some cases,  
4 efforts to make improvements actually made the  
5 situation worse, but they were decisions taken in good 12:37  
6 faith to try to manage a difficult situation.

7  
8 The normal bodies expected to be involved when events  
9 of abuse occur in a hospital facility were involved  
10 from the outset. The RQIA, the PSNI, the Department of 12:38  
11 Health. The then Chief Executive of the Belfast Trust  
12 previously acknowledged to senior officials in the  
13 Department of Health on the 3rd of November 2017, that  
14 various aspects of the Belfast Trust's initial response  
15 to what was then known, and it's important that that 12:38  
16 context is clear, in the summer and early Autumn of  
17 2017 was inadequate and deficient. The Belfast Trust  
18 apologised for that at the time and apologises for it  
19 again today.

20 12:38  
21 Many steps outwit what might be regarded as the normal  
22 response mechanisms were, however, taken by the Belfast  
23 Trust over the four year period from the summer of  
24 2017. Most of those are described in evidence Module  
25 6, the witness statement provided by Martin Dillon, 12:39  
26 that's a 105 page witness statement with 2,000 pages of  
27 exhibits, it wasn't, other than its adoption, opened  
28 with Mr Dillon when he gave his oral evidence, but you  
29 have it and can consider the chronological steps that



1 are set out.

2  
3 I'm going to have to cut out lots of things that I was  
4 going to deal with, I am going to highlight them to  
5 you, you are aware of the appointment of the 12:39  
6 independent assurance team or external support team in  
7 December 2017. The serious adverse incident  
8 investigation, it's a learning process, but it became  
9 in that case the Independent Level 3 where the Terms of  
10 Reference had to be externally agreed. And you have 12:39  
11 the minutes that indicate perhaps unusual invitation  
12 back to the Panel member who conducted, or was the  
13 Chair of the review with others, back to speak to the  
14 Board again in February of 2019.

15 12:40  
16 You have, you didn't hear from her herself, but you  
17 have evidence of the introduction of a carers  
18 consultant in 2019 and you have some of the product of  
19 that work in terms of newsletters in attempts to better  
20 communicate. In February 2019 you have the 12:40  
21 introduction of the weekly safety report originally  
22 known as the SitRep with various collation of data and  
23 how you will be able to see through the various reports  
24 the additional data sets that were added over time and  
25 that system was described by both Ms Traub and Ms Owens 12:41  
26 in their statements.

27  
28 And you had mentioned, you have Ms Flynn coming back to  
29 speak to the Trust Board in and around the time that

1 the RQIA serve three Improvement Notices. And there  
2 were various attempts to better manage the situation,  
3 so you have in February or the Spring of 2019, the then  
4 Director of Adult Social and Primary Care being freed  
5 up from other responsibilities just to concentrate on 12:41  
6 Muckamore.

7  
8 After the Improvement Notices then you have significant  
9 management change again where division of  
10 responsibilities involving three directors took place. 12:42  
11 You have, in the Spring of 2019, the engagement of a  
12 critical friend. Now, the report from the East London  
13 NHS Trust, I don't think was opened in evidence with  
14 anyone, but it's attached to Mr Dillon's witness  
15 statement. They attended in June 2019 at Muckamore and 12:42  
16 reported in August of 2019. That's a 24 page report  
17 and you'll find that at STM-107-1572. The report looks  
18 at some examples of good practice in each of the three  
19 particular areas that they looked at, including  
20 Positive Behaviour Support. 12:43

21  
22 And then within a short time of that you had the  
23 service of the three Improvement Notices from the RQIA  
24 which are very significant events in respect of the  
25 operation of a Health Trust, Health and Social Care 12:43  
26 Trust. And you then have very significant steps taken  
27 in management to try to deal with those Improvement  
28 Notices which occurred.

29

1 You heard of some direct hands-on assistance provided  
2 by Departmental Official in the form of Mr Rice. And  
3 you heard evidence about what would be an exceptional  
4 step in terms of remuneration, attempts to pay more to  
5 try to encourage staff to relocate to Muckamore. Now, 12:44  
6 you heard evidence that it didn't work, but that  
7 doesn't change the importance of the intent behind it  
8 as a step to try to help manage the staffing  
9 difficulty.

10  
11 You also have again, this is exhibited to Mr Dillon's  
12 statement, what I respectfully say is a reflective  
13 piece from three of the directors in March of 2021. It  
14 was a document that is entitled "what's different now"  
15 designed to try and critically look at the services 12:44  
16 being provided at the hospital. That was pursuant to a  
17 direct question that was asked by the Trust Board  
18 Chairman about what's different in Muckamore and that  
19 report is available to you.

20  
21 You heard some evidence about the then Chief Executive  
22 of the Belfast Trust, Dr Jack, organised and held a  
23 Stakeholder Risk Summit in April 2021 involving the key  
24 bodies with responsibility in respect of Muckamore. At  
25 that time there were still 42 patients in the hospital. 12:45  
26 It was held six weeks before the end of the time period  
27 of the Terms of Reference and at that meeting the  
28 senior departmental official, Mr Holland, when asked  
29 what more the Belfast Trust could do is recorded as

1           having replied:

2

3           "The focus given to MAH by the Trust should be  
4           recognised and accepted."

5

6           He's recorded as having:

7

8           "...acknowledged that MAH was being managed as well as  
9           it could and that the risks are collectively recognised  
10          across the system." 12:46

11

12          Does that mean that the Belfast Trust had been and was  
13          getting everything right? Of course it doesn't. It  
14          will be very easy, should the MAH Inquiry wish to do  
15          so, to find fault with all sorts of steps taken or 12:46  
16          not."

17

18          "It would be easy to find fault with all sorts of steps  
19          taken or not taken by well meaning staff in the Belfast  
20          Trust who worked on MAH related issues in good faith 12:46  
21          and doing the best they could, however imperfect that  
22          turned out to be."

23

24          One issue that the Belfast Trust would ask the Inquiry  
25          to consider is the extent to which whether it's 12:46  
26          necessary or fair to criticise individuals when it may  
27          well be that other individuals similarly placed, would  
28          not necessarily have acted or responded differently  
29          faced with the magnitude of the situation that was

1 being managed.

2  
3 At the same time, at the risk summit in April 2021, Mr  
4 Whittle, I think you heard from him, then a senior  
5 official at the Health and Social Care Board, now the 12:47  
6 SPPG, is recorded as commenting:

7  
8 "There was no magic bullet to address the situation.  
9 The issues and risks are shared and known."

10 12:47  
11 And what the RQIA is recorded as saying at the Risk  
12 Summit Meeting indicates that it wasn't just the  
13 Belfast Trust trying to respond in a proactive way to a  
14 difficult situation.

15  
16 Ms Hopkins, and you'll find this in STM-287-443, is  
17 recorded as saying, she noted:

18  
19 "The RQIA have completed a high number of inspections  
20 in the last two years, five multidisciplinary full-time 12:48  
21 inspections and two supplementary. These have provided  
22 additional assurances the risk that RQIA is carrying as  
23 a result RQIA have not been able to visit all of the  
24 other mental health facilities. There are two  
25 full-time RQIA Inspectors and Muckamore, assurance and 12:48  
26 monitoring which is not sustainable. During the last  
27 couple of inspections the RQIA have been impressed with  
28 the quality of care being provided despite all the  
29 risks described. There will always be a risk of poor

1 care but we're not seeing poor care when we visit. We  
2 are seeing effective and compassionate care. There has  
3 been. . ."

4  
5 This is Ms Hopkins from RQIA:

12:49

6  
7 "There has been an increase in adult safeguarding  
8 referrals but we see that as a positive increased  
9 recognition with staff being proactive. We do not  
10 believe this represents a deteriorating position and we  
11 feel it's only fair that we congratulate the Trust on  
12 what it has achieved in the last two years."

13  
14 Now the Trust is not looking for congratulations, there  
15 are all sorts of problems and difficulties as I have  
16 acknowledged and you will be able to identify those,  
17 but it's in a context of recognising at least the  
18 effort that was going in to try to manage a very  
19 difficult situation. And that included being asked to  
20 admit more people to Muckamore which is an indication  
21 of the difficulty with the system. Dr Jack wrote to  
22 the Permanent Secretary about that on the 10th of  
23 December 2021 and you'll find that at STM-287-439.

24  
25 I had recorded that I was going to say, I have moved  
26 very quickly through, but I have actually moved much  
27 more quickly through than I had intended.

28  
29 There are other aspects of matters, I hope you'll

1 understand that I have tried to be very careful not to  
2 go near issues that might be conceivably close to or  
3 connected to anything do with restrictions that could  
4 be said to do anything do with the police  
5 investigation, that's not to say the Belfast Trust 12:50  
6 isn't interested in them, it absolutely is.

7  
8 And I acknowledge that, respectfully, you will be able  
9 to identify deficiencies with various aspects of the  
10 response. I've only gone very briefly into some of the 12:51  
11 response. But it is submitted that you can find that a  
12 very large number of Belfast Trust staff at various  
13 levels were engaged over a prolonged period in trying  
14 to manage a very difficult situation that emerged and  
15 developed. It has caused much pain to patients and 12:51  
16 their families and the Belfast Trust has apologised for  
17 that, but the extremely difficult situation has also  
18 caused much pain to good people working in the Belfast  
19 Trust.

20 12:51  
21 I want to say, again I am not going to be able to deal  
22 with this in the way I would like, sir, but I want to  
23 say something about the Inquiry themes and I was going  
24 to use one of them as an illustrative example of the  
25 type of issues that arise over the quality of evidence 12:52  
26 which you will have to consider.

27  
28 Having heard most of the patient experience evidence,  
29 you indicated on Day 55 that it was intended to explore

1 a number of themes or topics because you were not  
2 engaging in individual findings per se. And you  
3 described it as a "living list", I am not going to go  
4 through it now but you have it, and it's not entirely  
5 clear to the Belfast Trust, it doesn't need to be, 12:52  
6 you'll have to deal with it, how the Inquiry is  
7 intending to approach those themes, whether it's making  
8 factual findings in respect of the themes themselves or  
9 whether looking by ward or particular periods of time  
10 or some other way, whatever approach is taken the 12:52  
11 Inquiry will obviously bear in mind, as with all of the  
12 evidence that it has gathered, that the experience of  
13 each patient and family at the hospital, particularly  
14 over an extensive time period was different.

15  
16 And what I've drawn your attention to, and I'll just  
17 ask you to look at it in the bundle, we can put it very  
18 briefly on the screen, but I am going to have to skip  
19 through. At page 110, a very simple issue in the  
20 context of day care which was a theme I was going to 12:53  
21 deal with for illustrative purposes, to perhaps in a  
22 way that -- so it's page 110, if we can put it up in  
23 the screen -- in a way that evidence might be more  
24 difficult to explain, this six page leaflet will allow  
25 you to see at that point in time in 2008, in September, 12:53  
26 the type of services that were being provided at the  
27 time. If we scroll through the leaflet, it's four  
28 pages. Now, just slowly. There is 240 patients in the  
29 hospital, there are 600 staff. The leaflet is itself



1 eight pages long summarising the type of programmes  
2 that were being provided by way of day care. Page two  
3 indicates four different centres of day care provision  
4 that were utilised. And there is a very long list of  
5 different types of therapeutic intervention that's  
6 being described in this very short document, so I'd  
7 invite you to read it as being of assistance to you in  
8 understanding how day care provision occurred.

12:54

9  
10 And that was a subject that was itself changing. So  
11 you heard from Mr Lewis and we have provided you with  
12 and we'll see it at page 114 of the bundle a day care  
13 review that was undertaken in October 2018, he  
14 mentioned that in his evidence. By that time there is  
15 76 patients and 473 staff of which 323 were involved in  
16 nursing care. There is still 87 commissioned beds.  
17 And that report, if we move to page 114, was intended  
18 to look at all aspects of the day care service  
19 provision.

12:55

12:55

20  
21 And I'll just ask you, if you wouldn't mind to consider  
22 pages two, where you'll see the extent of day care  
23 provision that was being provided. Page five, where  
24 you'll see the In-reach package -- if it's possible if  
25 we scroll through the document as we go -- the In-reach  
26 packages that were being provided for those who said  
27 they didn't want to leave the ward and so some steps  
28 were being taken to provide the care and services on  
29 the ward. And at pages five and six of the report

12:56

1 again you'll see the different forms of day care  
2 provided through Moyola, horticulture, Portmore,  
3 swimming pool, complimentary therapy and external  
4 contributors who were coming in to Muckamore to provide  
5 services and activities. 12:56

6  
7 You'll see at page 15 in the report an attempt to  
8 benchmark the day services against a comparator in the  
9 community. And you'll get an interesting comparison  
10 about the level of staff involved in day care provision 12:57  
11 at Muckamore, as compared to the community, and perhaps  
12 that speaks to perhaps the higher levels of complexity  
13 that were being managed in Muckamore. And in addition,  
14 Mr Lewis himself also conducted a review and report  
15 into the swimming pool over the previous 12 months and 12:57  
16 that report has been provided to you.

17  
18 And then at page 144, I'll leave you to consider that  
19 document as perhaps of assistance in contextualising  
20 some of the evidence that you have heard about day care 12:57  
21 provision. But at page 144 you'll see that there is an  
22 attempt at what I'm going to call "an outcomes report",  
23 an attempt to look at, having carried out the review,  
24 what changes have been made, how have they worked or  
25 not worked as the case may be over a service. 12:58

26 CHAIRPERSON: Just for context, this was in 2020.

27 MR. AIKEN: Yes, 2020, sorry, I should have said that  
28 to you, sir. It's January 2020. If I had been  
29 following what I was going to say I would have told you

1 that, so yes January 2020.

2  
3 If I try and do this in summary form: you heard lots  
4 of evidence from people telling their recollections,  
5 I'm not criticising them, but that's what it was. I 12:58  
6 ask you to go back to the contemporaneous documents or  
7 to seek them from the Belfast Trust if you haven't got  
8 them that would bear on an issue where you are dealing  
9 with recollection evidence. So you were told for  
10 instance that someone had closed down day care 12:58  
11 provision. Read the two reports, that's obviously not  
12 what has occurred and that person is unfortunately  
13 mistaken. There may well have been times when staff  
14 had to be pulled away and services weren't provided,  
15 but the idea that for months day care services weren't 12:59  
16 being provided is just wrong and that material is  
17 available to you to assess.

18  
19 And some of these are very important, I am conscious of  
20 the time, sir. 12:59

21 CHAIRPERSON: Can I just say this, I can tell that you  
22 are getting quite anxious. I think Ms Anyadike-Danes  
23 had a slightly longer time, three hours. I will give  
24 you another 10 minutes.

25  
26 If you want to sit for a moment and speak to your  
27 Junior or if you just want to go straight through,  
28 you'll understand that in order to be fair to those who  
29 have preceded you, it's not fair to give you a

1 significantly longer period. But if you want to think  
2 about what your concluding remarks should be, I will  
3 give you that time, even though others might complain.  
4 MR. AIKEN: I hope they won't. What I may do sir, with  
5 your leave, I am not going to be deal with it in the 13:00  
6 way that you're envisaging, so it might be that we  
7 provide it to you in writing and then you will be aware  
8 of it and can make of it what you will.

9 CHAIRPERSON: All right.

10 MR. AIKEN: There is, I will take the 10 minutes if 13:00  
11 that's all right, because there is an issue that I want  
12 to address so you understand the context of it and then  
13 it is necessary, as Mr Doran knows, for me to very  
14 briefly address you in restricted session which I had  
15 hoped to avoid. 13:00

16 CHAIRPERSON: How long will that be, do you know?

17 MR AIKEN: I am going to do it in about five minutes I  
18 would think.

19 CHAIRPERSON: If we can have five minutes now and that  
20 will give you a moment to speak to your Junior if you 13:01  
21 wish to.

22  
23 THE INQUIRY RESUMED AFTER A SHORT BREAK, AS FOLLOWS:

24  
25 MS. ANYADIKE-DANES: Sir, if it helps at all, the other 13:10  
26 Group 3 and the Department we've all spoken together,  
27 subject of course to you, it is the Panel's hearing,  
28 but we have no objection whatsoever to the Trust being  
29 given a little more time. In fact, we probably would

1 prefer the Trust to say whatever it has to say rather  
2 than saying it hasn't said something it was to say, it  
3 is of course subject to you, sir.

4 CHAIRPERSON: You've got your 10 minutes, Mr Aiken. I  
5 think part of counsel's skill, and you are very senior 13:11  
6 counsel, is to get in what you want to say in the  
7 appropriate time.

8 MR. AIKEN: It is obviously a very big subject.

9 CHAIRPERSON: It is, we understand, all right.

10 MR. AIKEN: I'm doing what I can. 13:11

11 CHAIRPERSON: Then let us know when we need to go into  
12 restricted session because then that is also in fact  
13 extra time.

14 MR. AIKEN: I was using day care as one of the themes,  
15 drawing your attention to information that's important 13:11  
16 you take into account and that applies across the  
17 themes.

18  
19 Equally, and I had a number of illustrative examples, I  
20 am going to just use one and I'll tell you about others 13:11  
21 to illustrate the point that we ask you to take into  
22 account, and this is not a reflection of any particular  
23 patient, I am not singling a particular family out, I  
24 am just dealing for illustrative purposes with one to  
25 ground the general submission that I'm making. 13:12  
26

27 One of the first witnesses that you heard from and this  
28 is in the context of the provision of day care  
29 services, on Day 6, so the 28th June 2022, was the

1 mother of P4, and the mother of P4 is a core  
2 participant. As I say, nothing I am saying is intended  
3 as a criticism of the mother of P4.  
4

5 P4 was a patient in the hospital between July 2014 and 13:12  
6 January 2016, and we can show page 155 of the bundle  
7 and then page 156, and I will just deal with it in very  
8 summary form. The recollection of the mother of P4 was  
9 that in the context of day care there was no help at  
10 all, nothing to do. There was one person was seen who 13:13  
11 came onto the ward but other than that, no exercise,  
12 nothing. And you'll see that on page 156 of the  
13 bundle, so this is page 154 of the transcript of that  
14 day, that P4's mother explained that she had enjoyed  
15 walking with her daughter elsewhere but that wasn't the 13:13  
16 kind of thing that occurred in Muckamore.  
17

18 Now, you did make a patient document request in respect  
19 of P4's time in Muckamore. There was some initial  
20 problems with the time period that you had understood 13:13  
21 she was in Muckamore wasn't the actual time period and  
22 when that had been ironed out, you have been given the  
23 records that you requested, the particular form.  
24

25 And what those documents show when you consider them 13:14  
26 is, and I'm dealing with this now in very truncated  
27 form but I'm asking you to look at the records to  
28 illustrate the points, the attendance at aromatherapy  
29 sessions, and what P4 is recorded as saying in the

1 records about those sessions, how shortly they began  
2 after P4 went into Muckamore, so just short of a month  
3 after the admission and various trips out that are  
4 recorded in the records. A walking schedule, that you  
5 will find in the records drawn up by Behaviour Services 13:14  
6 in 2014. Part of what's recorded as "assessing the  
7 need for structure" and attendance at the swimming  
8 pool. Cookery sessions and work skills with peers.  
9 And it included on one occasion, a complaint from P4  
10 that she didn't like the new timetable because it 13:15  
11 didn't allow her to see her friends the way the  
12 previous version had.

13  
14 So throughout the records that are available to you and  
15 which you hold, there are day care placement documents 13:15  
16 and one of those documents entails that attendance was  
17 generally five sessions per week. On a Monday morning  
18 it included the use of computers, on Wednesday there  
19 was baking, swimming on a Thursday morning, and you  
20 will see an analysis in the notes indicating why 13:16  
21 certain activities were being tried with P4 and  
22 recorded enjoyment of the session.

23  
24 Now, as I said to you I'm not, by using this  
25 illustrative example, and I was going to give you a 13:16  
26 number more just in the context of day care, not  
27 casting doubt on the strength of the belief evidence  
28 that you received, that's what the person believed was  
29 the position about their loved one and they told you

1 it.

2

3 But at least on this theme, and it may well be, we  
4 respectfully say it actually applies the across the  
5 themes, that what actually happened may have been

13:16

6 considerably different from what the person believed  
7 and recollected it to be in terms of what they  
8 explained to you in their evidence. And so, you

9 respectfully need to look at the notes and records,  
10 particularly on subjects that there is not really

13:17

11 debate to do with veracity or anything else, to

12 understand what was believed to be the position or what

13 recollection evidence that was given to you, the extent

14 to which that is in fact accurate. And that applies,

15 there are lots of examples in day care but the same

13:17

16 issue arises in respect of other themes.

17

18 And it is an issue about the care in making factual  
19 findings or determinations on general themes where the  
20 evidence has not been tested in that way. It's

13:17

21 uncorrected belief evidence which may not be consistent

22 with what's in the material and that that material

23 shows that the belief, however genuinely held, may in

24 fact be mistaken. And in fact the person could benefit

25 potentially from being aware that there was much more

13:18

26 activity with their loved one than they believe now was  
27 the case.

28

29 There are other illustrative examples of the same type,



1 I'm not going to deal with them now in view of the  
2 time.

3  
4 I am not going to be able to deal with Ennis in the way  
5 that I was. I want to show you one document which I am 13:18  
6 going to ask you to take into account. We've dealt  
7 with the subject in the written submission. If we can  
8 show page 165 to 167 on the screen. That's 165 to 167.  
9 This is a document that was at the very end of a  
10 witness statement that you obtained from someone from 13:19  
11 the PHA. And I'm not going to be able now to go  
12 through it in the detail that I wanted, but I am going  
13 to ask you to read the three pages.

14  
15 One of the points that we have made to you in the 13:19  
16 written submission is, while there was a lot of focus  
17 on the vulnerable adult process or the adult  
18 safeguarding process, you need, respectfully, to look  
19 at the wider process of which the vulnerable adult  
20 process was part. We have drawn out from the material 13:19  
21 that was subsequently provided a lot of the RQIA  
22 engagement which was not engagement but as part of the  
23 vulnerable adult or adult safeguarding process. If we  
24 can scroll down please.

25  
26 This is a meeting that's occurring between Ms Rafferty,  
27 who was then the Service Manager in 2012 and officials  
28 from the HSCB and PHA, Ms Kane and Mr Murray.  
29 Actually, as it turns out you have evidence from Mr

1 Brearty that Ms Kane was in fact one of the Mental  
2 Health Commission investigators, but she went in  
3 response to the report and Early Alert connected to  
4 Ennis.

5  
6 And you'll see, the memo wasn't opened during evidence  
7 with Ms Hynds or anyone else, and it's important we say  
8 it is examined. It gives you a snapshot of information  
9 that perhaps isn't available to you elsewhere, for what  
10 may no longer be remembered by those who were trying to  
11 give evidence about the matters at many years remove.

12  
13 If we just scroll down please to the next page? You'll  
14 see the conversation is a wider conversation, the PHA  
15 and HSCB have gone in the context of 'might this be a  
16 wider problem' and they are looking at that question.  
17 And you'll see that the Service Manager is not, in the  
18 information that she's providing, not restricting that  
19 information to just about the particular events that  
20 have prompted their attendance and there is a  
21 discussion back about other incidents that have  
22 occurred. And if we just scroll down a little she's  
23 obviously recounting the action taken. Just keep going  
24 down for me, please. Just pause there for a moment.  
25 And there may have been, given people are trying to  
26 remember back to events, an impression given to you  
27 that this was some sort of secret that was occurring.

28  
29 Now we've set out in the written submission all of the

1 people who were involved, but I'm drawing to your  
2 attention something that otherwise hasn't come out in  
3 evidence. You'll see that the hospital management of  
4 which the Service Manager was one, they were having a  
5 specific meeting with the Society of Parents & Friends 13:22  
6 of Muckamore in the context of the Ennis allegations.  
7 So I'm drawing your attention, there is material that  
8 perhaps casts a slightly different light on matters  
9 than may have been clear through the evidence sessions.  
10 I can't spend the time I was going to on that document, 13:22  
11 but I'm drawing it to your attention and asking you to  
12 look at it.

13  
14 This feels dreadfully inadequate but I just to want  
15 mention the word "safeguarding" and dealing with that 13:23  
16 in a couple of sentences isn't very suitable, but what  
17 I want to ask you to consider is the processes that are  
18 available within Trusts are generally borne out of  
19 whatever the regional framework is that's operating.  
20 There is obviously work being done in this area. You 13:23  
21 have heard all sorts of difficulties connected to the  
22 process, it tends to generate lots of documents.  
23 That's obviously an area that's very important. It is  
24 an area that is very important across the United  
25 Kingdom, it is probably something that you considering. 13:23  
26 But the Belfast Trust is alive to that and the fact  
27 that I am not dealing with it in any detail doesn't  
28 mean that it is not understood to be a very important  
29 issue that has to be addressed.

1  
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29

very briefly in open, sir, and I am again just going to deal with this in summary form and ask you to consider it. In paragraphs 12 and 13 of the PSNI closing submission, and it was repeated to you yesterday during the oral closing, I don't know if you have that to hand? But it appeared to be based on a mistaken premise or to misunderstand what the issue was or the difficulty that was being described to you in evidence. The issue wasn't about whether the Belfast Trust and its staff had information about any particular incident identified on CCTV. It obviously had that information. The issue was the extent to which officials within the Belfast Trust involved with the investigation, so that kept that information tight and who obviously did have it, the extent to which they were in a position to share that information or convey the detail of it to staff who were on the ground, such as the individual who became subject of some form of supervision and training, or the person acting as the supervisor of that person.

So the submission seemed to be suggesting the Belfast Trust was giving evidence that it was not being given the information, that is not the issue that was being addressed in the evidence. There is an obvious tension, and it's important I recognise that on behalf of the Trust, arising from concern not do anything to prejudice a criminal process in tightly controlling the

1 information flow and to allow the police to be the  
2 first to put something to an individual.

3  
4 As you heard, a way was eventually found to provide  
5 some information by way of broad themes, but when a 13:26  
6 police investigation takes as long as this one has and  
7 it results in staff being involved in the likes of  
8 supervision and training for an elongated period then  
9 there is an understandable difficulty that emerges if  
10 the information that can be provided is limited. 13:26

11  
12 There is, as you might expect, at times there is  
13 certainly copious, but it might be tortuous  
14 correspondence between the police and Belfast Trust on  
15 this issue and how it might be dealt with, and 13:26  
16 obviously that's correspondence that can be provided to  
17 you if that's a matter that you are interested in. But  
18 it's important, it was picked up by my clients who are  
19 particularly involved in this aspect, that what  
20 appeared to be being said was the Belfast Trust's 13:26  
21 position isn't what was being said to you in evidence  
22 and therefore, I'm flagging that to you.

23  
24 I want to just end the opening session trying to  
25 recognise that, you know, it's important how you've 13:27  
26 determined this should be done is fair to everyone.  
27 Nothing I have said today on behalf of the Belfast  
28 Trust which asks you to look at some difficult issues  
29 and to accept that there is a complexity and some

1 difficulty to be considered, it's very easy for it to  
2 be said at a very generalised way 'oh, everybody knew,  
3 everybody understood, this was being covered up'.  
4 Those are matters not borne out by the evidence. I  
5 respectfully say there is a very complicated issue at 13:28  
6 the heart of this, that you can contribute to, that the  
7 health and social care system is going to have to  
8 grapple with as, unfortunately what seems to be the  
9 case, more and more instances like this emerge. That  
10 is not to excuse any staff of the Belfast Trust who 13:28  
11 have behaved in the ways that they shouldn't. It's not  
12 to excuse any staff the Belfast Trust who should have  
13 reported things they saw. It's not to excuse any  
14 systems failures that resulted from the way the  
15 governance processes operated or didn't operate or the 13:28  
16 way in which things were responded to by this Trust.  
17 It will take whatever criticism that is due to it that  
18 you intend to give.

19  
20 But there is a significant issue underneath that, 13:29  
21 respectfully, you could contribute to knowledge and  
22 examination in respect of, and that's why I drew out  
23 the whorlton Hall example to sit alongside some of the  
24 evidence you have in respect of what occurred in  
25 Muckamore. 13:29

26  
27 Nothing that I have said this morning and into this  
28 afternoon is to dilute in any way from the Belfast  
29 Trust's acceptance that the abuse of patients, patients

1 it is responsibility for in one of its hospitals is  
2 completely unacceptable and will always be  
3 unacceptable. That does not mean the Belfast Trust  
4 will get everything right in how it responds. There is  
5 a huge amount of work to be done trying to rebuild 13:29  
6 trust with families that are understandably extremely  
7 damaged by how their loved one was abused and nothing I  
8 say, asking you to consider these issues, takes away  
9 from the apology and recognition that the Belfast Trust  
10 has tried to convey over and over again, that it 13:30  
11 understands this was not acceptable, nothing that I'm  
12 saying is to suggest in any way that it was.

13 CHAIRPERSON: Thank you. Would you now like a short  
14 restricted session.

15 MR. AIKEN: Yes, very short. 13:30

16 CHAIRPERSON: Because as I understand it, you now wish  
17 to refer to the term that is in fact already under  
18 Restriction Orders, nevertheless I will make a  
19 Restriction Order in relation to what follows for  
20 obvious reasons. 13:30

21  
22 That means that the only people who may remain in the  
23 room are obviously the lawyers present, the Inquiry  
24 staff, and any CP who has signed a Confidentiality  
25 Agreement. Anybody not falling into those categories 13:30  
26 must, I'm afraid, leave the room now and the feed to  
27 Room B will be cut. I forgot to ask this yesterday,  
28 but I'll ask the solicitor to the Inquiry to draw up a  
29 Restriction Order to cover both yesterday and today.

1           Could that now take place, if there is anybody in the  
2           room who ought not be here? There is no movement.

3  
4           THE HEARING ENTERS RESTRICTED SESSION

5  
6           OPEN SESSION

7  
8           MR. AIKEN: Sir, can I just, as with the nature of  
9           these things, my Junior has identified a mistake that I  
10          made? 13:45

11          CHAIRPERSON: That's the job of Ms King.

12          MR. AIKEN: well this particular Junior is very good at  
13          that and I am grateful for it and has lots of  
14          opportunity thankfully with the produce she --

15          CHAIRPERSON: Tell us what it is. 13:45

16          MR. AIKEN: when I was describing to you in rather  
17          swift and truncated form the walk around that Ms  
18          Mitchell was doing in May and July 2017, I indicated to  
19          you that the Director that she was walking around with  
20          was Marie Heaney. The Director she was actually 13:45  
21          walking around with was Cecil Worthington and Marie  
22          Heaney came after Mr Worthington had retired. So it's  
23          important that I, given that was on the public record,  
24          that I draw that to your attention.

25          CHAIRPERSON: well spotted, thank you very much indeed. 13:45  
26          10 o'clock on Monday, thank you very much.

27  
28          THE INQUIRY ADJOURNED UNTIL 10.00AM ON MONDAY, 10 MARCH  
29          2025