MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON, MONDAY, 3RD MARCH 2025 - DAY 121

121

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

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1 THE INQUIRY CONTINUED ON MONDAY, 3RD MARCH 2025 AS
2 FOLLOWS:
3
4 CHAIRPERSON: Good morning, and welcome back and I'm
5 sorry for the slightly delayed start. 10:17
6
7 Before we start to hear the closing statements of
8 counsel can I welcome everybody back. It's been quite
9 an extended break of course since October last year and
10 it's good to see so many people in the public gallery 10:17
11 and you're all very welcome.
12
13 Can I respectfully remind everyone of the rules of the
14 use of this room: Please no drinks, obviously other
15 than water, but no use of telephones. And if you can 10:17
16 please avoid moving around too much while counsel are
17 speaking. If you do need to pop out, could I ask
18 everyone to do that as quietly as possible, simply
19 because the microphones are very sensitive and they
20 will pick up other sounds. If you do want to use 10:18
21 telephones, then there's a slightly more relaxed regime
22 in Hearing Room B, although obviously if you are using
23 that room please be aware of those around you and be
24 sensitive to their needs.
25 10:18
26 Could you also remember that when we do finish, Hearing
27 Room B is three minutes behind us because there's a
28 delay, so could you give them the peace and quiet to
29 finish watching the proceedings.

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1
2 We have our excellent counsellors present both in this
3 room and in Room B so if anybody would like to avail
4 themselves of their services as a result of anything
5 they hear in these closing submissions or for any 10:18
6 reason, they wear a yellow lanyard, you will probably
7 all know them by know, but please do be free to speak
8 to them.
9
10 Just a reminder that the press and media are also 10:19
11 present, they too are very welcome but please can I ask
12 them to ensure that they respect people's privacy while
13 here in the building. Obviously no interviews should
14 be conducted in any public part of the building.
15 10:19
16 Could I remind counsel that their remarks are not only
17 being live streamed, but also they will be on a
18 transcript published on the Inquiry's website.
19 It's the duty of counsel to avoid referring to material
20 which has been restricted from publication under a 10:19
21 Restriction Order. Restrictions on patient and staff
22 names in particular must please be very carefully
23 observed.
24
25 Everyone in the room is, of course, aware that we've 10:19
26 managed to run this Inquiry simultaneously with
27 criminal court processes and a police investigation
28 ongoing. I don't want to prevent anyone from saying
29 what they feel they should; it is important, however,

1 to be aware of the particular and perhaps unusual
2 circumstances in which we operate, namely that there
3 may be a criminal trial in the relatively near future.
4 If counsel feel that any of their remarks are going to
5 stray into territory which could directly prejudice 10:20
6 those proceedings, please save such remarks for a
7 restricted session when such sensitivities will no
8 longer apply. But that being said, this is an Inquiry
9 into the abuse of patients at Muckamore and it's
10 understandable that the families of patients at 10:20
11 Muckamore will expect that to be reflected publicly in
12 the statements we will be hearing over the next few
13 days.
14
15 This morning we're going to hear closing statements on 10:20
16 behalf of Action for Muckamore and the Society of
17 Parents and Friends of Muckamore and this afternoon the
18 statement on behalf of Core Participants in Group 3,
19 the relatives and patients not affiliated to those two
20 societies represented by O'Reilly Stewart solicitors. 10:21
21
22 Tomorrow we will be hearing from counsel on behalf of
23 the PSNI and RQIA and also from the Department of
24 Health.
25
26 On Wednesday we'll be hearing from counsel on behalf of
27 the Belfast Trust.
28 The patient and client counsel have provided helpful
29 written submissions which have been circulated to CPs

1 but they have elected not to make an oral closing
2 statement.
3
4 And finally on Monday of next week we'll be hearing
5 from Mr. Doran KC, counsel to the Inquiry. 10:21
6
7 We start with Ms. Anyadike-Danes, Kings counsel.
8
9 CLOSING SUBMISSION OF MS. ANYADIKE-DANES
10 10:21
11 MS. ANYADIKE-DANES: Thank you very much. My name is
12 Monye Anyadike-Danes, senior counsel, I am assisted
13 junior counsel, Aidan McGowan, Amy Kinney and Hanna
14 Cullinan. We are instructed by Clare McKeegan and
15 Sophie McClintock of Phoenix Law. Together we act for 10:22
16 46 clients who are either affiliated to Action for
17 Muckamore or are members of the Society of Patients and
18 Friends of Muckamore and the Inquiry has referred them
19 as Core Participant Group 1 and Core Participant Group
20 2. 10:22
21
22 The body keeps the score.
23
24 This Inquiry was prompted by families who had been told
25 their vulnerable loved ones had been abused while they 10:22
26 were in Muckamore Abbey Hospital and under the
27 responsibility of Belfast Health and Social Care Trust.
28 There are some loaded words in that statement, firstly,
29 vulnerability. They had mental health issues, learning

1 disabilities and many were non-verbal, their
2 vulnerability was clear and is indisputable.
3
4 Secondly, loved. They were and are loved, the
5 commitment, perseverance and attention of their 10:23
6 families, who in many cases organised their lives
7 around visiting them to ensure they remained a part of
8 the family and received the care they required is an
9 abiding statement of that love.
10 10:23
11 thirdly, hospital. They were invariably admitted
12 during a time of crisis in their lives to what was a
13 specialist mental health and learning disability
14 hospital whose task was to assess, diagnose, treat and
15 care for them. 10:23
16
17 Fourthly, trust. The families trusted, desperately
18 wanting their loved ones to be helped and hoping and
19 believing they had been admitted to a place which would
20 do precisely that. 10:23
21
22 Fifthly, abuse. They were abused, physically,
23 sexually, psychologically, emotionally, neglected,
24 mis-diagnosed, inappropriately medicated and had their
25 property interfered with and that is the evidence of 10:24
26 them and their families.
27
28 So in that single statement is all the hope, belief and
29 expectation of the families as well as, so far as they

1 are concerned, the gross violation of trust and failure
2 of responsibility by the authorities. And in many
3 cases, it's that juxtaposition that has so inflamed
4 families and spurred them to take the action which has
5 brought about this Inquiry. But that's not the end of 10:24
6 it. What needs to be fully and properly understood by
7 all who had a hand in those alleged breaches and
8 failures, or who could and should have prevented them,
9 is the sheer extent of the harm that was done and it's
10 difficult to convey in words the abuse -- and it's 10:24
11 sometimes easy to get used to that reference to abuse,
12 but in a very real sense the body keeps the score.
13 There are permanent scars on bodies that stand as a
14 testament to the abuse inflicted and there are also
15 other impacts of the trauma suffered, different 10:25
16 scarring but just as enduring, which find expression in
17 altered behaviour and changes in mental and emotional
18 health. The families also have their own scars and
19 forever changed.
20
21 To have willingly taken your loved one to be cared for
22 in a specialist hospital at a time when, despite your
23 best efforts, you could no longer keep them safe, to
24 have voluntarily relinquished control with the
25 imposition of a Detention Order and then to be told 10:25
26 that they were subjected to abuse while there, well
27 that's a heavy burden for families to bear and some
28 have been absolutely heartbroken by it.
29

1 But even that is not all, the families and indeed the
2 public now know far more about what happened. The
3 Review Team for the Way to Go Report published back in
4 November 2018 watched just 20 minutes of CCTV. The
5 PSNI have reviewed 300,000 hours as part of the 10:25
6 Operation Turnstone. Designated Adult Protection
7 Officers also saw the same footage as the PSNI and
8 subsequent CCTV footage that also captured abuse, a lot
9 has been seen.
10 10:26
11 For over a year the families have heard from those who
12 had the responsibility to meet the needs of their loved
13 ones and establish the structures, processes and
14 systems that would ensure that they were properly cared
15 for and protected and, in listening to all of that, 10:26
16 their overriding need was to know that whether in
17 Muckamore, and some of them are still there, in a
18 community placement or admitted to a hospital during a
19 crisis, the needs of their loved ones would be properly
20 met, they would be cared for and, above all, they would 10:26
21 be safe and the evidence they have heard has not
22 convinced them.
23
24 The stark and distressing reality for many families is
25 that the care provided to their loved ones continues to 10:26
26 be deficient and they continue to be at significant
27 risk.
28
29 So they seek from this Inquiry that most important of

1 the objectives in its Terms of Reference: To ensure
2 that such abuse does not occur again at Muckamore or
3 any other institution providing similar services in
4 Northern Ireland.
5
6 Many of them now have no choice but to entrust the care
7 and wellbeing of their loved ones to some community
8 placement, and whilst they remain hypervigilant, they
9 are only too aware that that cannot be sustained
10 indefinitely and certainly not as they get older. 10:27
11
12 Therefore, they need to know their loved ones will be
13 looked after and safe when they can no longer intervene
14 to protect them and the public needs to know that the
15 vulnerable people in our society will be looked after 10:27
16 and safe and with a proper chance to live a good life.
17
18 Our clients' combined experience of Muckamore spans
19 nearly 75 years amounting to from within a year of
20 Muckamore's existence to the present day. That 10:28
21 experience covers patients who were without exception,
22 and that is their evidence, were abused in Muckamore,
23 some of whom have died there and others that are still
24 awaiting to be resettled into the community. And just
25 about every issue this Inquiry has explored is one 10:28
26 about which our clients and their loved ones have
27 direct knowledge and they are the true experts on how
28 Muckamore operated.
29

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The three core objectives of the Inquiry are set out in its Terms of Reference: Examine the issue of abuse of patients in Muckamore; determine why the abuse happened and the range of circumstances that allowed it to happen; ensure that such abuse does not occur again at Muckamore or any other institution providing similar services. And to meet that objective the Inquiry has heard evidence in four broad phases: The patient experience phase, evidence modules phase, staff phase and the organisational module phase and we make these submissions on behalf of our clients in the light of the evidence that has been heard during those phases.

It's simply not possible to provide the Inquiry with a detailed or comprehensive analysis of the evidence in relation to those core objectives. Nevertheless, we have sought to highlight the key points from our clients' perspective.

It's worth noting at the outset the general tenor of the evidence which was markedly different as between those four phases. The patient experience phase recounted extensive and widespread abuse and neglect of extremely vulnerable individuals with accountability and oversight mechanisms being completely inadequate and ineffective to identify or prevent the abuse.

The modules phase identified a system in which such

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1 abuse and misuse of power apparently shouldn't have
2 been possible.
3
4 During the staff phase many staff witnesses, with some
5 notable and very telling exceptions, sought to portray 10:29
6 a picture of Muckamore as a hospital at which nothing
7 was particularly wrong other, and that was an important
8 one, other than staffing issues.
9
10 The organisational module phase in large part heard 10:30
11 accounts from organisations that clearly do not seem to
12 acknowledge, accept or understand their
13 responsibilities for the abuse that happened at
14 Muckamore, with most seeking to shift the blame or
15 responsibility to others, especially to their 10:30
16 subordinates.
17
18 This last point in encapsulated most tellingly in the
19 statement of Cathy Jack who was the Chief Executive
20 Officer of the Belfast Trust. She said: 10:30
21
22 "It does not follow that because the Trust Board or
23 Executive Team or Directive level or hospital level
24 staff did not know that patients were being abused in
25 Muckamore in 2007 that this means there were not 10:30
26 effective structures and processes in place capable of
27 ensuring adequate oversight of Muckamore by the Trust
28 Board. Any governance system, no matter how well
29 developed and comprehensive, relies on individuals

1 doing the right thing. Each time an individual nurse,
2 doctor, manager or colleague failed to further inquire
3 or escalate a concern that they should or did have,
4 when they could and should have, then that also
5 unfortunately means that the governance systems of the 10:31
6 Belfast Trust failed as a consequence."
7
8 Well one would have thought that a governance system
9 should be designed to precisely identify when
10 individuals don't do the right thing. In any event, 10:31
11 the message was that it was the fault of the individual
12 nurse, doctor, manager and ultimately Director of
13 Service who failed to tell the Board. In many ways for
14 our clients the most concerning thing going forward is
15 the failure of the management within the Trust, the 10:31
16 RQIA and the Department to acknowledge, accept or
17 understand their responsibility for the abuse at
18 Muckamore. And even when they did understand that they
19 had a responsibility, they seemed unable to recognise
20 the corollary of being responsible was taking 10:32
21 responsibility when things go wrong and things most
22 certainly did go wrong. And yet it will not have
23 escaped attention that no one at senior level has been
24 sacked or resigned, whether the Trust who had charge of
25 Muckamore, the RQIA who was a regulatory body, or the 10:32
26 Department whose stated mission is to improve the
27 health and social wellbeing of the people of Northern
28 Ireland, or even a Minister who has statutory
29 responsibility for the direction and control of the

1 Department, and this is despite it being widely
2 reported that there were systemic failures and the
3 system was dysfunctional. That's not just our clients
4 evidence. Rather the hit has almost exclusively been
5 taken by frontline staff. At the opening of this 10:32
6 Inquiry it was reported that 83 staff had been
7 suspended, with seven sacked, there had been 34 arrests
8 with eight charged and since then there have been more
9 arrests and more prosecutions, but still, so far it has
10 been reported not anyone at senior level. 10:32
11
12 In those circumstances families have little hope, my
13 clients, that the Trust, RQIA or the Department are
14 capable on their own of implementing the necessary
15 changes to prevent such abuse. Therefore, the 10:33
16 Inquiry's recommendations and its actions into the
17 future to follow up and monitor the proper
18 implementation of its recommendations become even more
19 important. And we address some of those areas in which
20 our clients invite the Inquiry to make recommendations 10:33
21 and we've provided the Inquiry with a summary of them
22 as Appendix 1. I am not going to open the appendices
23 we have provided. We have provided those documents to
24 the Inquiry to assist.
25 10:33
26 So let's start with core objective one, examining the
27 issue of abuse of patients and let's go to the gravity
28 of that abuse.
29

1 Our clients consider the abuse at Muckamore was
2 horrendous, prolonged and widespread throughout the
3 hospital and they hope that all the evidence that has
4 been received will have persuaded the Inquiry of the
5 magnitude of abuse that occurred at Muckamore. 10:34
6
7 Now, we have provided the Inquiry separately with an
8 analysis of evidence at Appendix 2. Entirely separate
9 and consistent accounts of abuse were repeated day
10 after day during the patient experience phase, whether 10:34
11 from my clients or others.
12
13 Cathy Jack referred to:
14
15 "Some of the items of abuse that I witnessed on CCTV 10:34
16 footage were deliberate acts of force or taunting to
17 trigger vulnerable patients."
18
19 Which is an extraordinary thing for a chief executive
20 of an organisation to say. And she makes the point 10:34
21 that some of those instances occurred when the CCTV
22 captured sufficient staffing, so there was enough staff
23 there. And those who did watch CCTV footage have been
24 changed by the experience.
25 10:35
26 On the 2nd of November 2023 the Inquiry indicated its
27 intention to conduct a holistic examination of the
28 facts adopting a suitably appropriate, proportionate
29 approach in order not to lose sight of the larger

1 picture. It is not possible to detail every incident
2 of alleged abuse in this closing submission, there are
3 just too many. However, when the Inquiry makes its
4 findings on the larger picture it's important that the
5 specific pain inflicted on individual patients is not 10:35
6 lost or passed over and our clients, therefore, wish to
7 remind the Inquiry and the public who may be watching,
8 of the reality of abuse they experienced through a few
9 specific instances.
10 10:35
11 The Inquiry will be aware of the very considerable
12 evidence it has received from our clients, Trust staff,
13 across a full spectrum of abuse as defined in the Terms
14 of Reference and there are other examples that are
15 covered by Restriction Orders and so cannot be 10:36
16 described in an open session. However, our clients
17 believe there is enough in the unrestricted material to
18 bring home the nature of abuse that they say they
19 suffered and that has so deeply affected the lives of
20 them and their loved ones and which lies at the heart 10:36
21 of the centre of this Inquiry.
22
23 Let's start with admission and detention. The abuse
24 perpetrated at Muckamore started with emotional abuse
25 on admission. Many families gave similar and 10:36
26 consistent evidence of being told they were not
27 permitted to accompany their loved ones onto the ward
28 or to visit or see their loved ones for periods of
29 weeks or months, ostensibly to allow their loved one to

1 settle in, and this was incredibly distressing to the
2 patients and families. Such an approach caused trauma
3 from which many have not recovered. Yet this issue did
4 not even feature on the radar of staff or management of
5 Muckamore or within the Trust or Department. When 10:37
6 questioned about this policy, Dr. Milliken, who was a
7 consultant psychiatrist and Clinical Director from 2005
8 to 2018, appeared oblivious to it, seemingly having no
9 awareness of the trauma and harm it caused.
10
11 P16's parents tried to visit him at Christmas but were
12 turned away and it was the first Christmas they had not
13 been together as a family. They went back to the car
14 and literally cried their eyes out.
15
16 P124's mother told of how she was not allowed to settle
17 her 11 year old son into his bedroom and was forced to
18 leave while he cried out for her to stay.
19
20 P119's sister recalls how she and her mother were 10:37
21 blocked by a nurse as they went to follow P119 into
22 Muckamore. They were not allowed to visit for 12
23 weeks. He had never been away from home before and his
24 mother was distraught.
25
26 Such conduct exacerbated a time of crisis. Moreover
27 there was a persistent failure to explain to families
28 the purpose or the basis of admission, provide a
29 prognosis, treatment plan, explain their rights or

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1 explore effective alternatives to admission. Many
2 families, my clients, gave evidence that they expected
3 their loved one to be admitted for just a few weeks of
4 assessment and stabilisation, only to find they would
5 remain for years and in some cases a lifetime. And 10:38
6 despite this, there was no admissions protocol until
7 2020.
8
9 Many so-called voluntary admissions occurred simply
10 because the family felt they had no option but to agree 10:38
11 to admission. In our clients' experiences the
12 significance of formal admission was rarely explained
13 to them, who simply felt as though they had lost all
14 say over their loved ones' circumstances. And when it
15 came to Mental Health Tribunals they found the process 10:38
16 confusing and inaccessible with a lack of proper
17 advocates with the requisite expertise to provide
18 effective representation for them.
19
20 P119's mother told the Inquiry about going with her 10:39
21 husband to a Mental Health Tribunal with optimism,
22 hoping to take her home, overnight visit or even a
23 short holiday, but they were not admitted to the
24 hearing and their views were not heard. She left her
25 crying because her role as a mother, she felt, had been
26 taken from her.
27 CHAIRPERSON: Just for the transcript that is P119.
28 MS. ANYADIKE-DANES: I beg your pardon, P119.
29

1 Then physical, sexual, emotional abuse and for some
2 this is the heart of it. Our clients gave evidence of
3 the nature and extent of abuse and neglect at Muckamore
4 and, in doing so, they described the physical injuries
5 sustained by their loved ones, the psychological and 10:39
6 emotional abuse as well as the neglect of their care
7 and basic needs.
8
9 P124's mother told of the bruising to his neck which he
10 showed her had happened when he was held down with a 10:40
11 foot on his neck. And he also told of staff making him
12 crawl up a hill on his hands and knees.
13
14 P909's nephew recounted how she sustained a broken leg
15 in 2012 and no credible explanation provided by the 10:40
16 staff of how it had happened.
17
18 P128's parents told of a time when his privates were
19 bruised so badly that they turned black and, despite
20 the police being called, nothing ever seemed to come of 10:40
21 the investigation.
22
23 Other families recounted many, many other incidents of
24 a distressing nature.
25 10:40
26 Some staff did report abuse but did not seem to see
27 that they got much of a result in terms of appropriate
28 action.
29

One example is Shelly Crawford, an occupational therapist, she reported a member of staff booting a patient up the backside and swearing at him, only to be told 'OT's don't understand banter at Muckamore'.

Additionally the evidence of our clients is that their loved ones were subjected to emotional abuse and threatened.

P60 was teased about his much loved father dying. He was also the victim of a sectarian attack, the impact of which prompted his admission to Muckamore. His sister describes how he was subjected to further sectarian abuse when in Muckamore, which staff failed to stop. Another patient would go into his room and use sectarian language and beat him up in his room. This patient would call him a Fenian bastard and this was the language which was used when he was beaten up at the age of 21 years. That patient said he knew this because H512, who was a member of staff, had told him and this language was a trigger for P60.

This was not an isolated event, nor a hidden one, as is clear from the evidence of James Wilson, a team leader for a bespoke living facility for Muckamore patients who also worked in Muckamore. He refers to another patient who was known to be triggered by paramilitary references being intentionally taunted by references to 'get the boys in to shoot his knees' and 'the boys are

1 coming for him'.
2
3 The lack of supervision and neglect
4
5 There were patients who were assessed as requiring 10:42
6 one-to-one or two-to-one supervision to keep them safe
7 and they were left alone, sometimes locked in a room
8 for hours. This sometimes led to patients injuring
9 themselves, choking, or absconding. However, the
10 presence of staff didn't necessarily mean patients were 10:42
11 receiving attention. Some were being captured on CCTV
12 apparently ignoring patients, focusing on their phones,
13 chatting or refusing to help when it was clearly
14 needed.
15
16 P90's sister stated that on 25th February 2022 he was
17 left alone in a sensory room for two hours. In that
18 time he managed to take the cord from his joggers, tied
19 it around his arm to the point where he caused bruises
20 and bleeding. There was also a point where he was down 10:43
21 on the floor banging his head repeatedly. From the
22 CCTV it appeared that the staff were in a different
23 room talking and they were unable to observe him, which
24 according to his care plan is what they should have
25 been doing, from where they were and consequently he 10:43
26 was left unsupervised for about two hours with staff
27 only entering the room on a couple of occasions for a
28 minute.
29

1 It's also clear that personal hygiene needs were
2 ignored. P124's mother said that she and his father
3 were allowed into his room when he was in Erne.
4
5 "At times we found his bed had been made but there was 10:43
6 a strong smell of urine. I checked the bed and it was
7 soaking. This had been left for him to get back into
8 that evening. There were also times when we collected
9 him and we would find human faeces on him."
10
11 P90's sister states:
12
13 "He is and always has been completely dependent upon
14 carers for toileting and personal hygiene. I always
15 hoped that this was being done correctly but sometimes 10:44
16 during visits I noted faeces under his fingernails and
17 tips of his fingers and I have had to ask staff to wash
18 his hands and cut his toenails."
19
20 The failure to address something as basic as toenails 10:44
21 was widespread.
22
23 P105's mother states:
24
25 "There was also a lack of proper attention to his feet 10:44
26 and toenails which got into a terrible state. At one
27 stage his feet were covered in blisters and his heels
28 were cracked. His toenails were frighteningly long.
29 He had a fungal nail infection and at one point he lost

1 a toe nail."
2
3 P77's mother's evidence was his toenails were so long
4 that they grew over the top of his toe and curled at
5 the back. It wasn't the shoes that were the problem, 10:44
6 it was his toenails.
7
8 Medical neglect
9
10 Our clients consider that there was serious medical 10:45
11 neglect at Muckamore, which is an astonishingly thing
12 to say about a specialist hospital. The Inquiry heard
13 from P109's mother about how she suffered a severe
14 adverse reaction to prescription medication that was
15 persistently and wrongly diagnosed by staff as scabies 10:45
16 and it was only through the rigorous efforts of P109's
17 mother, which included taking her to the Accident &
18 Emergency Department, that it was eventually recognised
19 to be an adverse reaction from her Lamotrigine
20 medication which was then stopped. 10:45
21
22 P116's mother recounted a similar experience. He
23 suffered a severe deterioration from his health from
24 December 2016 with bleeding from his back passage and
25 substantial weight loss. She was desperate for him to 10:45
26 be seen by a doctor as she knew something was very
27 wrong but she was met with indifference and her
28 complaints were ignored. It wasn't until August 2017,
29 after she telephoned the Royal Victoria Hospital and

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1 begged a secretary there to get P116 an appointment and
2 had telephoned 999, that P116 was finally diagnosed as
3 having tuberculosis.
4
5 The evidence of P118's mother provides a further 10:46
6 example. In or around 2015 he was suffering from
7 chesty cold. She repeatedly asked the staff to call a
8 doctor and staff repeatedly failed to do so. It was
9 only when she insisted that she wasn't leaving until a
10 doctor was called that staff finally did call a doctor. 10:46
11 The doctor had P118 admitted to Antrim Area Hospital
12 where he was diagnosed with double pneumonia and spent
13 four days in ICU.
14
15 Dental neglect 10:46
16
17 The evidence indicates that the dental care of my
18 clients provided at Muckamore was appalling. P115's
19 father states:
20
21 "When he was first placed in Mallow his teeth were
22 inspected by a dentist, told me his teeth were fine.
23 In or around 2008 or 2009 he had to be referred to the
24 Royal Dentistry Department. I asked for this referral
25 as I could tell that he was in pain as when he was 10:47
26 eating he would lash out. We were seen by a dentist
27 who said that he needed several fillings and that he
28 had two impacted wisdom teeth which were infected. I
29 couldn't understand how this could have been allowed to

happen as a dentist in Muckamore said there was nothing wrong with his teeth."

P34's sister who states:

"His dental record in May 2023 details how he had to have two teeth extracted and had to receive seven new fillings. I remember how past and present I would have said to staff about supporting him in brushing his teeth, however I felt they always used the excuse that he wouldn't let them do it."

The evidence of P77's mother is in similar vein. She recounted that in 2018 the dentist telephoned her and asked for permission to do work on his teeth. The dentist advised her that P77's teeth had not been cleaned in years. Before he went to Muckamore she had ensured his teeth were brushed every day by doing it herself.

The Inquiry will be aware that many of these patients simply can't do something as basic as brush their teeth themselves.

Nutrition

Our clients view is that staff simply did not seem to recognise the importance of proper nutrition and refused to listen to the input of families in relation

1 to it. There are numerous examples from our clients of
2 their loved ones either gaining or losing too much
3 weight in the absence of any proper meal plan. Others
4 gave evidence of special requirements that were simply
5 ignored. 10:48
6
7 P77's mother brought flax seeds for her son because he
8 had a constipation problem and asked for these to be
9 sprinkled on his breakfast. On one occasion she
10 brought a new packed of flax seeds only to be told by a 10:49
11 member of staff to stop bringing them in because they
12 had 12 boxes in the kitchen already. Staff had simply
13 ignored her request to use flax seeds in P77's
14 breakfast as she had asked.
15 10:49
16 Inappropriate and overmedication
17
18 Our clients consider the approach to medication at
19 Muckamore was terrible. Staff placed heavy and, from
20 their point of view, inappropriate reliance on 10:49
21 medication to manage patients' behaviour because they
22 didn't have the knowledge, ability, willingness or time
23 to use alternative therapies such as positive
24 behavioural support. Worse, often it was the actions
25 of staff that triggered the deterioration of patients' 10:49
26 behaviour. Sometimes this was because staff lacked
27 learning disability experience and didn't know how to
28 provide proper care. But the evidence also shows some
29 staff intentionally sought to wind patients up for

1 apparent amusement.
2
3 Moreover, the general lack of staff meant patients were
4 deprived of activities to reduce the long periods of
5 boredom when they had nothing to do and no one to 10:50
6 interact with. There was also insufficient staff of
7 the right mix and seniority to properly manage the
8 wards and some staff had inadequate training or
9 experience to look after patients when they were at
10 their most challenging, and many of them were very 10:50
11 challenging, which is why they were in Muckamore, many
12 of them, in the first place.
13
14 In our clients' view the effect of this was an increase
15 in the use of PRN medication. Yet, Dr. Milliken, the 10:50
16 Clinical Director, acknowledged that PRN usage was not
17 subject to any trend analysis at Muckamore which would
18 have been helpful and one would have thought obvious.
19
20 P118's mother stated she felt he was very sedated with 10:50
21 the amount of medication that he had been prescribed.
22
23 "I felt this was a means of managing him rather than
24 treating him and this greatly annoyed me because very
25 often the staff do things to trigger P118's behaviour 10:51
26 in the first place and then they say that medication or
27 seclusion are necessary to control behaviours which
28 staff themselves have caused."
29

1 P90's sister said:
2
3 "It's my opinion that PRN was used as a first response
4 as opposed to the nurses using positive behavioural
5 support. I was advised on the 8th August 2022 by a 10:51
6 member of staff during a telephone conversation that
7 lazy staff on the ward were using PRN medications as a
8 first line management for his agitation outbursts and
9 that is contrary to his care plan."
10 10:51
11 The evidence of our clients is also that their loved
12 ones were inappropriately medicated. Serious errors,
13 so far as they were concerned, were made with
14 medication and administration was continued despite
15 extensive side effects affecting the quality of their 10:52
16 lives. They remained on medications for unduly long
17 periods of time and records were not properly kept.
18 Muckamore often remained unconvinced until families
19 were able to enlist the support of clinicians in other
20 hospitals or in more specialist disciplines about the 10:52
21 inappropriateness of medication.
22
23 Whilst the Inquiry has had evidence from staff and the
24 Trust that now supports much of what our clients have
25 told the Inquiry, that wasn't the experience of our 10:52
26 clients at the time abuse took place, which is when
27 they really needed the support. They felt they were
28 not listened to and were unsupported when they raised
29 legitimate concerns about medicalising, too much

1 medication, inappropriate medication, and a tendency to
2 rush prematurely to use PRN. All too often there was a
3 lack of respect for their knowledge and experience
4 about situations that triggered heightened behaviour
5 and calming techniques that were effective. The 10:53
6 pervading view seemed to be that clinicians and nurses
7 knew better. The evidence of my clients suggest that
8 very often they didn't.
9
10 Restraint and seclusion 10:53
11
12 The evidence of our clients is that there was an
13 overreliance on the use of restrictive practices such
14 as restraint and seclusion and that these practices
15 were regularly used as a form of punishment to instill 10:53
16 fear in patients or compliance.
17
18 They gave evidence of their loved ones being injured
19 whilst they were physically restrained.
20
21 P77's aunt and P115's father both refer to their loved
22 ones having broken and injured toes without any
23 adequate explanation of how that could have happened.
24
25 In relation to seclusion, P120's father stated his son 10:53
26 told him about the seclusion room in Muckamore. On one
27 occasion he was put in the corner of the seclusion
28 room, slapped across the head and had cold water thrown
29 on him. He said it was a padded room and staff would

1 call it the naughty corner. He believes it was used as
2 a punishment. P120 would be sat in a single chair and
3 locked in the seclusion room. He cried to get out and
4 the staff would say that P120 was being very bad. P120
5 was subjected to the seclusion room many times. 10:54
6
7 P124's mother said:
8
9 "I would ring PICU to get an update and quite regularly
10 would be told that he was in seclusion. I would have 10:54
11 contacted the ward two or three times a day. I would
12 feel upset each time because I knew how distressed he
13 would have been due to being put in seclusion. He told
14 me he hated the seclusion room. He does not like to be
15 on his own and this would have been a terrifying 10:54
16 experience for him as he just wouldn't have understood
17 why he was being put into the room. It was not at all
18 exceptional for staff to use seclusion."
19
20 It's clear our clients' loved ones, so far as they are 10:55
21 concerned, did not receive adequate care and support
22 whilst in seclusion and that the conditions of the
23 seclusion room did not ensure the safety, wellbeing and
24 dignity of patients.
25
26 P60's sister said he was locked up, he was put in
27 seclusion, he wasn't fed, he wasn't allowed to go out
28 to the toilet, you wouldn't treat an animal like that.
29

1 P109's mother provided a vivid description of a dark
2 corridor to the seclusion room.
3
4 "I was shocked by what I saw. The room was about three
5 and a half foot wide and it was more like a cupboard. 10:55
6 There was only a large leather chair inside which took
7 up most of the room. The room was very dark, there was
8 no window. It was a dismal small, cold, dark room and
9 not therapeutic in any way."
10 10:55
11 Interference with finances and property
12
13 So far as our clients are concerned, the evidence on
14 patients' property was similarly scandalous. There
15 were numerous consistent accounts of staff failing to 10:56
16 take adequate care of patients' money and property and
17 being completely indifferent to patients' interest in
18 having the benefit of their own belongings or even
19 something a simple as being dressed in their own
20 clothes. 10:56
21
22 Worse still, the evidence indicates that staff
23 regularly misappropriated and stole patients'
24 belongings, that is our clients' evidence. The
25 evidence of staff using patients' money to buy takeaway 10:56
26 food for themselves and of patients' property such as
27 toys, clothing, aftershave, cigarettes, CDs, phones,
28 radios, games consoles and of substantial amounts of
29 money as having gone missing is striking in its

1 consistency. These items were often specifically
2 chosen and bought for patients to be a reminder that
3 they were cared for by their families and when families
4 asked where these items had gone or complained about
5 their loss, they say they were met with obfuscation or 10:57
6 silence.
7
8 Brendan Ingram, Business Manager, confirmed that there
9 was a policy on patients' finances at Muckamore before
10 2021. However, Jan McGaw, the senior Service 10:57
11 Improvement Manager, gave evidence that the day-to-day
12 financial procedures weren't as tight as the policy
13 suggested that they should be. The financial
14 management procedures appeared to be out of date and
15 there was a need for review. 10:57
16
17 If we look at how from our clients' evidence money was
18 kept. Staff kept some patient money in locked drawers
19 on the ward and this was used by patients themselves if
20 there was something they wanted to buy such as a snack, 10:57
21 but it was also used by staff to purchase things on
22 behalf of the patient. The Panel asked Miriam
23 Somerville, the Director of Learning Disability for the
24 hospital and community services, about the extent to
25 which there was a failsafe accounting system. Her 10:57
26 response amounted to the patient would come and ask
27 either their named nurse or the Ward Manager for a
28 certain amount of money and that would be noted in an
29 envelope. Well, that of course doesn't exclude the

1 possibility of staff misappropriating a patient's money
2 and simply noting on the envelope as having been given
3 to the patient, so that cannot seriously be regarded as
4 an adequate accounting system.
5 10:58
6 Rona Shaw, the Deputy Director of Nursing, Quality,
7 Safety and Patient Experience, and confirmed that to
8 her knowledge what the money kept in the drawers was
9 spent on was not formally monitored and that prior to
10 2021 there was no policy around keeping money on the 10:58
11 ward, it was only custom and practice.
12
13 The reality is that there was insufficient and
14 inadequate oversight of patients' money, that is our
15 clients' very firm view. Families asked for receipts 10:58
16 of how money was being spent but found proper records
17 were not kept. Families also often were asked for more
18 money with no proper explanation as to how money
19 already provided had been spent. There were also
20 concerns that patients' money was inappropriately spent 10:59
21 by staff. And Shelly Crawford also gave evidence that
22 most service users were issued with comfort chairs that
23 they paid for themselves. They should not have paid
24 for this. As this was an assessed need the Trust would
25 have to meet their needs would have provided the 10:59
26 appropriate chairs and maintenance of them.
27
28 "We were left with all these chairs that were not fit
29 for purpose and were paid for by the patients. I did

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1 report my concern about misappropriation of patients'
2 finance to H717."
3
4 Some patients, claim my clients, were pressured to put
5 the Trust or Muckamore in control of patients' 11:00
6 finances. Yet neither, so far as they were concerned,
7 had a sufficiently robust system to take on that role.
8
9 P60's sister stated:
10
11 "I had been his financial controller from around 2014
12 after my father was no longer able to continue. I was
13 asked countless times about the Trust taking on this
14 role. I felt that I was being pressured and I declined
15 as I was concerned there would be insufficient 11:00
16 oversight of his money and in my view that was
17 necessary."
18
19 Justification for that position is provided by Marie
20 Heaney's evidence who refers to the turnover of staff 11:00
21 in finance and Muckamore management meant they had
22 failed to retain sufficient knowledge or robust systems
23 about the requirements of the Mental Health Order and
24 there was also a lack of clarity on whether the longer
25 term management of delayed discharge patients' finances 11:01
26 was the responsibility of the placing Trust or the
27 hospital. Of course the significance of a Mental
28 Health Order is whether any of these patients would
29 have had capacity to instruct anything in relation to

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1 their money.
2
3 in our clients' view it was just all highly
4 unsatisfactory.
5 11:01
6 Co-production - working with families and carers
7
8 Reports of serious failures in the care of vulnerable
9 people consistently identify the need to listen to and
10 work with families. The research indicates that such 11:01
11 working is to the considerable advantage of those being
12 cared for, yet there was a recurring theme throughout
13 the evidence of my clients of patients and families
14 feeling that they were not listened to by staff and
15 their concerns were not respected. 11:01
16
17 Our clients' experience is that staff lied and were
18 dishonest as well as often being rude and aggressive.
19 They had no trust in the staff at Muckamore and feared
20 that if they made complaints their loved one would 11:02
21 suffer or be punished in response.
22
23 P60's sister stated:
24
25 "I really felt I couldn't turn to anyone, whether 11:02
26 social worker, Ward Manager, Service Manager, RQIA,
27 no-one would listen."
28
29 Chair, you specifically identified co-production,

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1 working with families and carers, as one of the broad
2 themes emerging from the evidence and it was pursued as
3 a line of Inquiry which staff witnesses, including
4 Mairead Mitchell who was the Head of Learning
5 Disability Services at the Trust from 2016 to 2019. 11:02
6 She was specifically asked about the procedures or
7 processes that were in place to ensure co-production
8 between Muckamore staff and relatives of patients at
9 Muckamore. She said:
10
11 "In 2016 when I took up post there was little evidence
12 of co-production between staff and relatives. There
13 were meetings with relatives about care and treatment,
14 but this was information giving by ward staff and not
15 co-production. The Parents and Friends Group at the 11:03
16 hospital did not appear to have a role or have regular
17 meetings with management."
18
19 And she goes on to set out how in 2017 she presented a
20 plan for co-production within the hospital setting. 11:03
21 And, despite that plan, our clients do not consider
22 that there was any working system in place for
23 co-production between the staff at Muckamore and
24 families or carers of patients. Rather, their
25 experience was that staff were dismissed, were slow to 11:03
26 keep families updated about their loved ones, very
27 often they lacked common compassion.
28
29 P60 passed away as a patient in Muckamore. His

1 sister's evidence was on 7th January 2022, when P60
2 choked:
3
4 "If my family had been contacted and spoken to him he
5 might still be here but it's now too late. He was on 11:04
6 his own when he died and the fact that he never had his
7 family with him will never, ever leave me. No one from
8 Muckamore came to the wake or attended the funeral. No
9 flowers were sent. I was in the height of grief and
10 shock. Muckamore had been his permanent home yet no 11:04
11 one came to offer their condolences."
12
13 Our clients' experience is that they were provided with
14 little or no information, documentation or paperwork
15 explaining matters such as admission, detention, 11:04
16 seclusion, medication, or resettlement. No one took
17 the time to explain these processes to families, many
18 of whom were unfamiliar with them.
19
20 P22's sister stated: 11:05
21
22 "During her time at Muckamore I received no adequate
23 information from Muckamore staff as to her care,
24 treatment, or medication."
25
26 And P120's father said:
27
28 "I was never invited to meetings in Muckamore regarding
29 P120 and his care. Muckamore were only in contact when

1 they needed something."
2
3 None of that is A basis for co-production; it is not
4 sufficient for information sharing.
5
6 This is only a tiny sample of the experiences of our
7 clients. Nevertheless, the details describe starkly
8 the sheer, so far as my clients are concerned,
9 magnitude, duration and institutional nature of the
10 abuse that went on at Muckamore. The Inquiry has heard 11:05
11 evidence from senior personnel within the Trust and the
12 Department that the abuse and neglect were secret and
13 concealed and therefore almost impossible to detect,
14 notwithstanding effective systems of governance that
15 were in place. 11:06
16
17 Our clients ask the Inquiry to categorically reject
18 that kind of argument.
19
20 It's clear from their evidence, and that of other 11:06
21 witnesses, including some Trust staff, that it's just
22 not the case. Much of what went on in Muckamore was
23 done in plain sight and this is what has been so
24 difficult for patients to comprehend.
25
26 Furthermore, so far as they are concerned, abuse still
27 happens in Muckamore and in other facilities in
28 Northern Ireland caring for vulnerable people with
29 mental health issues and learning disabilities. And

1 that's not just the evidence of our clients, but also
2 others who are incredulous that abuse could possibly
3 continue in Muckamore despite it having been under a
4 spotlight for the seven years since the scandal broke
5 and under investigation by this Inquiry, at least what 11:07
6 happened there, under investigation by this Inquiry for
7 three years.
8
9 They say it brings shame on our society that such abuse
10 perpetrated against some of the most vulnerable 11:07
11 individuals in society happened at all and can still
12 occur in the present day.
13
14 I want just to say something about the timeframe. The
15 Trust, the Department and independent reviewers all 11:07
16 agree on the importance of CCTV in revealing the abuse
17 at Muckamore. Yet at the outset, the Trust had to be
18 required to watch all the available CCTV, not just a
19 small fraction. Our clients found that difficult to
20 understand in the face of evidence such as Peter 11:07
21 McNaney, the Chair of the Board who said:
22
23 "It was only the game changing impact of CCTV that
24 allowed the true picture of abuse on at least some
25 Muckamore wards and at least since 2017 to be revealed 11:08
26 and demonstrate that more effective action needed to be
27 taken."
28
29 Cathy Jack, Chief Executive Officer, said:

1
2 "I think the sea change in picking up the issues in
3 Muckamore was the CCTV."
4
5 Sean Holland, the Chief Social Worker Officer said: 11:08
6
7 "The initial incident that was raised in 2017, had it
8 not been for CCTV, could very easily have just been a
9 case of one person's word against the other."
10
11 And our clients agree with that view as that was almost
12 insurmountable for them, the he said, she said when it
13 came to reporting their concerns.
14
15 But, for them, the issue for the Inquiry is more: 11:08
16 Given the governance processes and structures that had
17 been put in place, why did it fall to the chance
18 viewing of CCTV in September 2017 for such abuse to be
19 discovered? CCTV was installed in 2015 in Cranfield
20 Wards 1 and 2 and Psychiatric Intensive Care Unit, 11:09
21 sometimes referred to as PICU, and Six Mile Ward. It
22 was commissioned and handed over to the Trust by the
23 contractor on the 9th July 2015. The Trust entered an
24 initial contract with Radio Contact for the maintenance
25 and upkeep of the CCTV system for the period 1st
26 December 2015 to 30th November 2020. The system was
27 periodically tested by Radio Contact and appears to
28 have been mistakenly left operational when it was
29 tested in February 2017, prior to the planned launch

1 date of the 11th September 2017, which for our clients
2 is an incredible two years after it was ready for use.
3
4 Countless staff and Trust witnesses came to the Inquiry
5 and expressed their apparent shock and surprise at the 11:10
6 abuse uncovered by the CCTV. Given that staff and
7 management have, for the most part, taken the position
8 that they were entirely unaware of the abuse or its
9 scale, it's not possible now to determine with clarity
10 or certainty how bad the situation was prior to the 11:10
11 viewing of the CCTV in August 2017, and that's a matter
12 that the Inquiry will have to try and deal with.
13
14 A variety of points have been made in evidence to the
15 Inquiry that appear to try and portray the abuse 11:10
16 discovered in 2017 as resulting from factors largely
17 outside the control of either Muckamore or the Trust.
18 Most prominent was the ongoing staffing crisis. But
19 that crisis had been apparent since at least 2011 with
20 staffing levels being referred to in 2012 by the 11:11
21 Associate Director of Nursing for Muckamore as
22 "dangerously low", which not only left some wards with
23 unsafe staffing but meant there were insufficient staff
24 with the appropriate kind of training and experience to
25 care for a patient population dominated by those with 11:11
26 serious learning disabilities.
27
28 Also referenced was the renewed drive to resettle
29 patients into the community and change the focus of

1 Muckamore from a facility catering to long stay
2 patients to simply a hospital. But resettlement had
3 been a feature of Muckamore since the Bamford Review of
4 2007, so there was nothing new in that. Whilst it may
5 have gained renewed focus for the 2012 publication of 11:11
6 Transforming Your Care Review that urged resettlement
7 to be completed by 2015, that was not the first
8 challenging resettlement target. The Programme For
9 Government 2008 to 2022 included the goal of ensuring
10 that by 2013 anyone with a mental health problem or 11:12
11 learning disability is promptly and suitably treated in
12 the community and no one remains unnecessarily in
13 hospital.
14
15 Our clients urge the Inquiry to reject any suggestion 11:12
16 that, however difficult those pressures may have been
17 to manage, and they probably were difficult, and not
18 only difficult, they were known, that they in any way
19 justify the abuse that they say was inflicted on their
20 loved ones in Muckamore or on any of the other 11:12
21 vulnerable patients or justify any of the other
22 evidence that this Inquiry has heard from patients and
23 families.
24
25 The Inquiry has heard evidence that the abuse 11:12
26 discovered at Muckamore, however shocking, should not
27 have been surprising to those in senior positions
28 charged with the responsibility to ensure that there
29 were adequate governance processes, systems and

1 structures. The avoidance and detection of abuse
2 should have been built-in to their very design. As
3 Sean Holland, the Chief Social Worker Officer, stated:
4
5 "I think there is a general point about the risks 11:13
6 associated with running facilities of this type. Those
7 risks are well known. Institutional care of vulnerable
8 people carries with it inherent risks that providers
9 should be aware. It's a known risk can when you care
10 for vulnerable people in large group living settings 11:13
11 that you need to be aware of and I think that should
12 just be part of the ongoing business."
13
14 Winterbourne View in England is frequently cited as an
15 example with its pertinent finding that we've been here 11:13
16 before, there's nothing new about the institutional
17 abuse of adults with learning disabilities and autism.
18 And no matter how depressing it is to hear that, it is
19 a fact that should have been built into their
20 government structures. 11:14
21
22 We don't actually need to step out of that Northern
23 Ireland for that kind of example. We have our own
24 institutions of shame: Evidence by the Historical
25 Institutional Abuse Inquiry, mother and baby homes, 11:14
26 Ralph Close, Cherry Tree House, Dunmurry Manor Home and
27 Bradley Manor Care home so people are aware of the
28 risks for vulnerable people.
29

1 So, whilst Muckamore may have been a place apart, as it
2 has been frequently described, in terms of a place
3 where there was a real risk of abuse, and it certainly
4 was not a place unique, our clients hope that the
5 Inquiry will have that context in mind when it 11:15
6 considers what should have been done to protect their
7 vulnerable loved ones and the extent to which those in
8 senior positions and at the very apex are entitled to
9 ring their hands, apologise but claim they could not
10 have known because a system of governance they had 11:15
11 installed didn't alert them to it.
12
13 The evidence, my clients suggest, strongly and
14 distressingly is that the abuse that was uncovered
15 through CCTV in 2017 was merely the tip of the iceberg 11:16
16 and that abuse of extremely vulnerable patients has
17 always been a feature at Muckamore.
18
19 The combined experience of our clients of Muckamore
20 spans almost its entire existence and their accounts 11:16
21 make clear that there has always been abuse at
22 Muckamore, even if there was no CCTV there to record
23 it. That is their evidence and that is their very
24 strong view.
25 11:16
26 the Inquiry has also heard of abuse dating back to the
27 1960s and 1970s that came to light in 2005 and gave
28 rise to the PSNI conducting a comprehensive review of
29 files which revealed 24 incidents that were potential

1 offences. Futhermore the Inquiry has received
2 extensive evidence of the abuse that occurred on Ennis
3 Ward in November 2012 and how Muckamore formed the view
4 that the issues were isolated to practices within Ennis
5 Ward, rather than hospital-wide institutional abuse, 11:17
6 with the result that a more extensive investigation
7 didn't take place.
8
9 In our clients' view abuse was certainly there and
10 should have been factored into the risk to be managed 11:17
11 by the governance systems and structures.
12
13 So then just to bring us up to the present day. The
14 current investigation of the abuse at Muckamore was
15 triggered by P96's father as acknowledged by the 11:17
16 Minister in 2020. His determination was central in
17 exposing the truth about Muckamore. It shouldn't have
18 been left to him to do this, but we should all be very
19 grateful that he did. Up to that point the Trust
20 simply had no handle on the abuse. Indeed, P96's 11:17
21 father faced substantial opposition from the Trust in
22 his efforts to obtain the CCTV that relates to his son.
23
24 Our clients are concerned that had it not been for the
25 efforts of P96's father in 2017, the scandal may never 11:18
26 have come to light and the situation at Muckamore could
27 have continued without scrutiny.
28
29 Nearly eight years later, the clear and consistent

1 evidence of our clients is that abuse continues.
2
3 So, for example, although P77's mother and aunt gave
4 evidence of the abuse suffered by their loved one in
5 Muckamore, which has been acknowledged, he continued to 11:18
6 suffer abuse. Furthermore they have numerous examples
7 of neglect concerning feeding, failure to provide any
8 activities and to follow procedures in terms of
9 safeguarding concerns and privacy.
10
11 There's also abuse, my clients' evidence is, in the
12 community placements to which patients are discharged
13 from Muckamore as, for example, P90's sister and
14 brother are only too aware. In their experience staff
15 in the community lack the necessary qualifications and
16 experience in learning disability and also staff who
17 were involved in Muckamore continue to work in the
18 community with no apparent effective mechanism for
19 families to identify this or to seek assurances that
20 their loved ones will not be placed in their care. 11:19
21
22 It's hoped that these issues and others will be
23 addressed in the forthcoming sessions on resettlement
24 and available community services, but the significance
25 of referring to them now is that invariably those in 11:19
26 authority are keen to identify to the public Inquiry
27 the lessons learned, what they've done, are doing, will
28 do and generally why things are completely different
29 now or certainly will be completely different. So

1 accordingly, this evidence from my clients as to what
2 is happening now that they provide is an important
3 context for the Inquiry to assess the evidence of staff
4 and officials on their intentions about the care of
5 vulnerable people with mental health issues or learning 11:20
6 disabilities. I am wondering, Chair, if that might be
7 a convenient moment.
8 CHAIRPERSON: Certainly. You are about a third of the
9 way through and we did start late, so I think we will
10 certainly run into the lunch hour. But we will take a 11:20
11 15 minute break now and then we'll continue. Thank
12 you.
13 MS. ANYADIKE-DANES: Thank you Chair.
14
15 AFTER A SHORT BREAK THE INQUIRY RESUMED AS FOLLOWS: 11:32
16
17 MS. ANYADIKE-DANES: So, I was summing up about core
18 objective one essentially. We move now to core
19 objective two to determine why the abuse happened and
20 the range of circumstances that allowed it to happen. 11:40
21
22 The inquiry's primary time frame is 2nd December 1999
23 to 14th June 2021. Across that period, the Inquiry has
24 heard evidence of gross failures, deficiencies, and
25 missed opportunities with the health and social care 11:40
26 system in general and within Learning Disability
27 Services in particular and our clients are asking the
28 Inquiry to make a clear finding that the failures were
29 institutional, systemic and substantial.

1 Our clients consider it is necessary not only to
2 identify the causes of abuse, but also to hold those
3 responsible to account. In their view the lack of
4 accountability in the past is one of the fundamental
5 reasons why they believe serious and widespread abuse 11:41
6 was able to continue for so long. So far as our
7 clients are concerned, frontline staff perpetrated
8 abuse without accountability and hospital management
9 displayed an utter disregard for patients and families,
10 also without accountability. 11:41
11
12 Leadership of Learning Disability Services, the Trust,
13 the Board and the Department completely, so far as they
14 are concerned, abdicated their responsibilities without
15 accountability. Those tasks withholding health and 11:41
16 social care organisations to account similarly failed
17 in their roles without accountability.
18
19 From our clients' perspective, there has been no
20 accountability with regard to the dysfunctional 11:42
21 implementation of CCTV. There has been no
22 accountability with respect to incompetent staff
23 planning. There has been no accountability with
24 regards to dysfunctional safeguarding investigations or
25 complaints processes. There has been no accountability 11:42
26 of healthcare assistants who were unregulated and
27 therefore able to move on to other community jobs, even
28 when there had been problems with their work in
29 Muckamore. There has been limited accountability for

1 the failure of senior personnel to engage with the
2 Leadership and Governance Review. There has been no
3 accountability for RQIA's casual disregard of families'
4 complaints. There is no accountability for the
5 ineffective representation by advocacy services within 11:42
6 Muckamore and before Mental Health Review Tribunals.
7 And many of those responsible didn't even come to the
8 Inquiry, retiring or getting new jobs and leaving it to
9 newly appointed personnel to come to the Inquiry and
10 account for actions or decisions of which they had no 11:43
11 personal knowledge or experience.
12
13 in this way, our clients' view is that individuals who
14 bore responsibility escaped direct scrutiny for their
15 conduct. So far as our clients are concerned the lack 11:43
16 of accountability and the apparent impunity of those
17 working within the system, even when they manifestly
18 failed to discharge their responsibilities is a core
19 cause of the abuse.
20 11:43
21 Our clients have a legal right to have individuals held
22 accountable for their specific roles in the abuse at
23 Muckamore. Their loved ones, so far as they are
24 concerned, were subject to serious and prolonged abuse
25 to the extent that their rights pursuant to Articles 2 11:43
26 and 3 of the European Convention on Human Rights are
27 engaged. Consequently the State has a mandatory duty
28 to conduct an effective investigation into the abuse to
29 ensure accountability of those responsible. Now the

1 Inquiry has not sought to discharge the full extent of
2 the state's Article 2 and Article 3 obligations for the
3 reasons given in the Chair's statement of the 2nd
4 November 2023, the Inquiry adopted a holistic approach
5 to ensure it could complete its work within a 11:44
6 reasonable timeframe. That was a matter for the
7 Inquiry but it does mean that the Article 2 and 4
8 investigative obligations have not yet been discharged
9 through this Inquiry and that, for my clients, is an
10 issue of fundamental importance. 11:44
11
12 The obligation has also not been discharged by the
13 police investigations. The current Operation Turnstone
14 investigation is limited in temporal scope to the CCTV
15 recovered from March 2017 to November 2017 and that 11:44
16 relates to only a fraction of the alleged abuse. In
17 any event, as the jurisprudence shows, an effective
18 investigation goes well beyond facilitating a
19 prosecution.
20
21 Furthermore it has not been discharged by the various
22 investigations by the Trust which, as the Inquiry has
23 heard, were ineffectual and cannot on any analysis be
24 regarded as adequate, independent or conducted with the
25 necessary elements of public scrutiny and participation 11:45
26 of the next of kin.
27
28 Inquests will discharge the obligation in some
29 circumstances, but this mechanism does not apply to

1 circumstances in which individuals were threatened,
2 were subjected to life threatening treatment short of
3 death, or for those who were subjected to treatment
4 contrary to Article 3.
5
6 The issue of accountability for my clients, their view
7 is that that is intrinsic to preventing such conduct in
8 the future which is a key aim of the Inquiry's Terms of
9 Reference. Thus there is a need for a further
10 investigation and a failure to hold those responsible 11:45
11 to account means that the system of providing Learning
12 Disability Services within the community can be
13 populated by some of the staff, management and
14 leadership who are themselves responsible for abuse at
15 Muckamore and who have never been properly held to 11:46
16 account or experienced any form of disciplinary or
17 other sanction for their role.
18
19 Our clients gave accounts of personnel from Muckamore
20 who turn up as staff at their loved ones' community 11:46
21 placement, retraumatizing them. This is, in their
22 view, entirely inappropriate and it is only possible
23 because there has been no comprehensive mechanism to
24 secure accountability of all involved. So our clients
25 seek a finding from the Inquiry that the State's 11:46
26 investigative obligations under Articles 2 and 3 have
27 not been discharged by the investigations to date, and
28 certainly not by this Inquiry, and that there is need
29 for a further investigation into the individual

1 allegations of mistreatment to ensure that those
2 responsible can be identified and, if possible, brought
3 to account. Our clients suggest that such an
4 investigative mechanism could operate in tandem with an
5 appropriate remedial scheme, which is something that 11:47
6 the Inquiry has the power to recommend.
7
8 I just want to give an overview of key events. We have
9 provided separately to the Inquiry a chronology of
10 relevant events as Appendix 3, so we provide now a 11:47
11 brief overview of the key matters within the Terms of
12 Reference which illustrate the failure to learn and the
13 failure to take proper responsibility for the discharge
14 of functions. Our clients regard this as fundamental
15 to understanding how the abuse was able to happen. 11:47
16
17 Bamford and Equal Lives
18
19 In 2005, the Equal Lives Report, which was part of the
20 Bamford Review, set out a vision for developing 11:47
21 services for those with learning disabilities for the
22 following 15 to 20 years. The forward states:
23
24 "The Equal Lives Review has concluded that progress
25 needs to be accelerated on establishing a new service 11:48
26 model which draws a line under outdated notions of
27 grouping people with a learning disability together and
28 their segregation in services where they are required
29 to lead separate lives from their neighbours. The

1 model of the future needs to be based on integration
2 where people participate fully in the lives of their
3 communities and are supported to individually access
4 the full range of opportunities that are open to
5 everyone else. The success of implementing the Equal 11:48
6 Lives recommendations depends on the contribution of
7 many stake holders, but most of all government who must
8 give a lead on implementing the process of change. We
9 fully recognise the resource implications and urge the
10 government, in particular the Department of Health, 11:48
11 Social Services and public safety..."
12
13 As it was then.
14
15 "...to begin the necessary process of reform and 11:49
16 modernisation of these services immediately."
17
18 The direction of travel is clear. It's equally clear
19 that we are not there yet and for entirely foreseeable
20 reasons. The Inquiry heard from Professor Sir Michael
21 McBride, Chief Medical Officer, that:
22
23 "I regret that I wasn't more thoughtful in terms of the
24 risks that transition from one service in-patient
25 service model into working to provide a service in the 11:49
26 community. We did not have an overarching strategy for
27 that other than a commitment."
28
29 This was a rare public acknowledgment. In general

1 though there is a reluctance to be open with those with
2 mental health issues, learning disabilities, their
3 families and the public in general about the problems
4 in realising the Bamford vision and how those problems
5 will be fixed. Rather, there is simply the continued 11:50
6 public restatement of the commitment to the Bamford
7 vision which our clients consider an insult to their
8 intelligence as they know the reality on the ground.
9 For them, such restatements and repackaged commitments
10 ring hollow. 11:50
11
12 In short we do not yet have the learning disability
13 service model and it's unclear when we will or what it
14 will ultimately look like when we do and, in truth, we
15 are nowhere near implementing the Bamford vision. The 11:50
16 resettlement programme is not yet complete and the
17 state of community based services, so far as my clients
18 are concerned, is dire. For many of those who have
19 been resettled their circumstances are a far cry from
20 Bamford's vision of a model based on integration where 11:50
21 people participate fully in the lives of their
22 communities and are supported to individually access
23 the full range of opportunities that are open to
24 everyone else. For many of our clients the
25 resettlement programme has only served to shift the 11:51
26 problems from Muckamore into the community. The system
27 is failing people with learning disabilities. Whilst
28 there are a number of reasons for this, two factors are
29 clear as far as my clients are concerned: Lack of

1 funding and the lack of workforce strategy, both of
2 which were identified as long ago as the Department's
3 1995 review, Care in the Community, and are
4 specifically addressed by Bamford. This warrants
5 further analysis starting first with the December 2005 11:51
6 review by the Eastern Health and Social Services Board
7 and the North-West Health and Social Services Trust.
8
9 That review was within a couple of months of Equal
10 Lives and was prompted by the discovery of allegations 11:51
11 in the 1970s by a former patient in Muckamore who
12 alleged sexual assaults by patients and staff. The
13 case note review not only confirmed that reports of
14 sexual abused been made, but identified other similar
15 incidents involving other patients. The Board and the 11:52
16 Trust commissioned a review of current practice and
17 care in Muckamore. That review was carried out by
18 Miriam Somerville, the Director of North and West
19 Belfast Health and Social Care Trust, with the
20 objective being to assure the Trust and Board of the 11:52
21 robustness of vulnerable adult procedures.
22
23 The review was an internal entirely paper-based
24 exercise, there was no interview of patients, families
25 or staff. And some of our clients actually had loved 11:52
26 ones in Muckamore at the time and were unaware of the
27 review or its circumstances, despite the fact that it
28 covered complaints procedure, patient discussion
29 groups, independent advocacy, management of visitors

1 and communication processes, all of which directly
2 involve patients and their families.
3
4 Our clients regard the review to be of limited value in
5 meeting its Terms of Reference and cannot see how it 11:53
6 could provide the assurance on the appropriateness and
7 robustness of the procedures that the Trust and Board
8 were legitimately seeking.
9
10 The following year, Andrew McCormick, the Permanent 11:53
11 Secretary, felt it necessary to write all Health and
12 Social Care Trust Chief Executives reminding them that
13 whilst the incidents of sexual abuse dated back some
14 years, it remains essential that we have in place
15 appropriate and proportionate procedures to prevent 11:53
16 such abuse and seeking formal assurance that all
17 appropriate policies and procedures to prevent and,
18 where they occur, detect and manage allegations and
19 incidents of abuse are in place and are being
20 consistently and robustly applied. The Department 11:53
21 needs to be assured that services are safe, so they
22 were all warned.
23
24 So then let's go to 2007/2009. The Review of Public
25 Administration was launched in 2002 to review the 11:54
26 existing arrangements for the accountability,
27 administration and delivery of public services in
28 Northern Ireland and bring forward options for reform.
29 The first phase in 2007 led to the creation of the

1 Belfast Trust as by far the largest Health and Social
2 Care Trust in Northern Ireland, having been formed from
3 the amalgamation of six legacy trusts. This was
4 significant for Muckamore which went from being under
5 the control of the Northwest Belfast Health and Social 11:54
6 Care Trust, a community trust in which it was the only
7 residential facility, to the Belfast Trust that, not
8 only had responsibility for Muckamore as one of several
9 acute in-patient units dealing with mental health and
10 learning disabilities, but also several other major 11:54
11 teaching and training hospitals.
12
13 It would seem from the evidence that the Inquiry has
14 heard, including from the Permanent Secretary, Andrew
15 McCormick, that insufficient consideration was given to 11:54
16 that very fact. He said:
17
18 "I probably regret not taking what was said to me
19 slightly more seriously. It would have meant going to
20 the Minister and saying 'you see you see that plan 11:55
21 we've got, we need to hit the pause button'. That
22 would not have been a welcome intervention."
23
24 The evidence to the Inquiry demonstrates that following
25 the creation of the Belfast Trust, the focus on 11:55
26 Learning Disability Services both in the community and
27 in Muckamore was substantially reduced. The relevance
28 is that after 2007, instead of increasing the focus on
29 Learning Disability Services to realise Bamford's

1 vision, Belfast Trust seemed to lose its focus on
2 Learning Disability Services and treated them with
3 lesser importance. Whilst much has been made in
4 evidence to the Inquiry of the size of the Trust and
5 its impact on governance, our clients categorically 11:55
6 reject any suggestion that the size of the Belfast
7 Trust was the root of this problem. The problem was
8 that leadership of the organisation focused on acute
9 services and failed to maintain rigorous and effective
10 oversight with respect to the Learning Disability 11:56
11 Services for which they were equally responsible.
12
13 The second phase in 2009 involved the reform of the
14 health and social care system which transferred the
15 functions of the Mental Health Commission to RQIA, 11:56
16 replaced the four boards with the single regional
17 Health and Social Care Board, established the Public
18 Health Agency and established the Patient and Client
19 Council. So far as our clients are concerned those
20 reforms did not secure any positive outcome for 11:56
21 Muckamore. These bodies were, again so far as they are
22 concerned, completely ineffective in terms of
23 preventing abuse. The RQIA's regulatory activities
24 failed. HSCB had responsibilities with respect to
25 performance management, service and quality 11:56
26 improvement, delegated statutory functions, complaints,
27 serious adverse incidents, legacy adverse incidents,
28 early alerts, safety and quality alerts, but from my
29 clients' point of view each of these processes failed

1 to pick up or identify the abuse at Muckamore.
2
3 PCC was the advocacy body on behalf of patients, but it
4 had no specific focus on Muckamore between 2009 and
5 2019 and many families say they never heard of it. The 11:57
6 PHA was so ineffective so far as they are concerned
7 that on the first day of hearings on professional
8 organisation its Chief Executive, who came to give
9 evidence, didn't even seem to appreciate that the PHA
10 had any significant role in relation to Learning 11:57
11 Disability Services, even though its full title is the
12 Regional Agency For Public Health and Social Wellbeing.
13
14 Ennis
15
16 On 7th November 2012, a member of staff from Bohill
17 Care Home, a private sector community placement
18 provider, reported THAT a Staff Nurse, A health care
19 support worker and student nurse at Muckamore had
20 physically abused four patients in Ennis Ward. In 11:58
21 response to these allegations there was a police
22 investigation, safeguarding investigation and
23 subsequently a disciplinary investigation. The staff
24 were referred to the Independent Safeguarding Authority
25 and the Nursing and Midwifery Council was notified of 11:58
26 the precautionary suspension of the registered nurse
27 who was involved. An Early Alert was issued to the
28 Department of health and the Chief Nursing Officer.
29 However for my clients the real issue was the lack of

1 proper oversight exercised by the Belfast Trust or the
2 Department which had been notified by an Early Alert
3 and should have been exercising oversight. This, they
4 consider, is demonstrated by just a few points.
5
6 1. There was already a staffing crisis at Muckamore in
7 2012 before Bohill staff reported abuse on Ennis Ward.
8 So the Directorate level response to that of
9 introducing 24-hour monitoring of staff on a
10 supernumerary basis had the entirely foreseeable effect 11:59
11 of imposing a substantial additional financial and
12 staff burden and introducing additional risk into what
13 was already a crisis. Although the Trust Board was
14 made aware of the Ennis allegations they simply took
15 the approach that because the matter was receiving 11:59
16 attention there was nothing further for them to do. It
17 appears the matter was not even considered by the
18 Assurance Committee, which is supposed to provide
19 independent scrutiny of what is going on through the
20 non-executive directors. And that, my clients say, is 11:59
21 a failure of leadership.
22
23 2. The HSCB repeatedly recommended to the Belfast
24 Trust that the matters be treated as a serious adverse
25 incident, but the Trust declined. That the Board 11:59
26 consider the incident should be treated as an SAI and
27 the fact that it had not been, cried out for proper
28 scrutiny and oversight from the leadership of the
29 Trust. That oversight did not happen and the evidence

1 of the Department to the Inquiry is that it was
2 warranted and it may have resulted in the notification
3 of an SAI and subsequent review which could have opened
4 up learning for the Trust and wider health and social
5 care system. 12:00
6
7 3. Aine Morrison, the dedicated Adult Protection
8 Officer in charge of the safeguarding investigation,
9 and John Veitch, who was then the Co-Director for
10 Children and Adult Learning Disability Services, had a 12:00
11 different view on the issue of institutional abuse. He
12 thought there was no concern about institutional abuse.
13 She felt it wasn't possible to reach a conclusion on
14 whether there had been institutional abuse. This
15 difference of views was never resolved. It's clearly 12:00
16 of itself a serious matter that should have received
17 scrutiny and consideration from a higher level within
18 the Trust, but that did not happen.
19
20 4. The Safeguarding Report and the disciplinary report 12:01
21 came to inconsistent conclusions. So far as my clients
22 are concerned that is a startling proposition and it
23 cries out for further examination.
24
25 Our clients consider Ennis was a missed opportunity 12:01
26 because had the Trust leadership become involved, the
27 nature of the staffing crisis at the hospital should
28 have become apparent at a senior level and then should
29 have received the attention it required. But that

1 didn't happen because the leadership in the Trust were
2 failing to report, to properly take responsibility for
3 the discharge of their functions and because the Trust
4 Board were far more concerned about issues in acute
5 services than in Learning Disability Services, at least 12:01
6 that's the view of my clients.
7
8 Way to Go
9
10 Dr. Margaret Flynn chaired the independent team which 12:01
11 carried out a Level 3 Serious Adverse Incident Review
12 in 2018 and this was one of a series of assurance
13 measures established by the Trust and notified to the
14 Department in response to the abuse discovered in 2017.
15 Our clients questioned the methodology for what was 12:02
16 being presented as a truly independent review. It
17 seems the Trust selected the Terms of Reference without
18 any ability for the Review Team to provide input.
19 There was no agreement on whether the report would be
20 made public or at least provided to the patients and 12:02
21 families directly involved. The timeframe of 2012 to
22 2017 was chosen by the Trust without any initial
23 explanation of its significance. Furthermore, and
24 again without initial explanation, the reporting of
25 adult safeguarding incidents in PICU and Six Mile Ward 12:02
26 focused narrowly on the period August 2017 to October
27 2017. The 69 safeguarding files to be reviewed were
28 selected by the Trust without any explanation of the
29 method by which they had been singled out and, whilst

1 the Review Team was informed involved of CCTV footage,
2 it was not provided as part of the material for them to
3 consider, rather it was left to them to request sight
4 of it as a matter of curiosity to assess its quality.
5 Ultimately a mere 20 minutes was watched and it's 12:03
6 unclear what they were told to inform their choice or
7 why such a limited period was viewed, given the primary
8 objective was to examine safeguarding procedures.
9
10 The report, A Way to Go, produced by the Review Team 10 12:03
11 months later identified multiple serious problems at
12 Muckamore, however, it failed to hold individuals
13 responsible for failings in their duty, particularly in
14 relation to that part of its Terms of Reference that
15 required it to assess the leadership within Muckamore 12:03
16 Abbey Hospital. It made just two recommendations, both
17 of which essentially sought a renewed commitment to the
18 implementation of Bamford. Our clients were
19 disappointed that more was not done by the review to
20 further the aim of safeguarding, especially as the 12:04
21 Review Team was aware of the early reports of abuse at
22 Muckamore in 2005 and 2012.
23
24 Some six years on from those recommendations it's
25 clear, so far as my clients are concerned, that the Way 12:04
26 to Go Report represents a further missed opportunity
27 for the Trust and the Department. It's another example
28 in a long line of examples of recognition of what is
29 required to happen, but of failure on the part of the

1 Trust and the Department to take the necessary steps to
2 bring about effective change.
3
4 Then finally we have the Review of Leadership and
5 Governance published in July 2020. That's another 12:04
6 opportunity to address governance shortcomings in
7 Muckamore and, by association, in the Trust. That was
8 provided when the Department, the Board and the PHA
9 commissioned that independent review to examine
10 critically the effectiveness of governance. The 12:05
11 essence of the Terms of Reference was to review and
12 evaluate the clarity, purpose and robustness of the
13 leadership, management and governance arrangements in
14 place at Muckamore Abbey Hospital in relation to the
15 quality, safety and user experience. That should have 12:05
16 been enough to capture everything important. This was
17 to take in a series of issues including strategic
18 leadership across the Trust, clinical leadership and
19 accountability which seemed to have been prompted by
20 the belief that the Way to Go Report did not cover 12:05
21 leadership and management issues to the degree that
22 they wished to have it covered.
23
24 The timeframe for the review was 2012 to 2017, the same
25 as Way to Go. It examined the key milestones of Ennis, 12:06
26 CCTV and complaint of P96's father. The report was
27 highly critical, highlighting that Muckamore was
28 allowed to operate under the radar of the Trust and
29 that leadership at Muckamore was dysfunctional. There

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1 was a lack of interest and curiosity at Trust Board
2 level. Staff felt a loyalty to one another rather than
3 to the Trust. And matters were not appropriately
4 escalated to the Executive Team or Trust Board as a
5 means of finding solutions. However, so far as our 12:06
6 clients are concerned, of huge significance was its
7 conclusion that the Trust had adequate governance and
8 leadership arrangements in place but that these were
9 not appropriately implemented at various levels within
10 the organisation. So far as they are concerned this 12:06
11 deflected attention from the system of governance
12 itself and focused instead on the role of the
13 individuals down the chain of command.
14
15 Not surprisingly, Cathy Jack relied on the review's 12:07
16 findings to support her assertion that the structures
17 and processes in place in the Belfast Trust were
18 sufficient and the issue was individuals not doing the
19 right thing. So whilst a need for curiosity at all
20 levels was acknowledged, nonetheless the Board's 12:07
21 position was that the hierarchical governance system
22 which relied on an escalation of concerns up to the
23 Executive Team on board had been largely exonerated by
24 the review. In our clients' view the conclusion
25 reached by the review was incorrect and unsupported by 12:07
26 the evidence. They feel that this was exposed when
27 David Bingham, a member of the Review Team gave
28 evidence to the Inquiry and he was forced to concede
29 that, having already recognised that medical leadership

1 was not involved in clinical governance, it was simply
2 incorrect to say the Trust had appropriate governance
3 in place.
4
5 furthermore, the Board, and particularly the 12:08
6 non-executives, should have been proactively asking for
7 assurance information rather than waiting for serious
8 incidents to be reported through SAIs, i.e., it was the
9 job of non-executives not to passively wait for
10 information to come to them but to actively go out and 12:08
11 seek assurance about things.
12
13 The upshot for my clients is that the review was yet
14 another missed opportunity to alert the Trust to the
15 deficiencies that permitted significant patient abuse. 12:08
16 Worse yet, it allowed a misplaced confidence in the
17 essential elements of the system to continue which
18 necessarily avoided a focus on what was really needed
19 to be addressed to ensure the safety and interests of
20 clients would be properly safeguarded. 12:08
21
22 Our clients find it difficult to understand how the
23 review that took nearly two and a half years to produce
24 could have been undermined so quickly. It leaves them
25 with little confidence in the ability of the Trust to 12:09
26 examine and correct its failings, given the apparent
27 need to have this Inquiry identified and for them.
28
29 So, if I round that all up as to what my clients

1 believe were the circumstances that caused and allowed
2 the abuse to happen, they identify nine main factors
3 and they are not mutually exclusive but are cumulative
4 and overlapping, each is exacerbated and the risk of
5 abuse made more likely by the failure to hold all those 12:09
6 responsible to account.
7
8 1. Vulnerability.
9 The abuse at Muckamore was perpetrated against people
10 who were particularly vulnerable. They relied on 12:09
11 others for their care and to keep them safe. They were
12 often unable to communicate when that care fell below
13 the required standard or they were being abused and,
14 even when they could do so, their efforts and those of
15 their families to report or draw attention to it were 12:10
16 often ignored, went unnoticed or were not believed.
17 That's their evidence and its difficult in those
18 circumstances to imagine a more vulnerable set of
19 people at the risk of harm.
20 12:10
21 The answer to the abuse is not simply to complete the
22 resettlement programme, it was not designed to prevent
23 abuse. So while completion of the resettlement
24 programme is necessary, the solution is not merely
25 resettlement to a community setting, it is essential, 12:10
26 so far as my clients are concerned, that this
27 fundamental point on vulnerability and its implications
28 is properly appreciated by all stakeholders who should
29 not be relying on completion of the resettlement

1 programme as a means of ensuring the safety of our
2 clients' loved ones into the future. In some respects
3 they may actually be more vulnerable in their community
4 placements because their placements will be smaller and
5 dispersed throughout Northern Ireland without the level 12:11
6 of scrutiny that is currently trained on Muckamore.
7
8 The essential point is that abuse is inextricably
9 linked vulnerability. If abuse is to be prevented in
10 the future it must be appreciated by everyone involved 12:11
11 that risk goes beyond institutional settings and is
12 present in any setting in which vulnerable individuals
13 are accommodated, small or large, public or private.
14 Proper adult safeguarding and vulnerable people
15 requires more than a change of setting. 12:11
16
17 As indicated by Sean Holland, there is a high
18 probability that such abuse is currently going on in
19 other places where vulnerable individuals are
20 accommodated, including in community placements, 12:11
21 particularly if there is an absence of strong oversight
22 and no CCTV.
23
24 So in identifying the various causes of abuse and
25 effective ways to prevent it from happening again, it 12:12
26 is an essential and urgent factor in the successful
27 placement of our clients' loved ones and others in the
28 community that that connection between vulnerability
29 and abuse is properly recognised.

1 2. Culture.
2 So far as our clients are concerned there was a toxic
3 environment with poor practices resistant to outside
4 scrutiny and those seeking to make improvements,
5 disrespect and mistreatment of families and ultimately 12:12
6 patients abused, often openly on multiple wards with
7 prolonged impunity for the staff concerned.
8
9 3. Failure of leadership throughout the system.
10 Our clients consider that many of the failures in 12:12
11 relation to Muckamore are linked by a common theme:
12 The failure to take proper responsibility for the
13 discharge of functions. This failure, they believe,
14 can be seen at every level in every organisation and
15 across the system. Far too often the Inquiry heard 12:13
16 evidence from senior personnel who sought to shift
17 blame for failings to their subordinates and declaring
18 it was their subordinates fault for not telling them
19 when things went wrong. This position was taken, so
20 far as my clients are concerned, by management at 12:13
21 Muckamore, leadership of the Trust and by leadership
22 within Department. They all seemed to consider it was
23 an appropriate exercise of governance to wait to be
24 told by someone else. Indeed that's actually how the
25 system was set up, as Gordon Smyth, the non-executive 12:13
26 director and Chair of the Audit Committee within the
27 Belfast Trust from 2016 stated in his oral evidence:
28
29 "As non-executives it wasn't for us to go down and see

1 what was happening at the coal face. We were relying
2 on our directors coming back to us and saying this is
3 A, B and C and what we were seeing from our reports we
4 were getting back was that we were making progress."
5
6 The Department and Trust leadership time and time again
7 sought to emphasise that the basis of the system was
8 delegated responsibility. So as far as my clients are
9 concerned it is fundamental principle that any system
10 of delegation that responsibility remans with the 12:14
11 delegator. This is not and should not be a hollow or
12 meaningless responsibility. It means that that when
13 the delegator's subordinates fail to properly discharge
14 that responsibility, the delegator is ultimately
15 responsible and must bear full accountability for the 12:14
16 consequences. Leadership requires proper oversight, it
17 needs people who, through delegating power, retain
18 responsibility over the exercise of that power and act
19 accordingly and that requires rigorous efforts to
20 ensure that power is in fact being properly used, to 12:14
21 ensure that outcomes are being achieved, and to ensure
22 that the information used to make those assessments is
23 of good quality. This is because the delegator
24 understands that if things go horribly wrong,
25 irrespective of whether they have delegated their 12:15
26 power, they will be both responsible and accountable.
27
28 However, in my clients' perspective that doesn't seem
29 to be the approach adopted for Muckamore. The Inquiry

1 heard failure to exercise proper oversight described as
2 a lack of interest and curiosity. Now, whilst our
3 clients do agree that those in senior positions were
4 professionally incurious to an astonishing degree,
5 particularly given the risks associated with an 12:15
6 in-patient facility such as Muckamore, in their view
7 the problems at Muckamore were not merely caused by a
8 lack of professional curiosity. The problem was
9 greater than that, it was bad governance. It was a
10 case of professionals completely abdicating their 12:15
11 oversight functions to subordinates and then seeking to
12 blame subordinates when things went wrong. It was a
13 failure by leadership and management to recognise that,
14 although delegating power, they continued to be
15 responsible and continued to have a duty to exercise 12:16
16 rigorous and effective oversight over matters for which
17 they remained professionally responsible and
18 accountable. Moreover, it was a failure by leadership
19 and management to recognise that if they did not
20 exercise proper oversight they are both responsible and 12:16
21 accountable for any harm that is caused as a result and
22 this point applies, so far as my clients are concerned,
23 throughout the system but it applies with greatest
24 force to the leadership of the system. If the
25 leadership fails to exercise rigorous and effective 12:16
26 oversight it is far more likely that everyone else in
27 the system will follow suit, and our clients consider
28 that is precisely what happened in relation to
29 Muckamore.

1 4. Inadequate funding
2 There was, so far as my clients are concerned,
3 inadequate funding for staff at Muckamore, resettlement
4 programme, investment in community services and
5 Learning Disability Services generally. Miriam 12:17
6 Somerville summed up the problem when she said:
7
8 "It was difficult to encourage both trusts and boards
9 to believe that investment in community services would
10 actually result in the changes in the hospital that 12:17
11 everybody wanted and that had been on the cards since
12 the mid 1990s. I don't know why that was the cause but
13 there were just very limited investment in community
14 services and frustrating is absolutely the word."
15 12:17
16 But the fault doesn't only lie with trusts and boards,
17 the Department must also bear some responsibility. The
18 Bamford Equal Lives report made clear that substantial
19 additional funding would be required to realise the
20 Equal Lives vision. The evidence demonstrates, so far 12:17
21 as my clients are concerned, that despite repeated
22 commitments to implement Bamford, including at the
23 highest level and within the Executive's programme for
24 government, nowhere near the requisite level of funding
25 was made available. The reality is additional 12:18
26 resources for resettlement for 2008 to 2011, to which
27 Sean Holland refers, and the substantially reduced
28 additional resources for 2011 to 2015 to which he
29 doesn't refer, provided nowhere near the level of

1 resources that Equal Lives said would be required to
2 achieve the resettlement programme. In the
3 circumstances it's unsurprising that families were
4 reluctant to agree with various proposed resettlements,
5 because many community placements, so far as they were 12:18
6 concerned, were simply not fit for purpose and that
7 continues to be the case. And that in turn contributed
8 to delayed discharge and other problems in Muckamore.
9
10
11 The Department and the relevant Health Ministers are
12 responsible for this state of affairs because they
13 sought to implement Bamford without providing the level
14 of funding to develop the placements and the community
15 infrastructure that Equal Lives said would be required 12:19
16 and without being transparent, so far as my clients are
17 concerned, about the fact that they were failing to
18 provide the necessary funding. Moreover, there
19 appeared to be little or no engagement with or
20 recognition of the fact that the implementation of 12:19
21 Bamford would actually require double funding for a
22 period so as to run the hospital at the same time as
23 developing community services to the requisite standard
24 to enable resettlement to be successful. As a result
25 our clients consider that the proliferation of groups, 12:19
26 teams, monitoring structures directed at practical
27 implementation of the resettlement programme was
28 largely a waste of time and money. Since while there
29 may have been difficulty and complexity in managing

1 specific individual resettlement of patients, the
2 overall problem was simple, there had been in adequate
3 funding of community services to enable safe and
4 effective resettlement of all patients, and that's the
5 point that had to be grappled with, and so far as my 12:20
6 clients are concerned, was not and has not been
7 sufficiently grappled with.
8
9 5. Inadequate expertise within the system
10 Learning Disability Services were staffed, managed and 12:20
11 led by too many people who lacked sufficient
12 qualifications or experience in learning disability,
13 that's my clients' view. The Inquiry heard much
14 evidence of the lack of staff with any learning
15 disability experience and the approach of using staff 12:20
16 with mental health experience instead. Our clients
17 give the following non-exhaustive examples that are
18 illustrative of the extent to which the various levels
19 of leadership and management lacked adequate knowledge
20 or qualifications in learning disability and were 12:20
21 therefore heavily reliant on subordinates.
22
23 Esther Rafferty, Service Manager and later on the
24 Associate Director of Nursing.
25 Mairead Mitchell, Senior Manager Service Improvement 12:21
26 Modernisation in Adult Social and Primary Care and then
27 Head of Learning disability services.
28 John Veitch, Co-Director for Children and Adult
29 Learning Disability Services.

1 Moira Mannion, Co-Director of Nursing Education and
2 Learning and then Deputy Director of Nursing and
3 Workforce Education, Regulation and Information
4 Technology.
5 Cecil Worthington, Director of Social Work, Children's 12:21
6 Community Services and then Interim Director of Adult
7 Social and Primary Care services.
8 Catherine McNicholl, Director of Adult Social and
9 Primary Care services.
10
11 None of them gave any evidence as to their
12 qualifications or experience in learning disability.
13 Then if we move to the Board level:
14 Brenda Creaney, Executive Director of Nursing and User
15 Experience. 12:21
16 Gordon Smyth, Non-Executive Director and Chair of the
17 Assurance Committee. He was a retired banker.
18 Bernie Owens, Director with responsibility for
19 Muckamore from 2019 to 2020 and then Deputy Chief
20 Executive. 12:22
21 Peter McNaney, Chair of the Trust, he was a solicitor
22 by profession.
23 Martin Dillon, Interim Chief Executive and then Chief
24 Executive, he was an accountant by profession and a
25 finance officer. 12:22
26 Even Professor Sir Michael McBride, Chief Medical
27 Officer for Northern Ireland was clear he didn't have
28 that knowledge or expertise.
29

1 Our clients have been clear all along about the safe
2 and effective care of their loved ones with learning
3 disabilities, especially those with complex behaviours
4 and conditions requires individuals who are trained,
5 qualified and experienced in the field of learning 12:22
6 disability. This means people with the right knowledge
7 and the right skills to provide the right type of care
8 and the requisite level of care. It also requires
9 leadership and, management with sufficient knowledge of
10 the particular context of learning disability to know 12:22
11 what assurances to look for, what information is
12 required to make those assurances meaningful and to
13 recognise when things go wrong.
14
15 6. Inadequate staffing 12:23
16 There was inadequate staffing so far as my clients are
17 concerned. Insufficient numbers of staff and the
18 working terms and conditions were not such as to bring
19 about any real change. Bamford identified that a
20 workforce strategy would be required and made 12:23
21 recommendations accordingly, but they were not properly
22 implemented and a wrong turn was taken on foot of the
23 DeLoitte report on workforce planning which the
24 Department obtained in 2009. As a result, reliance was
25 placed on the release of staff from Muckamore as 12:23
26 patients were resettled. Well, ultimately that
27 particular strategy proved ineffective because staff
28 weren't released in that way.
29

1 The upshot of all of that was that there was a staffing
2 crisis in Muckamore from 2010. That crisis was
3 apparent to everyone who conducted even a basic
4 analysis of the position. However the evidence of
5 Moira Mannion was that even when staffing was 12:24
6 increased, the increase would then be followed by a
7 round of cuts and reduction in numbers to contribute to
8 the required 3% saving. Moreover, the crisis was made
9 worse by the response to the Ennis Investigation which
10 required additional staff to supervise care on the 12:24
11 wards over a prolonged period of time and made worse
12 again by the abuse scandal in 2017 and the suspensions
13 that necessarily followed. This in turn led to even
14 greater reliance on bank and agency staff who often
15 lacked qualifications or experience in learning 12:24
16 disability.
17
18 Additionally, whilst the Trust oversaw a reduction in
19 the number of nurses and healthcare assistants in
20 apparent furtherance of a vision of care in the 12:24
21 community placements rather than in long stay
22 hospitals, there was no joined up thinking about
23 securing a consequent increase in the social care
24 workforce with learning disabilities experience and
25 expertise. Moira Mannion, who acknowledged that: 12:25
26
27 "At that time the approach by our social work
28 colleagues and the approach by nursing were a little
29 discordant with one another and there was a need for

1 joined up thinking and joined up training
2 opportunities."
3
4 So far as our clients are concerned, to add to the
5 whole incoherence of this system there was an 12:25
6 underspend on staffing from 2016, despite the serious
7 staff crisis and that they consider to be just
8 incomprehensible.
9
10 Thus the problem is not simply that the staffing system 12:25
11 lacks sufficient resilience to respond in times of
12 crisis, it was due to the lack of coherent staff
13 planning, the staffing system was not fit for purpose
14 even before the crisis hit and the crisis led to a
15 further spiral. Thus when some witnesses suggested 12:26
16 that the staffing crisis was no different from the
17 general staffing problems seen across the health
18 service, from my clients' perspective they were wrong
19 and they missed the serious additional and avoidable
20 staffing problems which were present in Muckamore. 12:26
21
22 As if all that was not bad enough, this took place in a
23 context where leadership and management seemed not to
24 appreciate the difficulties and complexities of the job
25 that staff in learning disability services have. 12:26
26 Professor McConkey referred to them as:
27
28 "To a large degree an exploited workforce with minimum
29 pay often being offered to them because the

1 Commissioners have been trying to drive down costs, but
2 if you look at value for money in terms of what quality
3 of life you are buying for the money you're spending on
4 staff, that changes the agenda considerably."
5
6 So far as our clients are concerned, what is required
7 is a resilient workforce trained and qualified in
8 learning disability who are provided with working terms
9 and conditions that reflect the difficult and complex
10 job they are required to do and the responsibilities 12:27
11 placed on them when they do it. Minimum pay and bad
12 working conditions won't cut it. The system will only
13 change once it is recognised that a properly skilled,
14 properly paid workforce is essential. So far as my
15 clients are concerned, there is currently nothing even 12:27
16 close to that.
17
18 7. Failure to treat Learning Disability Services with
19 the same value as acute services.
20 Cecil Worthington's statement to the Inquiry is: 12:27
21
22 "It often felt like there was a more immediate focus on
23 acute services at the Trust Board itself. I think it
24 was around 2014 there were huge pressures on the Trust
25 to comply with the various standards and targets in 12:27
26 Accident & Emergency. For example, there was a patient
27 waiting for a bed the Royal Victoria, they passed away
28 and it was major media news. It was the only time in
29 my career that the Health Minister came to the

1 Executive Team and made it very clear what he expected
2 in terms of meeting targets. It is no coincidence in
3 that year the Chief Executive and Medical Director both
4 sought other jobs because there was a lot of pressure
5 on the Executive Team at that time. That heightened 12:28
6 the focus on 12 hour breaches and four hour targets so
7 I can well understand why my colleagues were so focused
8 on acute events."
9
10 Unfortunately the Inquiry doesn't have the evidence 12:28
11 from a Minister on these assertions which seek to
12 explain what led to the focus of the Trust on acute
13 services at the expense of social care. The impact,
14 though, of policy decisions is clearly an important
15 issue as was recognised by the Permanent Secretaries in 12:28
16 their evidence.
17
18 John Veitch gave evidence to the Inquiry:
19
20 "That when I came into post [in 2011] I saw learning 12:29
21 disability as an underdeveloped service. When I first
22 went round some of the wards in Muckamore I was pretty
23 shocked by dormitory living for patients which I didn't
24 think was appropriate. The people in learning
25 disability who had worked there all their lives said it 12:29
26 was almost a Cinderella service."
27
28 H51's statement to the Inquiry states:
29

"During the majority of my career as a nurse [which spans 1972 to 2015] I have worked with patients with learning disabilities and I have no doubt that this part of the health service has been what I would call the Cinderella of the health system, it is often under resourced and under staffed."

Others gave similar evidence, including Richard Pengelly, the Permanent Secretary.

The inherent problem lies in the fact that there is a systematic culture and attitude of treating Learning Disability Services with less value than acute services, that is my clients' belief, that that problem will only be resolved by recognising it is wrong and changing attitudes throughout the system.

8. Failure of accountability mechanisms
I start with the RQIA. The RQIA was the regulator that had statutory oversight of quality and of care and treatment. The extensive evidence during the patient experience phase shows it failed in its task of regulation, that is my clients' belief and evidence. Failings such as inadequate dental care, inadequate podiatry care, absence of basic hygiene, unlawful detention, theft of personal items, urine soaked mattresses and many other consistent features of the patient experience evidence should have been picked up by the RQIA but very often they were not. Our clients

1 contend that failure was caused by a range of factors
2 including rushed and superficial inspections,
3 unannounced inspections never truly being unannounced,
4 inadequate engagement with or respect for families,
5 inadequate attention to the particular context of 12:31
6 Learning Disability Services, inadequate advocacy
7 services that could have engaged with RQIA on behalf of
8 families, inadequate use of CCTV and an inexplicable
9 bias so far as they are concerned in favour of the
10 organisations they were charged to inspect. And this 12:31
11 last factor, from my clients' perspective, is starkly
12 demonstrated by the evidence of P96's father. When he
13 was told by staff at Muckamore that his son had been
14 assaulted and he telephoned RQIA to advise them of this
15 fact, the RQIA's response was that they found this hard 12:31
16 to believe. Indeed the RQIA didn't accept it as true
17 until they telephoned Muckamore to confirm it.
18
19 When the Regulator approaches its duties in this way it
20 is largely irrelevant whether they have high quality 12:32
21 policies, procedures and inspections mechanisms.
22 Processes and procedures cannot be a substitute for
23 subjecting the service provider to the proper level of
24 suspicion and scrutiny, and that's what is required
25 when you're dealing with a facility that deals with 12:32
26 patients who are vulnerable and at risk.
27
28 The Inquiry heard evidence of improvements that the
29 RQIA are seeking to make including a shift from solely

1 wards based inspections to systems based inspections
2 and efforts towards a new IT system that should allow
3 for better analysis of information. Such improvements
4 are obviously essential but, so far as my clients are
5 concerned, the reality is that RQIA can only be 12:32
6 successful if it subjects the service providers to a
7 strong level of suspicion and scrutiny and if it is
8 combined with other strong oversight mechanisms
9 including the use of CCTV, a skilled advocacy service
10 and fundamentally a strong and effective system of 12:33
11 governance and assurance within the Trusts themselves.
12
13 Advocacy groups
14
15 Advocacy groups so far as my clients' experience, were 12:33
16 unacceptably weak and ineffective. This can be
17 demonstrated by a simple consideration of the Flynn
18 Report which noted that the extent of the advocacy
19 assistance at the same time as abuse was being alleged
20 at Muckamore when staffing levels were dangerously low 12:33
21 and the resettlement programme was dysfunctional, the
22 extent of that assistance was seeking a shelter for
23 smokers. So far as my clients are concerned this is
24 demonstrative of the gap between what was provided and
25 what was required. Our clients contend that the 12:33
26 vulnerabilities of people with learning disabilities
27 mean that a strong, effective advocacy service is
28 essential in order to keep their loved ones safe and
29 this is no less important in respect of Learning

1 Disability Services in the community. If anything, it
2 is more important because individuals and their
3 families will be more disparate, less able to identify
4 systemic issues on their own and therefore there may be
5 less scrutiny on each individual placement. 12:34
6
7 9. Inadequate respect for families, their knowledge
8 and experience
9 The system, so far as my clients' experience is, did
10 not respect the input of families, did not seem to 12:34
11 value the knowledge and experience they had, not just
12 in dealing with their loved ones but in the
13 practicalities of dealing with those with learning
14 disabilities. This attitude applied even to those with
15 professional training such as P90's sister. 12:34
16 Consequently, there was a failure to reckon with the
17 value that families might bring to a system that was
18 lacking in learning disability training and experience
19 and yet had to provide safe and effective care to
20 patients with extremely challenging behaviour, and this 12:35
21 was a problem throughout the system. My clients gave
22 consistent evidence of their mistreatment, of a
23 patronising approach by professionals, and a
24 frustrating and distressing lack of communication.
25 Such an approach, they feel, is entirely unacceptable 12:35
26 and it emphatically requires a culture shift within the
27 system.
28
29 So, I turn now to the core objective three, ensure that

1 such abuse does not occur again at Muckamore or any
2 other institution providing similar services in
3 Northern Ireland.
4
5 For our clients the importance of this objective cannot 12:35
6 be overstated. The recommendations which the Inquiry
7 makes and the actions which it identifies are required
8 to follow up and monitor implementation of those
9 recommendations will be vital to securing the safety
10 and wellbeing of their loved ones into the future. 12:36
11 They believe that simply cannot be understated, how
12 important that is. In that regard it will be no use to
13 our clients if the Inquiry makes recommendations which
14 are accepted in principle but never properly
15 implemented. So far as they are concerned this has 12:36
16 happened too many times before.
17
18 Nor will it be any use if recommendations are made, if
19 the requisite funding is not made available and that is
20 a matter of concern to my clients because the reality, 12:36
21 so far as they can see it, is that the requisite level
22 of funding to secure an adequate community based system
23 has never been made available.
24
25 In summary, for our clients, what is required can be 12:36
26 identified with relatively simplicity: Properly
27 funded, properly staffed community-based learning
28 disability service with rigorous up-to-date governance,
29 assurance and oversight systems which also include the

1 use of CCTV and leadership and management that has
2 knowledge or access to knowledge of Learning Disability
3 Services, an effective regulator and effective advocacy
4 services.
5 12:37
6 Our clients consider that the recommendations the
7 Inquiry makes should be focused on securing that
8 outcome and securing it as soon as possible.
9
10 In summary our clients identify the following key 12:37
11 findings and recommendations they wish the Inquiry to
12 make, however, recommendations on this objective of its
13 Terms of Reference will also be informed by the
14 forthcoming session on resettlement and available
15 community services. 12:38
16
17 1. Funding and the need for information on Learning
18 Disability Services
19 The requisite level of funding must be determined
20 according to the needs of people with learning 12:38
21 disabilities. That requires proper data on the numbers
22 of people with learning disability and data on their
23 level of need. It's only once those needs are known
24 that what is required to discharge them in a community
25 based system can be identified and the requisite level 12:38
26 of funding determined. Our clients contend that the
27 requirements of those with learning disabilities have
28 never been comprehensively identified or met. There
29 continues to be the need identified in the Equal Lives

1 report to establish better systems for tracking people
2 as well as for funding and assessing outcomes. Without
3 accurate information it has been and will continue to
4 be impossible to coherently fund or provide for an
5 effective community based system of Learning Disability 12:39
6 Services.
7
8 Our clients, therefore, seek a finding that the current
9 information system is inadequate and a recommendation
10 on the need to implement a coherent system for 12:39
11 gathering and maintaining accurate information on the
12 size of the population in need of Learning Disability
13 Services and the services and supports they require and
14 what is currently available.
15 12:39
16 2. Staffing
17 The system must be staffed with people with adequate
18 skills, qualifications and training in learning
19 disability. That will require an increase in the
20 current workforce. It will require strategic workforce 12:39
21 planning. It will also require updated training
22 courses that provide up-to-date learning and which
23 consciously and rigorously strive to embed the
24 necessary culture in students and trainees from the
25 outset. It will also require working conditions that 12:40
26 recognise the difficulty and importance of working in
27 Learning Disability Services and the higher level of
28 skill and knowledge required.
29

1 3. Governance, assurance and oversight
2 This Inquiry has shown that the voluminous policies and
3 procedures, well at least from my clients' perspective,
4 were not merely ineffective, but may in fact have been
5 part of the problem. This is because it provided a 12:40
6 false appearance of assurance and a false belief
7 throughout the leadership and management that the
8 system in which they were engaged provided effective
9 governance and assurance. It meant that leadership and
10 management throughout the health and social care system 12:40
11 completely failed to understand what was required or
12 where they were going wrong.
13
14 Our clients consider the focus must be on the difficult
15 task of changing the culture of reliance on long and 12:41
16 complex policies and procedures at the expense of
17 effective outcomes. They ask the Inquiry to make a
18 finding with a view to embedding a clear message within
19 the health and social care system that a system of
20 governance assurance based on upward reporting through 12:41
21 single source relying on low quality evidence simply
22 will not work. Proper governance and assurance require
23 leadership and management to proactively seek assurance
24 on all matters under their responsibility, including
25 the absence of poor care and the presence of good care 12:41
26 and should require high quality evidence with multiple
27 lines of assurance. Moreover, when things go wrong due
28 to leadership and management failing to properly
29 discharge that function, it is essential that

1 leadership and management are properly held accountable
2 and responsible.
3
4 4. Involvement of families
5 Our clients seek findings on the need for: 12:42
6 (a) Establishment of the entitlement of families to be
7 properly informed and involved in decisions concerning
8 the placement, care and wellbeing of their loved ones.
9 (b) Development of a mechanism to give effect to that
10 entitlement. 12:42
11 (c) Establishment of a ready means for families to
12 enforce their entitlement to be informed and involved
13 and recommendations to that effect.
14
15 5. CCTV 12:42
16 The use of CCTV is inherently linked to the issue of
17 governance, assurance and oversight because, so far as
18 my clients are concerned, it provides objective
19 evidence of standard of care being provided. Our
20 clients consider it is essential that the Inquiry makes 12:42
21 a strong recommendation on the need for CCTV to be used
22 in community placements as a tool to safeguard their
23 loved ones and as a means of developing and improving
24 learning. Furthermore, it's necessary to have a proper
25 regional policy on CCTV that will ensure consistency of 12:43
26 approach irrespective of the nature or location of the
27 placement or the identity of the provider.
28
29 Our clients also ask the Inquiry to assist with

1 permitting them to view the CCTV of their loved one's
2 abuse in Muckamore. While some of them don't want to
3 see it, others do, and for them it's a matter of
4 torment to be left with only their mental images from
5 the evidence of others about what happened to their 12:43
6 loved ones. That's probably difficult to adequately
7 convey, that you're left with a picture in your mind of
8 what happened and that picture may well be worse than
9 the reality. But whatever it is they want to see the
10 reality, they feel they should be able to view it and 12:44
11 they believe that actually would happen in line with
12 the hope that you, Chair, expressed in your opening
13 statement. So they ask the Inquiry to make a formal
14 finding that they should be entitled to view the CCTV
15 in relation to their loved ones if they wish to do so. 12:44
16 There may well be conditions that have to be placed on
17 that, but nonetheless that is what some of them want to
18 do.
19
20 6. Regulator 12:44
21 The RQIA's oversight must be a rigorous process,
22 proactively seeking a range of streams of high quality
23 evidence, including from families and from effective
24 advocacy services, which provides strong and coherent
25 assurance as to the quality of care. Our clients seek 12:44
26 a finding to that effect and recommendations to help
27 make that a reality since for them it is a matter of
28 real concern that none of this really came to the fore
29 from the action of the Regulator.

1
2 7. Advocacy
3 Individuals and their families need a strong, effective
4 advocacy service that is well known and proactively
5 made available. Our clients ask the Inquiry to endorse 12:45
6 the recommendations set out in the statement of 4th
7 March 2024 made on behalf of the PCC by its then Chief
8 Executive Officer, Ms. Mullaghan, particularly those on
9 the independence of advocacy services which my clients
10 consider to be of considerable importance. 12:45
11
12 8. Culture
13 Our clients are firmly of the view that there must be a
14 cultural change within the system. Learning disability
15 can no longer be a Cinderella service and they mean can 12:46
16 no longer be treated in that way, even if they change
17 the name and nobody ever refers to Cinderella again,
18 that's not the point, it can no longer be treated in
19 that way. There must be a proper recognition of the
20 importance of Learning Disability Services. 12:46
21
22 Accordingly, they consider that the Inquiry's
23 recommendations must address the need to embed this
24 message throughout the system at every stage and at
25 every level. 12:46
26
27 9. Regulation of healthcare assistants
28 My clients believe that this is an urgent need, that
29 there should be formal recognition of healthcare

1 assistants to ensure that those who have been involved
2 in abuse and neglect cannot continue working in
3 Learning Disability Services simply by moving jobs.
4 There has to be a professional body or some form of
5 regulation in relation to them who can be notified of 12:47
6 that so that everybody can understand if one is dealing
7 with somebody who is subject to some form of action in
8 relation to their professional body. Our clients seek
9 findings and recommendations on this. The Inquiry will
10 be aware of the important role that healthcare 12:47
11 assistants play in providing care for those within
12 Learning Disability Services. So if they are going to
13 be playing that role then there needs to be a way of
14 addressing this point and it shouldn't be only those
15 who are regulated by the Nursing Midwifery Council or 12:47
16 the GMC, it shouldn't be just them, everybody involved
17 directly in the care of those with learning
18 disabilities, there needs to be a way of identifying if
19 they have been involved in something where their
20 conduct is in question. And, for that matter, so the 12:48
21 family of those residents or patients can know that.
22
23 10. Duty of candour
24 Northern Ireland remains the only part of the UK not to
25 have introduced a duty of candour. Our clients 12:48
26 consider that should happen and it should happen as a
27 matter of urgency and they invite the Inquiry to
28 reflect that in its recommendations. It's been in
29 recommendations before, it was done in the O'Hara

1 Report, in the 2018 Hyponatraemia and Related Deaths
2 Inquiry and in the 2020 Dunmurry Investigation. So
3 it's not the Department and Executive aren't aware of
4 it, they are, but our clients believe that if the
5 Inquiry includes that in its recommendations, it may 12:48
6 well add some force to that move. One would have
7 thought that all professionals would conduct themselves
8 with a duty of candour, but other places in the rest of
9 the United Kingdom have found it necessary to enshrine
10 that and they ask for recommendations to that effect 12:49
11 for Northern Ireland.
12
13 11. Resettlement and community based Learning
14 Disability Services
15 In general it is submitted on behalf of our clients 12:49
16 that what is required is clear, a properly resourced,
17 properly staffed, properly governed and regulated
18 system of community based learning disability service.
19 This will require increases in funding, coherent staff
20 planning, improvements in governance and oversight and 12:49
21 the provision of additional services.
22
23 They are aware that there is a further session relating
24 to these matters and that is yet to take place and our
25 clients are strongly of the view that the Inquiry 12:49
26 cannot really make properly targeted and effective
27 recommendations on these matters without further
28 information on the up-to-date position in the
29 community, very likely from a range of people, not just

1 them. This is a matter of key importance to our
2 clients because it goes to the current safety and
3 wellbeing of their loved ones as well as into the
4 future. In those circumstances, our clients will seek
5 to provide further submissions on resettlement and 12:50
6 community based services once the sessions are complete
7 and the additional material is made available.
8
9 12. Accountability
10 Our clients consider that, for the most part, save for 12:50
11 frontline staff, the actions, omissions and failures
12 that caused the abuse have been perpetrated with
13 complete impunity and that has to be rectified. To
14 ensure the failures at Muckamore do not happen again
15 it's essential that there is an adequate investigation 12:50
16 capable of ensuring the accountability of all those
17 responsible for the abuse. So far as my clients are
18 concerned, individuals at Muckamore were subjected to
19 treatment contrary to Articles 2 and 3. Thus the state
20 has a positive obligation to conduct an investigation 12:51
21 that is independent, adequate, conducted promptly and
22 with reasonable expedition and conducted with the
23 necessary element of public scrutiny and participation
24 for the next of kin. That is what is required for an
25 Article 2 and 3 compliant investigation. 12:51
26
27 Our clients ask the Inquiry to formally recommend that
28 a dedicated mechanism is set up that has the capacity
29 to investigate the allegations with respect to

1 individuals at Muckamore. That is not something that
2 the Inquiry set out itself to do, but my clients ask
3 that the Inquiry makes a recommendation that that
4 happen, that such an Inquiry or investigation rather
5 happen. Such capacity to investigate must not be 12:52
6 limited merely to the frontline staff responsible for
7 actively perpetrating abuse, but to discharge the
8 investigative duties under Articles 2 and 3 must be
9 capable of securing accountability of all those who
10 fail to discharge their responsibility in ways that 12:52
11 could have prevented the abuse.
12
13 13. Redress scheme
14 The Inquiry has heard extensive evidence of the
15 traumatic impact that the abuse at Muckamore has had 12:52
16 upon patients and their families. Our clients submit
17 that there is a need for a dedicated redress scheme for
18 individuals who were resident in Muckamore and for
19 their families and they ask the Inquiry to make that
20 recommendation, as is provided for in its Terms of 12:52
21 Reference at paragraph 24G. Such a scheme should:
22 1. Provide a dedicated mechanism for considering and
23 identifying the full impact of the abuse on individuals
24 and their families and identifying the necessary
25 support, treatment and counselling that is required to 12:53
26 address, mitigate and reduce that impact.
27 2. Provide redress, including financial redress, for
28 the personal injury, loss and damage caused to
29 individuals in Muckamore and their families which needs

1 to properly reflect the gravity and duration of the
2 abuse suffered.
3
4 Chair, I have one last section but I doubt that I would
5 get that done so I am just wondering, this might be a 12:53
6 place to pause.
7 CHAIRPERSON: I am going to ask you if you personally
8 need a break because you have been going for an hour
9 and quarter. So we'll stop there for lunch, we'll try
10 and come back at 1.55, give everybody just more than an 12:54
11 hour, because we have another address to hear from
12 Mr Maguire and I don't want anybody to feel rushed. So
13 1.55. Thank you very much.
14
15 LUNCHEON ADJOURNMENT
16
17 THE INQUIRY RESUMED AS FOLLOWS:
18
19 MS. ANYADIKE-DANES: Thank you, Chair. Public
20 inquiries have become an increasing feature of public 13:56
21 life when the public sector gets it badly wrong and
22 people are harmed. In my clients' experience rarely
23 are the views of those who experience prompted the
24 Inquiry heard on the processes adopted for delivering
25 on its Terms of Reference. And yet the success of that 13:56
26 process has the capacity to do considerable good over
27 and above the findings and recommendations that the
28 Inquiry makes.
29

1 Our clients want to make clear that they found the
2 Inquiry to be a challenging process. Now, they
3 anticipated that it would be very hard to relive their
4 experiences and hear some of the evidence but they did
5 not reckon that it would otherwise be so difficult. 13:57
6
7 They refer to five aspects with a view to
8 constructively identifying matters that they hope will
9 assist future investigations.
10 13:57
11 1. Failure to put patients and families at the centre
12 of the process
13 This Inquiry, as everyone now knows, came about through
14 the campaign by our clients who had found previous
15 processes to be obstructive and opaque with few people 13:57
16 properly listening to what they had to say. It was
17 therefore, important to them that the examination of
18 abuse at Muckamore was carried out in public and that
19 their voice was properly heard. They did not consider
20 the Inquiry statements such as: 13:58
21
22 "I regard the patients and their relatives and carers
23 who have been abused or received poor cure as being at
24 the front and centre of this Inquiry."
25
26 Were always demonstrated in practice. For example:
27 The difficulties with the statement making process
28 requiring them to have their statements taken by
29 individuals they did not know and with whom they had

1 developed no relationship of trust, which although
2 ultimately modified, for them, that was a bad start
3 because by then a lot of worry and frustration had
4 built up.
5 13:58
6 2. Provision of large volumes of important
7 documentation only shortly in advance of the evidence
8 sessions which made it very difficult for them to
9 absorb and provide instructions in time for those
10 instructions to be of any use to their legal team. 13:59
11
12 3. Restrictions on downloading and receiving hard
13 copies of materials where electronic viewing for them
14 was problematic, and it was problematic for some of
15 them. 13:59
16
17 4. Hearings that could only be viewed in real-time
18 when some were at work or otherwise engaged.
19
20 Questions submitted for witnesses without any mechanism 13:59
21 for confirming beforehand which of their suggestions
22 were accepted and if not, the reason for that.
23
24 Correspondence raising important issues that went
25 unanswered or unaddressed. 13:59
26
27 Failure of the Inquiry to make use of its power to make
28 interim recommendations when requested without any
29 proper engagement or explanation for that. As a

1 result, many of them, including those who are elderly
2 or continue to have significant caring
3 responsibilities, felt unable to properly engage with
4 the vital material that was often dealing with their
5 loved ones or issues they had specifically raised and, 14:00
6 therefore, had a clear interest in following how the
7 evidence was delivered. These points were made on
8 their behalf in correspondence many times over the
9 course of the Inquiry but, so far as they are
10 concerned, met with little change. 14:00
11
12 Our clients are fully aware of the difficulties which
13 are inherent in any public inquiry and the inevitable
14 need for processing of large volumes of documentation
15 within relatively short timeframes. They are also 14:00
16 fully aware of the importance of this Inquiry of
17 avoiding any steps that could frustrate or detract from
18 the criminal justice process, they more than anyone are
19 concerned to earn sure the integrity of that process.
20 However, they consider it would have been possible to 14:01
21 find practical ways of addressing their concerns and
22 they were left with the feeling that the failure do so
23 indicated the Inquiry's true view of the significance
24 of their role which, although characterised as to
25 further the work of the Inquiry and assist in 14:01
26 fulfilling its Terms of Reference, to them it didn't
27 always feel like that.
28
29 As a result, whether justified or not, the message our

1 clients took from the Inquiry's approach to evidence in
2 general was that the Inquiry considered it had the
3 necessary expertise to gather information and analyse
4 the issues and didn't need to engage with our clients'
5 assessment of the evidence. Unfortunately this was 14:01
6 redolent for them of their experience of Muckamore and
7 the Trust and as a result, many lost faith in the
8 Inquiry that they had fought so hard to bring about.
9
10 2. Information gathering rather than accountability. 14:02
11 One of the key aims of our clients in campaigning for
12 the Inquiry was to secure this accountability of those
13 responsible for the abuse of their loved ones. They
14 were particularly concerned to ensure that those in
15 positions of leadership and management were held to 14:02
16 account for the abuse perpetrated under their authority
17 and which engaged their responsibilities under Articles
18 2 and 3. As was stated in their opening, not just what
19 individual care workers or nurses did in the ward but
20 those in charge, our clients are particularly anxious 14:02
21 that they should be looked at as well because they had
22 that ability to ensure accountability and oversight.
23 In the event, it appeared to our clients that the
24 evidence sessions were approached more as an
25 information gathering exercise with witnesses for the 14:03
26 most part being treated and questioned as information
27 providers rather than as a people who had authority in
28 and over Muckamore and who thus bear a high level of
29 responsibility for the abuse which they say was

1 perpetrated and should be held accountable accordingly.
2
3 This omitted the important function of publicly holding
4 those who are responsible to account and using these
5 sessions to recover some of the public's loss of trust 14:03
6 and confidence in the health and social care system.
7
8 For our clients, this was starkly demonstrated by the
9 Inquiry's approach to evidence from Professor Sir
10 Michael McBride. Initially the Inquiry did not propose 14:03
11 to call him to give oral evidence on the basis that his
12 statement was sufficient. Our clients simply couldn't
13 understand this given the fact he was double jobbing as
14 CMO and Trust's Chief Executive at a key time just
15 prior to the abuse scandal breaking. Even when 14:04
16 ultimately the Panel agreed to call him it did so
17 stating that:
18
19 "It remains of the view that this witness is very
20 unlikely to be able to contribute more than what is 14:04
21 already contained in his written evidence."
22
23 Which may account for why only one hour was set aside
24 purely for core participant questions to be posed to
25 the witness through counsel to the Inquiry and:
26
27 "Topics upon which Professor Sir Michael McBride will
28 be questioned must be furnished to the Inquiry and in
29 light of the very short notice shall be forwarded to

1 Professor McBride."
2
3 Unfortunately this statement had the effect of
4 exacerbating matters, not least because the one hour
5 that was set before the Inquiry had received any 14:04
6 proposed questions from our clients or, for that
7 matter, anybody else.
8
9 For our clients the apparent deference, which is how it
10 seemed to them, shown to this witness was both 14:04
11 inappropriate and unwarranted. The Inquiry's claim
12 that they were calling him solely in the interests of
13 working together with the Core Participants was
14 unfortunately viewed as patronising. In essence the
15 Inquiry was calling the witness not because the Inquiry 14:05
16 considered him to be relevant, but to allow Core
17 Participants to ask questions which the Inquiry
18 expressly viewed as irrelevant. In the event when he
19 attended to give evidence his oral evidence went
20 further than his written statement and his evidence was 14:05
21 reported that evening as a main headline on the BBC
22 news online.
23
24 Many of our clients felt the Inquiry had failed to give
25 adequate weight to the importance of public 14:05
26 accountability as a core aspect of the Inquiry's role.
27 They feel the Inquiry almost completely failed to
28 discharge this important aspect of the function of a
29 public Inquiry. In contrast they look at the Post

1 Office Inquiry and Covid 19 Inquiry which, in their
2 view, were both clearly and obviously aware of their
3 function in holding those with responsibility publicly
4 to account and managed to hold the public's attention
5 over a prolonged period. 14:06
6
7 3. Timing of the hearings
8 March 2023 to June 2023 was spent on an information
9 gathering exercise describing and explaining structures
10 and law and was not focused on the effectiveness of the 14:06
11 legislation, policies and regulations or where they
12 failed. Our clients consider by contrast that
13 insufficient time was made for modules that were
14 focused on the crucial evidence of the failures at
15 Muckamore by leadership and management. The 10 14:06
16 organisational modules started at the end of May 2024
17 and were completed over approximately eight weeks
18 interspersed with staff and other evidence. Large
19 volumes of documentation were disclosed with little
20 time for my clients to engage with or analyse material, 14:06
21 notwithstanding repeated requests in correspondence for
22 earlier provision of the hearing schedule and
23 associated documents. That was done specifically to
24 avoid that problem. The oral evidence from the RQIA
25 was limited to just two evidence sessions. The module 14:07
26 on resettlement opened on 24th June and closed on 25th
27 June. Only two days and two half days were spent on
28 the Trust Board and the Department's evidence was just
29 three and a half days.

1
2 In the circumstances, our clients were left feeling the
3 most important part of the Inquiry had been rushed over
4 with little opportunity for their consideration or
5 input. 14:07
6
7 4. Changing approach
8 At times the Inquiry would change its approach without
9 identifying that it had done so or explaining its
10 reason. For example, Chair statement issued on 13th 14:07
11 February 2023 the Inquiry outlined its plan for the
12 remaining evidence including patient experience, staff
13 and other relevant authorities and then expressly
14 stated at paragraph 4 that the final area of evidence
15 to be received will be expert evidence on a number of 14:07
16 different topics to assist the Panel on potential
17 recommendations.
18
19 Following the Chair's subsequent statement and plan for
20 2024 our clients immediately asked whether there was a 14:08
21 preliminary schedule of experts from whom the Inquiry
22 intended to hear. No response to this query was
23 received and the Inquiry appeared to have changed its
24 plan. Our clients don't know why. In their view
25 evidence from appropriate experts could have provided a 14:08
26 valuable input to the Inquiry, could have assisted in
27 explaining publicly the regular references in the
28 evidence to matters that could not properly be engaged
29 with or understood by them or the lay public, such as

1 the appropriate approach to risk management as well as
2 the complex issues involved in governance and
3 assurance. And while our clients do not doubt the
4 expertise of the Inquiry, from their point of view it's
5 not sufficient for a public Inquiry to have expertise 14:08
6 itself, they feel it must examine the issues in a
7 manner that can be engaged with and understood by the
8 Core Participants and the public.
9
10 5. The requirement to file closing submissions prior 14:09
11 to the resettlement session. Our clients, some of
12 whose loved ones are still in Muckamore awaiting
13 discharge to a community placement requested an
14 opportunity to provide further information to the
15 Inquiry on discharge and resettlement. In response the 14:09
16 Inquiry agreed to have a separate session on
17 resettlement. However, the Inquiry is proposing to
18 conduct this session as information gathering rather
19 than as an evidence session and to schedule it after
20 these closing submissions are provided. The issue of 14:09
21 resettlement into community placements is of vital
22 importance to our clients in enabling the Inquiry to
23 make recommendations that will ensure the safety and
24 wellbeing of their loved ones for the future and others
25 with mental health issues and learning disabilities. 14:10
26
27 Our clients consider it is important that closing
28 submissions can be made on the totality of the
29 discharge and resettlement material provided to the

1 Inquiry to inform its delivery of its Terms of
2 Reference and recommendations. However, the Inquiry
3 has proceeded with closing submissions ahead of the
4 resettlement and available community services sessions
5 so our clients now look forward to making submissions 14:10
6 at the end of those sessions.
7
8 Then in conclusion on the process: From our clients'
9 perspective the purpose of a public Inquiry is not
10 simply to gather the evidence and make appropriate 14:10
11 findings and recommendations, but that where, as here,
12 it is dealing with breaches of the most serious human
13 rights the proper inclusion of families in the process
14 is an essential end in itself. This is particularly
15 where the abuse scandal has caused a loss of Trust and 14:11
16 a key purpose of the Inquiry is to try and restore that
17 Trust and confidence in the system.
18
19 Now I just want to have an overall conclusion. To sum
20 up, our clients believe that there can be little doubt 14:11
21 that the most serious abuse was perpetrated against the
22 most vulnerable of people over a prolonged period. So
23 far as they are concerned it is a matter of shame for
24 all involved, staff, management, leadership and
25 oversight bodies repeatedly came before the Inquiry and 14:11
26 expressed shock at the abuse. They had faith in their
27 governance systems and say they had no idea how it
28 could have happened. They say essentially they still
29 have no idea. They say they are looking to the Inquiry

1 to tell them what to do to stop the abuse from
2 happening again or, rather, to prevent it happening
3 again.
4
5 For many of our clients this failure of leadership and 14:12
6 management to understand what they were doing wrong or
7 to understand their own responsibility for the abuse
8 that they say was perpetrated at Muckamore is gravely
9 concerning. For them it means there can be little
10 confidence in the ability of these bodies to make the 14:12
11 necessary changes to prevent abuse in future. It also
12 means that in all likelihood, so far as they are
13 concerned, the abuse would have continued if not for
14 the CCTV and if not for the rigorous efforts of P96's
15 father to gain access to that CCTV and that is why the 14:13
16 forthcoming sessions on resettlement and available
17 community services are so important. For many of our
18 clients their community placements are as bad or, in
19 some cases, worse than their experience at Muckamore.
20 Yet there continues to be no understanding or awareness 14:13
21 of what is going wrong or how to improve it or, if
22 there is that kind of understanding, it's certainly not
23 being articulated.
24
25 Muckamore is scheduled to finally close when the 14:13
26 remaining few patients are discharged to their
27 community placements. The focus is therefore now on
28 what happens in the community and the placements caring
29 for those with learning disabilities and mental health

1 issues. Accordingly, our clients regard it as
2 essential that the Inquiry identifies the position in
3 the community and makes strong, effective
4 recommendations capable of assuring abuse cannot happen
5 in those community placements. 14:14
6
7 Most of them have no choice but to have their loved
8 ones in those community placements and they are
9 therefore, to a large extent, relying on this Inquiry
10 to make the recommendations that they hope will ensure 14:14
11 they are safe whilst they are there.
12
13 Then, Chair, finally a tribute to Geraldine O'Hagan.
14 Our clients wish to conclude these submissions to the
15 Inquiry by paying special tribute to Geraldine O'Hagan 14:14
16 and we, as their legal team, wish also to pay tribute
17 to her. The Inquiry is well aware of the special role
18 that she played for families and patients, the support
19 that she provided, the consideration that she gave to
20 them and the care that she showed to them. All of that 14:15
21 stands in stark contrast to the treatment that many of
22 our clients and their loved ones experienced from
23 others connected to Muckamore. She went above and
24 beyond to advocate for them, to care for them, even
25 sacrificing her time in her final days to give evidence 14:15
26 to the Inquiry in order that their welfare and safety
27 could be assured into the future. If the Department,
28 Trust, RQIA and other health and social care bodies and
29 personnel wish to understand the type of attitude that

1 is required and the qualities that are needed to
2 provide proper levels of care and safety of our
3 clients' loved ones, then they need do nothing more
4 than look to the example of Geraldine O'Hagan. So far
5 as our clients are concerned she exemplifies everything 14:16
6 that the system must strive to achieve. Thank you very
7 much, Chair.
8
9 [APPLAUSE]
10 14:16
11 CHAIRPERSON: Thank you very much indeed. Can I also
12 thank you for the written material including the
13 chronology the other appendices into which a lot of
14 work has been done, so thank you.
15 14:16
16 We're now going to move on to Group 3. Mr Maguire, I
17 gather you would like to address the Panel from where
18 you sit and we can make arrangements for that. It has
19 to be one of the two front desks, for those who are
20 sitting behind and awaiting their turn, but we'll break 14:16
21 now for just 10 minutes to allow the reorganisation to
22 take place and then we'll hear from you Mr Maguire,
23 thank you very much indeed.
24
25
26
27
28
29

1 THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:
2
3 CLOSING SUBMISSION BY MR. CONOR MAGUIRE
4
5 CHAIRPERSON: Mr Maguire. 14:29
6 MR. MAGUIRE: Good afternoon, Chair, Professor Murphy,
7 Dr. Maxwell and thank you. As you know, Panel, but for
8 the benefit of the record, I am Conor Maguire KC. I am
9 instructed as senior counsel for a group of patient
10 relative Core Participants at the Inquiry. And for 14:30
11 ease this group consisting of 17 clients relating to 14
12 patients has been referred to as Core Participant Group
13 3 or CP3. I am instructed along with my junior
14 counsel, Ms. Victoria Ross. I'm instructed by Mr Tom
15 Anderson solicitor of O'Reilly Stewart solicitors. 14:30
16
17 it has been a privilege to represent these families who
18 themselves will have advocated, many quietly, but
19 firmly on behalf of their relatives who were patients
20 at Muckamore Abbey Hospital and who suffered abuse 14:31
21 there.
22
23 The group was initially described as being patients and
24 relatives of patients at Muckamore who are not
25 affiliated to Action for Muckamore, AFM, and the 14:31
26 Society of Parents and Friends of Muckamore, SPFM, but
27 nevertheless have a close interest in the events at
28 Muckamore. In fact, Panel, our clients had more than
29 just a close interest in events, because the harm

Gwen Malone Stenography Services Ltd.

1 suffered was not just by a distant group of adults with
2 learning disabilities and mental health issues who
3 happened to be classed as patients at this hospital,
4 but by beautiful, albeit vulnerable, people who were
5 and are loved sons and daughters, brothers and sisters, 14:32
6 uncles and aunts, who have all been deeply affected by
7 the ill-treatment, poor care, neglect and abuse
8 suffered by their dearly beloved relatives at Muckamore
9 Abbey Hospital.
10 14:32
11 A senior Trust director the Panel heard, Catherine
12 McNicholl, said when asked about trends of patient
13 abuse, she said:
14
15 "I am not going to use the word abuse." 14:32
16
17 She said:
18
19 "Accidents and incidents is the term used in the
20 Belfast Trust." 14:33
21
22 For ease, and consistent with the Terms of Reference,
23 we prefer and will use the term "abuse" and we'll use
24 it to cover a range of improper conduct perpetrated by
25 staff on patients at Muckamore but we will refer to 14:33
26 types of abuse within that range more specifically
27 where required.
28
29 So vulnerable were the patients at Muckamore and so

1 deserving of wrap around care were they, they should
2 have been provided with specialist care in a safe
3 environment and with an expectation, at the very least,
4 of a hospital which didn't breach one of the most basic
5 and fundamental principles of any healthcare service, 14:34
6 that is first do no harm.
7
8 Muckamore unfortunately was a place apart. Even the
9 location was problematic, being geographically remote,
10 and it was part of a service on the periphery of 14:34
11 healthcare with learning disability and mental health
12 getting lost within a vast system of competing needs
13 and demands, a service the Department of health
14 acknowledged through the former Permanent Secretary,
15 Andrew McCormick, was "struggling" he said to get 14:34
16 attention.
17
18 Our clients, Panel, now look to you to assess the
19 evidence, reach conclusions and make recommendations so
20 that no family in the future finds itself in the same 14:35
21 position as our clients and their relatives have found
22 themselves in and that no vulnerable learning disabled
23 adult or their family will be faced with the same
24 situation that so traumatised our clients and their
25 relatives. We are conscious, though, that among many 14:35
26 continuing issues for the families, two of them still
27 have a relative living at the hospital. And as many of
28 our clients and families continue on the resettlement
29 journey, about which you have heard some reference this

1 morning, whether at home or in residential care, we say
2 they must not be forgotten about by the health and
3 social care authorities.
4
5 All of our clients, Panel, have a similar set of aims 14:36
6 and objectives and whilst we acknowledge the efforts
7 made by AFM and SPFM to ensure, among other things,
8 that this Inquiry was set up, and we thank them for it,
9 it is important to say that the Core Participants in
10 Group 3, many of whom you see today in this room, are 14:36
11 being represented as individuals who are not aligned to
12 or affiliated with the two groups, and it is to these
13 families I will shortly turn.
14
15 The Inquiry has heard much evidence about governance, 14:36
16 regulatory frameworks, structures, processes and
17 procedures and will report on these and make
18 recommendations in respect of them. The Panel has
19 heard evidence and the public has had the opportunity
20 to hear evidence from what in societal terms might be 14:37
21 considered very important people, Professors and
22 doctors, managers and directors. We've heard from
23 senior nurses and social workers. We have heard from
24 Permanent Secretaries and Chief Executives. But the
25 Panel we say was right to identify at the very start of 14:37
26 this process, and you in particular, Chair, that the
27 patients and their families are to be at the front and
28 centre of this Inquiry. What is clear, we say, is that
29 no governance regime and none of the structures,

1 processes or procedures in place over the time of the
2 Inquiry's Terms of Reference and, in particular, up to
3 the disclosure of abuse by examination of CCTV in and
4 around September 2017, protected vulnerable adults from
5 mistreatment, poor care, neglect or abuse at Muckamore. 14:38
6
7 Sometimes that abuse or neglect resulted in physical
8 injury and should have been obvious to a critical
9 observer. In many incidents there was insidious
10 goading behaviour by staff that included, for example, 14:38
11 pulling loved soft toys from vulnerable patients simply
12 to get a rise out of them. Dr. Cathy Jack, the most
13 recent former Belfast Trust Chief Executive, described
14 in her evidence what she had viewed on CCTV footage and
15 she said: 14:39
16
17 "In fact some of the items of abuse that I witnessed
18 were deliberate acts of force or taunting to trigger
19 vulnerable patients and there is no place for that and
20 there never will be." 14:39
21
22 This, though, tragically is typical of the accounts
23 relayed by our clients in evidence and there is a
24 common view that you have heard reference to this
25 morning, Panel, that but for CCTV footage being 14:39
26 uncovered little of the abuse or neglect or
27 mistreatment that has been evidenced in this Inquiry
28 would have come to light. I will return to the issue
29 of the use of CCTV within learning disability care

1 facilities, the benefits of which, we say, are obvious.
2
3 On our clients: They were the first to give evidence
4 to this Inquiry, some going back to June 2022, nearly
5 three years ago. They took time preparing their 14:40
6 statements with the assistance of Cleaver Fulton Rankin
7 solicitors, through drafts and re-drafts, always keen
8 to make sure the Panel heard their family's full story
9 in the most articulate and comprehensive way, with each
10 of them hoping to play their part in ensuring the 14:40
11 mistreatment, poor care, neglect and abuse in this
12 place apart was exposed.
13
14 The Inquiry also heard evidence from numerous academic
15 and professional witnesses, important evidence about 14:41
16 governance and regulation and structures and processes
17 but it is the evidence of the patients and their
18 families, we say, that forms or should form the very
19 foundation of the Inquiry's business. As you,
20 Professor Murphy, sensitively but we say astutely put 14:41
21 it during the questioning of Dr. Cathy Jack, you said:
22
23 "Culture means a lot of things obviously, but what I'm
24 thinking about is the culture in relation to people
25 with learning disabilities in Muckamore and the extent 14:41
26 to which they were treated as human beings would want
27 to be treated, that kind of culture."
28
29 "The extent to which they were treated as human beings

1 would want to be treated, that kind of culture. "
2
3 Our clients, along with other patient relative
4 witnesses, presented to you that human side. And
5 whilst the substance of the evidence they gave was 14:42
6 often necessarily disturbing, giving us a window into
7 the world of the horrendous abuse and inhumane
8 treatment suffered by patients at Muckamore, it was
9 also, as you will have noted, Panel, I'm sure, it was
10 also tender and endearing and personal as we learned 14:42
11 about these loved family members, these loved human
12 beings.
13
14 Most of our clients gave oral evidence and, whilst they
15 were well looked after by Inquiry staff, the experience 14:42
16 was a difficult and emotional one for them. The Panel
17 will be aware, though, that whilst they gave their
18 sworn evidence passionately, they did so, each of them,
19 with great dignity, giving a voice to their children
20 and siblings, none of whom, because of their 14:43
21 vulnerabilities, because of their learning disability,
22 could do so themselves and many who literally had no
23 capacity to speak. They were the advocates.
24
25 So what was the reality for these vulnerable children 14:43
26 and adults as patients at Muckamore Abbey Hospital?
27 They were abused or provided with substandard care
28 within that hospital environment. And whilst in most
29 cases at most times hospital was not the proper place

1 for care to be provided to them, and you've heard a lot
2 of evidence about that, Panel, it was a place at least
3 in which they should have been safe and should have
4 felt secure. And such abuse, whatever its form, took
5 place without reasonable or appropriate scrutiny being 14:44
6 brought to bear.
7
8 The patients and their families, as has been
9 acknowledged now many times and by many people, were
10 let down. And, yes, of course they were let down by 14:44
11 their abusers and those that neglected their caring
12 responsibilities or managed the patients without
13 dignity or respect, but they were also let down by
14 those who bore the ultimate responsibility for their
15 care, including the senior managers, the directors, the 14:45
16 Chief Executives of the Belfast Trust, including the
17 senior officials and ministers in the Department of
18 health, including those senior personnel in
19 organisations tasked, whose job it was to advocate for
20 patients and assist with or oversee or regulate the 14:45
21 provision of care. Meanwhile the patients themselves,
22 by virtue of their disabilities and vulnerabilities,
23 were often without the physical voice or the means to
24 communicate, even to a caring third party, about the
25 abuse they suffered or were suffering. 14:45
26
27 Loving relatives of these abused patients, our clients,
28 when they brought issues to the fore were frequently
29 ignored or sidelined or humiliated with devastating

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1 consequences for the patient and their families.
2
3 Very early on in this Inquiry process as a legal team
4 with the benefit of taking detailed instructions from
5 our clients, normally in advance of them giving 14:46
6 evidence, we identified issues of concern that proved,
7 unfortunately, to be the rule rather than the
8 exception. And they related, Panel, not only to adult
9 safeguarding issues, but to the lack of ordinary,
10 decent, basic humane care. 14:46
11
12 In broad terms we identified, and you m have heard
13 evidence about the following: Inadequate ratio of
14 staff to patients, lack of trained carers, misuse of
15 seclusion, the ill-treatment and manhandling of 14:47
16 patients which, along with seclusion was used as a
17 punishment, inappropriate medication regimes and use of
18 PRN. The lack of caring and basic needs not being met,
19 and that included hygiene, clothing, foot and dental
20 care. And ou also heard about weight problems suffered 14:47
21 by patients, either in dramatic weight loss or weight
22 gain. Parents being excluded from bedrooms and
23 residential or ward areas. Lack of communication with
24 parents or other relatives and dismissal and at times
25 humiliation of them when they raised issues including 14:47
26 at professional meetings.
27
28 You heard about poor record keeping and no openness
29 around care plans, assessments or formal reviews. You

1 heard about the misuse of mental health detention to
2 remove patients' rights and their enforced separation
3 from relatives for hospital expediency. You heard of
4 poor accounting for and of patients' finances and
5 personal belongings and indeed you heard specific 14:48
6 reference to that earlier in the previous submission.
7 You also heard evidence, Panel, from our clients on
8 poorly planned and botched resettlement attempts with
9 the consequent further emotional damage to patients and
10 their families. You have heard evidence from our 14:48
11 clients on resettlement and you are aware, as I have
12 said, that two of the families have sons who are yet to
13 be resettled into the community. Others that have been
14 resettled have had mixed experiences and you have
15 acknowledged, as a Panel, that the resettlement journey 14:49
16 does not stop with a patient leaving Muckamore Abbey
17 Hospital, nor does it cease to be an issue at the
18 conclusion of the Terms of Reference.
19
20 In addition to these many issues, of course, that I 14:49
21 have highlighted, you have heard evidence about the
22 abuse and mistreatment perpetrated by staff on patients
23 at the hospital and you will make findings on the type
24 of abuse that happened and the extent to which it
25 occurred. That, we say, is not a difficult task. And 14:49
26 the victims of the abuse were among the most vulnerable
27 people in our society. They could not protect
28 themselves. They could not speak for themselves and
29 they were deserving as a minimum of protection from

1 harm. You have heard the human stories. You have
2 heard the families of patients give voice to their
3 vulnerable, learning disabled relatives, something that
4 few, if any, as you have heard, could do for
5 themselves. 14:50
6
7 You have also heard, Panel, from the family liaison
8 social workers that advocated for the families, both in
9 their fight for services and in their engagement with
10 this Inquiry. 14:50
11
12 Sadly, Geraldine O'Hagan passed away last year.
13 Despite being gravely ill she gave powerful testimony
14 on behalf of the patients and their families. We have
15 already acknowledged that without Geraldine's support a 14:50
16 number of our clients simply would not have engaged
17 with this process and you heard another tribute earlier
18 this afternoon. Geraldine spoke eloquently but humbly
19 about her role as a family liaison social worker
20 saying: 14:51
21
22 "I came into my post to speak up for the voiceless and
23 to support the families on this difficult journey."
24
25 Geraldine's testimony in unrestricted session and 14:51
26 available on the Inquiry website gives an insight from
27 a professional perspective into the world of the
28 Belfast Trust. She talked about what she saw on CCTV
29 and described how horrific it was watching it and

1 seeing vulnerable people being treated so badly. But
2 concluding her evidence she said:
3
4 "I believe there are too many unnecessary obstacles for
5 families in delivering services for people with 14:52
6 learning disabilities within the system. In my
7 experience the main obstacles continue to be poor
8 communication, poor investment in community services
9 and an imbalance of power between those who deliver
10 care and those in receipt of care." 14:52
11
12 And now we give voice again to those patients and their
13 families and they are at the core of these closing
14 submissions. No longer, we say, is the abuse to be
15 hidden behind the walls of the hospital. No longer 14:52
16 will it be hidden in the offices of a Trust. No longer
17 will the families be sidelined or humiliated by medics
18 or managers or directors. No longer will the public or
19 should the public be kept in the dark about the abuse
20 at Muckamore Abbey Hospital and the failures of the 14:53
21 learning disability and mental health system. And no
22 greater platform do our clients have to be heard than
23 in the public domain in this Inquiry. They are at its
24 heart. They are why we, and respectfully you, Panel,
25 are here. So now, we turn again to give voice to those 14:53
26 patients and their families.
27
28 The following witnesses gave evidence in unrestricted
29 session:

P1 was known to the Inquiry as Martin. He was a patient in Muckamore Abbey Hospital between 1990 and 2015. His sister, Antoinette, gave evidence on 28th June 2022 and was the first witness to do so. Antoinette reflected a view consistent with the evidence from our other clients that, but for CCTV footage being uncovered in September 2017, the regime that caused so much pain and suffering to patients would have continued. Antoinette gave powerful evidence, not only of the circumstances of Martin as a patient in Muckamore, but also of the impact this has had on her and Martin's family and especially their elderly parents.

What of the abuse? Antoinette recounted that:

"A lot of things happened to Martin and a lot of things we had probably forgotten and suppressed."

She then evidenced that within a couple of months of admission to Muckamore Martin had lost an awful lot of weight. She said:

"He moved into Conicar when he was 16. He was a healthy weight and then by the Christmas he had dropped to five stone."

Martin's rapid physical deterioration was laid bare in

1 the photographs she shared with the Inquiry. And we
2 must pause and reflect that this was under the care of
3 a hospital, a hospital staffed with nurses and doctors,
4 a hospital overseen by managers and directors.
5 Antoinette said her parents expressed concerns about 14:56
6 this but they were dismissed. Unfortunately the
7 dismissal by staff and senior personnel of the views
8 and opinions of relatives of patients was a feature of
9 the evidence of our clients and this, we say, on every
10 such frequent occasion was to the patient's grave 14:56
11 detriment.
12
13 Martin, who is a much loved son and brother, is a
14 highly vulnerable young man with no speech. Mentally
15 Antoinette said he was like a baby. He engaged in 14:56
16 self-injurious behaviour and whilst under the
17 professional care in Muckamore this led to his face
18 becoming deformed. Antoinette described the regime at
19 the hospital as being a Victorian model of care that
20 was only making him worse. This was a hospital, this 14:57
21 was his home and it was only making him worse.
22
23 Martin spent time on the Erne Ward which Antoinette
24 described as being:
25
26 "Very cold and uncomfortable, absolutely appalling and
27 not fit for human habitation."
28
29 A ward about which H112 said in 2017:

1
2 "Felt like the forgotten ward".
3
4 This was Martin's home. And we must remember, when
5 Antoinette described how this impacted on Martin she 14:57
6 said:
7
8 "When my parents used to leave him back he would lie
9 down on the sofa and he would turn his back to us and
10 would cry, it was just appalling." 14:57
11
12 Who knew about Martin's case? Antoinette's parents
13 wrote to senior Belfast Trust personnel in late 2014
14 and early 2015 about their concerns over the abuse that
15 Martin was suffering. The letters were exhibited to 14:58
16 Antoinette's statement. In her view having received
17 responses from Catherine McNicholl, then Director of
18 Adult Social and Primary Care, on behalf of Professor
19 Sir Michael McBride, then Deputy Chief Executive of the
20 Belfast Trust, the Trust knew of the abuse suffered by 14:58
21 her brother and her concerns more generally about
22 Muckamore. And yet tragically Martin continued to
23 suffer there despite that correspondence.
24
25 P16 14:58
26
27 P16 has Down's Syndrome and was educated at a special
28 school. He was first admitted to the Iveagh ward in
29 Muckamore aged 13. He spent two periods as a child

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1 there for five months from late 2011 and 10 months from
2 mid 2015 and experienced a series of failed
3 resettlements. P16 was represented at the Inquiry by
4 his mother, she gave evidence on the 20th of September
5 2022. She described how her son was an expert 14:59
6 navigator who could use Street View to plan journeys
7 all over Northern Ireland. She said:
8
9 "He is funny and very witty."
10
11 But on his 18th birthday P16 moved to a care home. It
12 soon became clear from his mother that it was doomed to
13 fail. She described of that placement:
14
15 "There was a lack of support for the young people and 15:00
16 their needs."
17
18 His mother gave a straightforward summary of what she
19 felt P16 needed to transition smoothly, not rocket
20 science. 15:00
21
22 "They needed preparation, a social story for some time,
23 maybe months in advance so that P16 knew what to
24 expect."
25
26 But this didn't happen and P16 experienced, to his
27 detriment, botched move after botched move. In 2016
28 P16 was moved to Muckamore as a detained patient. His
29 mother's description of Moyola Ward was disturbing.

1 She said:
2
3 "It was badly run down. It was horrible with old
4 corridors and carpet. It was filthy. P16 was sitting
5 at the very end of the building naked. P16 only takes 15:00
6 off all his clothes when he is really distressed and
7 agitated."
8
9 What parent, we say, would want to leave their child in
10 that environment? Not P16's mother who demanded, 15:01
11 demanded he was moved that very day and didn't budge
12 until he was. Yet this environment was considered
13 acceptable. What nurse, doctor, manager or director
14 would consider that a satisfactory environment for
15 their child? Yet it was deemed satisfactory and P16's 15:01
16 story, as the Panel has heard, unfortunately, was not
17 an isolated one.
18
19 When returning to Muckamore after home visits P16 often
20 became agitated and it was clear at such times that he 15:01
21 did he not want to go back there. In light of what we
22 learned from CCTV footage and also from the evidence of
23 other Core Participants, P16's mum questions herself,
24 she said:
25
26 "I feel guilty. Now I think there was a reason for it
27 and he was trying to tell me something."
28
29 We say why should P16's mum feel guilty when all of

1 those experts were in place to ensure P16 was cared
2 for?
3
4 P16 moved to another placement that was also described
5 as being filthy. The placement only lasted for 10 15:02
6 weeks before his mother said:
7
8 "I just lifted him and walked out."
9
10 And she said she regrets not taking him sooner. 15:02
11 Fortunately P16's mother said P16 is now in a great
12 placement close to his home where he has his own
13 apartment with bedroom, bathroom, activity room and A
14 private garden. There are lots of activities for him.
15 The family is described as being so happy about this 15:03
16 after what P16's mum described a:
17
18 "Such a hard road to get here."
19
20 P57
21
22 P57 known to the Inquiry as Ciaran, experienced
23 Muckamore over an 18 year period, save for three years,
24 between 1992 and 2010 when his mother Patricia, who
25 gave evidence in October 2022, could take no more and 15:03
26 removed him from the hospital to take him home. Ciaran
27 was a vulnerable child with severe learning
28 disabilities, yet he was admitted to Conicar Ward, an
29 adult ward where he slept in a dormitory.

1
2 Ciaran was described by his mother as a bright wee boy
3 who at the time of his admission to Muckamore could
4 read and write. After his admission Ciaran wrote about
5 wanting to escape Muckamore which he described as: 15:04
6
7 "A horrible place" in which "everywhere was locked and
8 the staff walked around with keys."
9
10 Ciaran was in Conicar adult ward for two years before 15:04
11 he moved to a children's ward. He moved again aged 16
12 or 17 to ward M7A where he was abused and
13 inappropriately touched by a patient a decade older
14 than him. This prompted his parents to remove him from
15 Muckamore and he stayed with his family for the next 15:04
16 three years until his behaviours became incapable of
17 safe management at home. Patricia said:
18
19 "The only option at the time was to agree for him to go
20 back to Muckamore." 15:04
21
22 So at around 20 years of age Ciaran was admitted to
23 M7B, a locked ward. In addition to suffering physical
24 injuries, Ciaran contracted dysentery and scabies on
25 the ward in the hospital, all whilst under the care of 15:05
26 nurses and doctors.
27
28 Patricia described her and her family's pain at
29 Ciaran's plight. She said:

1
2 "When times were bad and I was driving to Muckamore to
3 drop Ciaran off after a weekend visit I used to think
4 to myself if I just keep driving over the ditch that
5 would be the end of this for both of us. It was so 15:05
6 devastating."
7
8 The system that led Patricia to feel like that about
9 her and her son.
10 15:05
11 In 2010 Patricia and her husband removed Ciaran from
12 Muckamore and he never returned. Patricia remains
13 concerned, though, that there is still no Social
14 Services or health services planning for a crisis that
15 may happen. Reflecting back on Ciaran's time at 15:06
16 Muckamore, Patricia, like many of our clients pointed
17 out that unfortunately there were no cameras when
18 Ciaran was there so she will never know what exactly
19 happened to her son. But Ciaran can, to a degree fill
20 in the blanks. Unlike many other patients at 15:06
21 Muckamore, he is verbal and his heartbreaking response
22 to any reference to the hospital is telling. He
23 repeats:
24
25 "You're not going back to this ward, you're not going 15:06
26 to hurt me, you're not going back to this ward, you're
27 not going to hurt me."
28
29 P18

1 P18, George, was admitted to Muckamore in 2016 when
2 when he was 18 years old. Geraldine, his mother, gave
3 evidence on the 21st of September 2022. George, she
4 said, is part of a big loving family, being one of five
5 siblings. He is six foot tall and a music lover with a 15:07
6 passion for Elvis. He was described as being a big
7 gamer and also a competent technician.
8
9 George has a diagnosis of autism and ADHD. He is
10 verbal and can communicate, however doesn't always 15:07
11 understand what is going on. His mum said people think
12 he has a better degree of understanding than he does.
13 He suffers from anxiety and can have physical
14 outbursts. George was able to come home most weekends
15 from Muckamore and Geraldine felt it was clear he was 15:08
16 relieved to be home. On four or more occasions George
17 came home, his mother said:
18
19 "Covered in bruises on the back of his arms and legs."
20
21 Yet Geraldine never saw body charts or records relating
22 to this. Geraldine now believes being at home for long
23 periods is what stopped him being hurt more. She,
24 Panel, like many of our clients had little opportunity
25 to see George's ward or living space at Muckamore. 15:08
26 When collecting George, and this is a familiar refrain
27 among our clients, she had to do so from the reception
28 area. She was in no doubt, however, about how George
29 felt about the hospital and she said:

1
2 "Well he doesn't like Muckamore. He doesn't like being
3 there. He's had water threw over him, coffee threw
4 over him which is lucky enough they give it at a
5 certain temperature." 15:09
6
7 Geraldine wanted from Muckamore what society should
8 expect of a hospital caring for learning disabled
9 adults. She said:
10
11 "I never thought the staff at Muckamore would do
12 anything like that to harm George."
13
14 George should have had a safe living environment that
15 was not a hospital. Like many other patients he 15:09
16 experienced a failed resettlement attempt in a facility
17 where Geraldine said staff simply could not handle him.
18 George is still a patient in Muckamore. He has home
19 visits and goes shopping with his mum but yearns for
20 his new home. Geraldine fears that Muckamore will in 15:09
21 fact close before he is resettled and George may have
22 to be moved to yet another hospital environment.
23 Geraldine stated simply in evidence:
24
25 "All I want for George is to come away from there and 15:10
26 have his own wee place."
27
28 P28
29

1 P28, known to the Inquiry as Danny, was a twin, one of
2 four children, and he was in Muckamore from January
3 2017 to February 2019. He was then settled into the
4 community.
5
6 Daniel's mum and dad, Helen and Bob, gave evidence on
7 28th of September 2022. They talked about how Danny
8 loved music and singing and he would go to bed with his
9 favourite toys including Barney and Tigger and he would
10 sing the Barney song. He liked animals. Danny, who 15:10
11 had a mental age of an 18 month old child, had two
12 years being cared for in a facility in Donaghadee but
13 sadly the care he received there was poor and he
14 suffered unexplained injuries. His medication was
15 mismanaged and his basic care needs were neglected. 15:11
16
17 Helen and Bob described their experiences with Social
18 Services and that they raised issues with them they
19 said in evidence, but they were brushed aside and they
20 were not listened to. 15:11
21
22 They, Danny's parents, didn't want Danny to be admitted
23 to Muckamore but he was detained there under the Mental
24 Health Order. Danny's beloved Barney and Tigger toys
25 were left with him however Danny's parents said they 15:11
26 cried all the way home feeling they had abandoned him.
27 Helen said:
28
29 "Cranfield Ward felt alien and intimidating, more like

1 a prison."
2
3 This was Danny's home, more like a prison. Danny was
4 supposed to be in Muckamore for six to eight weeks but
5 the prison sentence, as his parents put it, lasted for 15:12
6 two years during which, among other things, he became
7 more and more withdrawn, his epilepsy medication was
8 mismanaged. His beloved Barney was stolen. He lost
9 significant weight to the extent that his mother
10 described his trousers were falling off him. His basic 15:12
11 needs were neglected and he was often noted to be dirty
12 and smelt of strong body odour and urine. Unexplained
13 bruising was dismissed by staff as having been caused
14 by Danny himself or otherwise explained away.
15 15:13
16 On the abuse allegations Helen said:
17
18 "I know in my heart that Danny was ill-treated and
19 neglected and that was never addressed. Our worst
20 fears were realised when news broke of the abuse cases 15:13
21 in Muckamore, you can imagine our horror."
22
23 Before Danny's release from Muckamore his mum described
24 that:
25
26 "He was looking frail and his face was grey and his
27 eyes sunken. He no longer sang. He was no longer
28 happy. The joy had simply been switched off."
29

1 When he had left Muckamore Danny's parents were
2 informed that CCTV footage had shown at least 17
3 incidents involving Danny and his mistreatment by
4 staff. The impact on Danny and his family, as with
5 other patients and their relatives, we say cannot be 15:14
6 overstated and must not be ignored. Helen said:
7
8 "I trusted them. Muckamore said it was the best place
9 for Danny but it was the worst place for him. This has
10 crushed our family. I feel we have been failed and our 15:14
11 most vulnerable families have been failed."
12
13 And speaking of the Inquiry, she said:
14
15 "It has been a very painful experience to do this but I 15:14
16 just don't want this to happen to anyone else."
17
18 That, we say, is at the front and centre of the
19 Inquiry's business.
20 15:14
21 P13
22
23 P13, known to his family and to the Inquiry as Greg,
24 was represented by his sister, Nicola, who gave
25 evidence on the 5th July 2022. Gregg, who has a 15:14
26 learning disability and challenging behavioural issues
27 is described by his sister as a loving brother who
28 loves to listen to music and with a particular fondness
29 also for Elvis and for Daniel O'Donnell. Gregg was in

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1 Muckamore at various times over a 40 year period. He
2 has no sense of danger and his behaviour can be
3 challenging. He was nine years old when he was first
4 admitted to Muckamore as he couldn't be cared for at
5 home. Nicola said of Muckamore: 15:15
6
7 "We felt that it was best suited to his needs and had
8 appropriate nursing care routine and activities that he
9 enjoyed. He never complained to us about care at
10 Muckamore." 15:15
11
12 However, there were numerous failed resettlement
13 attempts over a 35 year period from 1983 on. Despite
14 being happy with Greg's care at Muckamore, Nicola and
15 her family were left shocked and upset when they heard 15:16
16 in July 2020 from their Family Liaison Officer, Ms.
17 O'Hagan, that CCTV footage showed two incidents
18 involving Greg. By the time CCTV abuse allegations
19 came to light, Greg had already been discharged from
20 Muckamore. In respect of the allegations of abuse, 15:16
21 Nicola said:
22
23 "This came as a huge shock to me and my family and I
24 find it hard to believe that this was allowed to happen
25 to vulnerable adults in the care of Muckamore. It was 15:16
26 wrong that my brother and other vulnerable adults had
27 to go through this horrible ordeal and I believe that
28 the people involved need to be held accountable for
29 their actions."

1
2 P97
3
4 P97 is now 59 years old. He is non-verbal. He was a
5 patient at Muckamore between 1982 and 2000. His sister 15:17
6 made a statement which was read to the Inquiry on the
7 13th of September 2022. As a child and growing up as
8 part of a family of five brothers and sisters P97,
9 despite having special needs and being autistic was
10 described as being affable. P97's sister said: 15:17
11
12 "He was fun loving and enjoyed a good, warm
13 relationship with me and the rest of our family."
14
15 The family lived in rural Fermanagh and there was 15:17
16 little community or Social Services support for them in
17 respect of P97.
18
19 In line with other witnesses, including professional
20 witnesses, P97's sister commented on how isolated and 15:18
21 lonesome Muckamore was. It was a place, as I have
22 said, a place apart, at least geographically.
23
24 When P97 and their siblings were older and either
25 working or at university in Belfast, they visited him 15:18
26 regularly. She said starkly:
27
28 "Visits in those early days were bleak and depressing
29 for me, I felt powerless seeing P97 so unhappy."

1
2 P97's depression worsened over time. He was
3 increasingly confined to bed and he became overweight.
4 P97's sister presented a mixed view about staff in
5 Muckamore, some of which she said: 15:18
6
7 "Got on like they were prison staff or bouncers... they
8 were there should strong people be needed to intervene
9 with patients."
10
11 And we know, Panel, from other evidence, that strong
12 people did intervene with patients for the wrong
13 reasons.
14
15 P97's head became deformed during the time he spent at 15:19
16 Muckamore and his sister believes this was due to him
17 banging his head against things when he was unsettled.
18 P97's sister said:
19
20 "In retrospect I never inquired what measures Muckamore 15:19
21 staff were taking to minimise the damage that P97 was
22 inflicting upon himself when he was banging his head on
23 the floor or wall."
24
25 P97 still does this, albeit staff now provide him with 15:19
26 a mat. This is used instead of restraining measures
27 and prevents P97 from injuring himself.
28
29 P97 who was a detained patient at Muckamore was

1 initially resettled into a facility catering for
2 autistic adults. His sister described that although
3 the resettlement was well handled it broke down because
4 of the competing needs of resident. He then had a
5 successful placement where P97 is supported to live as 15:20
6 independently as possible.
7
8 P97 is able to socialise with his siblings and enjoys
9 going to restaurants. Now he is living in the
10 community and being taken out at weekends. He is 15:21
11 described as continuing to thrive within the supported
12 housing framework which is well suited to his needs.
13
14 As a result of the Inquiry P97's sister reflected on
15 her family's experience of Muckamore. She concluded: 15:21
16
17 "Muckamore caused both P97 and our family to adapt to
18 an institutionalised approach. I feel that P97 has
19 been deprived of a large part of his youth, family life
20 with his parents and siblings, freedom and a lot of 15:21
21 happiness. I do not think that Muckamore was
22 appropriate for P97."
23
24 And with P97 being non-verbal and having left Muckamore
25 prior to CCTV footage going live or recording going 15:22
26 live, his family fear that they'll never know the true
27 extent of what happened to P97.
28
29 P4

1
2 P4, known to the Inquiry as Kirsty, is now sadly
3 deceased. She was a patient in Muckamore over a two
4 year period up to 2018. She was a loving and loved
5 daughter and sister. Her mother gave evidence on the 15:22
6 first day of the Inquiry's hearings and was only the
7 second witness to present her testimony. Initially she
8 did not want to give evidence and when asked by Inquiry
9 counsel why she had changed her mind, she said simply:
10
11 "Because I wanted Kirsty's story to be told, the way
12 she was treated, because she is not here to do it for
13 herself and she tried to get people to listen to her
14 and they didn't so that's why I decided it was the best
15 thing for me do, to come forward and give her 15:23
16 statement."
17
18 Kirsty did not have a learning disability but after
19 leaving school at 16 it was clear she was a troubled
20 young woman. She did get jobs but couldn't hold them 15:23
21 down given her alcohol and drugs problems. She needed
22 help. Her mother, who had two much younger children,
23 needed help but they didn't get it. Kirsty was
24 initially admitted to a hospital unit then went as a
25 detained patient to a mental health unit. She was 15:23
26 diagnosed with paranoid psychosis and a personality
27 disorder. Kirsty remained in this unit for a number of
28 years before, without any consultation with Kirsty or
29 her mother, was moved to Muckamore. Kirsty's mum said:

1
2 "I got a phone call from Kirsty to say that she was
3 waiting on an ambulance and was being taken to
4 Muckamore. To this day I do not know why she was
5 transferred or who transferred her." 15:24
6
7 She then went on to say:
8
9 "Kirsty did not like it from the start. It was not the
10 right place for her and I feel that the care team and 15:24
11 the system failed her."
12
13 How? Kirsty's mum gave evidence that Kirsty had mental
14 health issues with addiction to drugs and alcohol. She
15 heard voices and did not like to be on her own. She 15:24
16 did not get any treatment for these issues at
17 Muckamore. There was nothing for her to do, no
18 recreation, no walks, no gym or exercise. When Kirsty
19 went into Muckamore she was a size 10. Two years later
20 when she left Muckamore she was a size 20. Kirsty 15:25
21 looked and was a completely different person after
22 Muckamore. This unfortunately is a common refrain of
23 our clients.
24
25 Kirsty's mum said she had very little communication 15:25
26 with staff and:
27
28 "They didn't let me know what was happening with her
29 treatment or care. They said she was an adult and I

1 was never informed about things like medication
2 changes. I would ask for family meetings but I never
3 got an answer."
4
5 Kirsty expressed her view of Muckamore to her mother, 15:25
6 she said:
7
8 "Mammy, this is a terrible place."
9
10 In her words she hated in Muckamore. Kirsty was not 15:25
11 learning disabled. She was vocal but she wasn't
12 listened to. Kirsty's mum regularly noticed marks and
13 bruising on Kirsty's upper arms and each time Kirsty
14 told her they had held her down to put her in seclusion
15 where she said she could be there for hours on her own. 15:26
16 Kirsty's mum described this as being physical and
17 mental abuse.
18
19 Kirsty's mum gave evidence that her daughter became
20 increasingly more drowsy and sleepy on her visits being 15:26
21 doped up and became very bloated and overweight which
22 made her very depressed.
23
24 In 2018 Kirsty was discharged into a community
25 placement which soon broke down and her belongings were 15:26
26 sent to her mother's homes in bin bags. Another
27 placement failed because Kirsty could not cope on her
28 own and she was placed in a central Belfast hostel
29 where one week later she was found dead aged 31 on 2nd

1 September 2020.
2
3 And what could life have been like for Kirsty?
4 Her mum said:
5
6 "I would have liked to have seen if Kirsty had got the
7 proper help where she would have been with her life now
8 and what she would be doing if she had been put into
9 the proper place."
10
11 Kirsty's mum concluded her evidence saying:
12
13 "I would like to see some justice for Kirsty. She
14 suffered mental and physical abuse at Muckamore and was
15 failed by the system when she was released into the 15:27
16 community without the proper support or help that she
17 needed. I am still grieving for my daughter and it is
18 very difficult but I want to tell the Inquiry what
19 happened in Muckamore for Kirsty."
20 15:27
21 P113
22
23 P113's mum and dad gave evidence on 26th September
24 2023. He was admitted to Muckamore on 13th April 2017
25 aged 20 and has a diagnosis, among other things of 15:28
26 severe learning disability and autism. He is the
27 middle of three sons. He speaks but has limited
28 vocabulary. P113's mum said about her son:
29

"When he is in good form he's smiley. He laughs very heartily. He loves eating. He has to have a magazine. He lives around his magazine deliveries. He just loves being at home with us."

His admission to Muckamore came at a time of crisis borne out of P113's distress and challenging behaviours and a lack of appropriate community support. His mum felt:

"Every door was closed and nobody wanted to help us care for him."

After a short emergency respite placement his parents were called and told he was being driven to Muckamore handcuffed to a police officer. His dad described feeling distraught about the nature of his son's admission. The decision to admit P113 initially PICU and then to Cranfield was out of their hands and they said they trusted the professionals. His dad said he felt reassured that they could help P113 who had been admitted as a detained patient for assessment. He said he thought that his son would stay in Muckamore for a short period and did not imagine that he would still be there almost six and a half years later. His parents noted times when he was overmedicated and lethargic. His mum said he presented as if he was in a trance, stumbling and dribbling with glazed eyes. His parents visited him regularly. On their arrival P113 was often

1 either not dressed or he was wearing old, worn clothes,
2 not those they had bought and labelled for him. This
3 too was a common theme in our clients' evidence to the
4 Inquiry. Good and sometimes very expensive clothes and
5 trainers would disappear or be seen on other patients. 15:30
6 P113's mum gave evidence that sometimes he would be
7 sitting in soiled clothing and she would have to wash
8 him.
9
10 He was the subject of a number of resettlements which 15:30
11 failed due to lack of planning and staff training.
12
13 In May 2018 his mother when on a day out with her son
14 received a phone call from a social worker during which
15 she was told P113 had suffered abuse at the hospital. 15:30
16 His parents were shocked this had happened but also
17 being told about it in this way. His mum said:
18
19 "I felt completely numb and sick."
20 15:31
21 In 2018 PSNI officers met with the parents in their
22 home about the police review of the CCTV footage.
23 P113's dad said police were sympathetic and tried to
24 assure us that justice will be served. P113's dad
25 concluded his evidence stating as follows: 15:31
26
27 "It makes me angry when I think about how my son has
28 suffered. I feel helpless as I did not know that he
29 was suffering so I could do nothing about it. My son

1 cannot tell me what happened so I may never know the
2 full details. I feel let down by Muckamore as I
3 trusted that my son would be looked after in a safe and
4 secure environment."
5
6 These experiences, Panel, are just a short reflection
7 of the testimony given by our clients in unrestricted
8 session.
9
10 Other witnesses gave evidence in a restricted session 15:32
11 and I will return to those at the end of this closing.
12 CHAIRPERSON: I think you are going to now move on to a
13 different section?
14 MR. MAGUIRE: I am.
15 CHAIRPERSON: So would that be a convenient moment to 15:32
16 take a break?
17 MR. MAGUIRE: Subject to you, Chair, and the Panel.
18 CHAIRPERSON: You have been going for just under an
19 hour and it is also time for the stenographer so we
20 will take a 10 minute break. Can I ask everybody to 15:32
21 try to get back when the bell goes because we are going
22 to probably have to sit a little bit later than we
23 normally do tonight. I am aware of the Inquiry staff
24 and the stenographer. Ten minutes.
25
26 AFTER A SHORT BREAK THE INQUIRY RESUMED AS FOLLOWS:
27
28 MR. MAGUIRE: Thank you, Chair. I am moving on Chair,
29 to deal with the issue of accountability that you have

1 heard reference to already from our clients.
2
3 Who was responsible for ensuring these vulnerable
4 children and adults were in a safe and secure
5 environment? There is no doubt, we say, that despite 15:46
6 the many good, decent, well intentioned staff tasked to
7 care for, treat and manage learning disability patients
8 at Muckamore, some of whom, as we know, bravely
9 whistleblew, there were other staff who perpetrated
10 abuse, mismanaged care, neglected patients and their 15:46
11 families or even simply treated them without dignity or
12 respect. There were also staff who we say did not fall
13 into this category but who witnessed what was happening
14 to these vulnerable patients and did nothing or who
15 knew or suspected there was abuse and failed to act. 15:47
16 This has been referred to in evidence as the first line
17 of defence, the staff on the ground.
18
19 But responsibility where abuse was so widespread lies
20 beyond this so-called first line of defence, we say. 15:47
21 Having examined the issue of abuse of patients at
22 Muckamore as a core objective of the Terms of
23 Reference, you, Panel, will not only determine why the
24 abuse happened, but also as set out in the Terms of
25 Reference the range of circumstances that allowed it to 15:47
26 happen and ensure that such abuse does not occur again
27 at Muckamore or any other institution providing similar
28 services in Northern Ireland.
29

1 You said, Chair, in your opening remarks:
2
3 "What an Inquiry is not allowed do is rule on or to
4 determine anybody's civil or criminal liability."
5
6 Now that doesn't prevent the Panel forming and
7 publishing conclusions which may lay blame at an
8 individual or organisational door. And that view was
9 reinforced by senior counsel to the Inquiry, Mr. Doran,
10 in his opening address. He said: 15:48
11
12 "An Inquiry Panel is not to be inhibited in the
13 discharge of its functions by any likelihood of
14 liability being inferred from facts that it determines
15 or recommendations that it makes. This provision 15:48
16 underpins the inquisitorial nature of the Inquiry."
17
18 If there is blame to be laid we urge you on behalf of
19 our clients, many of whom are in this room today, and
20 their loved ones, to do so. The families, Panel, we 15:49
21 say, deserve no less.
22
23 Staff, management, directors and executives may say,
24 and some have in effect said, 'I'm sorry about what
25 happened but that wasn't four square within my remit or 15:49
26 my area of responsibility', and maybe that too was part
27 of the problem. There were so many tiers and layers
28 from top to bottom and so many boundaries and barriers
29 across each level that clear sight was simply

1 impossible. Organisations and groups within those
2 organisations were in Silos and no one quite knew where
3 the responsibility lay. What seemed appropriate at the
4 top masked what was festering at the bottom. Maybe
5 there should have been more of what Andrew McCormick, 15:50
6 former Permanent Secretary of the Department of Health,
7 referred to as "management by wandering about".
8
9 But it was worse, when H330 gave evidence in
10 unrestricted session, they were asked about the 15:50
11 presence of senior management or Belfast Trust Board
12 members on wards and H330 said:
13
14 "As things became more and more destabilised at
15 Muckamore managers would be less and less visible." 15:50
16
17 The Terms of Reference for this Inquiry also dictate
18 that, as follows:
19
20 "The Inquiry will examine the primary and secondary 15:50
21 causes of such abuse and will address the question of
22 whether the abuse resulted from systemic failings
23 within Muckamore or the wider healthcare system in
24 Northern Ireland."
25
26 The question we ask, therefore, is: How did a
27 persistent culture of abuse develop where it was
28 happening on many wards across a vast hospital estate
29 and over decades?

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1 In the top tier, and ultimately responsible for the
2 region's health, is the Department of Health and in the
3 case of Muckamore, at least from 2007, the Belfast
4 Trust was responsible for delivering that care. There
5 is little doubt, we say, that the system for provision 15:51
6 of safe, effective and appropriate care for vulnerable
7 learning disabled adults within the timeframe of this
8 Inquiry's Terms of Reference was inadequate and
9 deficient. We know this. We know it from the opening
10 statements of the Department of Health and the Belfast 15:52
11 Trust. We know this from the evidence of the patient
12 relative witnesses. We know this from the apologies of
13 senior departmental officials and Trust personnel and
14 from those corporately responsible for delivering that
15 care. 15:52
16
17 Chair, you said in your opening remarks in June 2022,
18 that:
19
20 "Without predetermining any issue it is quite obvious 15:52
21 that bad practices were allowed to persist at the
22 hospital to the terrible detriment of a number of
23 patients."
24
25 But you have heard the evidence now and you have heard 15:52
26 the apologies from Chief Executives and Permanent
27 Secretaries, from Chief Medical, Nursing and Social
28 Work Officers and from senior Trust Directors and
29 Managers. And on the 22nd of October this year,

1 Professor Sir Michael McBride gave an unreserved
2 apology as both CMO and the former Chief Executive of
3 the Belfast Trust for what he said was:
4
5 "The systematic failings that occurred, the abuse that 15:53
6 occurred and the harm and distress that was caused to
7 the individuals who had a right to expect better. It
8 was a fundamental breach of Trust. It was an abuse of
9 power. It was fundamentally wrong and it should never,
10 ever have happened." 15:53
11
12 He said.
13
14 Only our clients themselves can speak to their view of
15 how sincere they believe this and other apologies are. 15:54
16 But the common view among them is that the pain of
17 their experience at Muckamore has not eased or been
18 dissipated by the apologies.
19
20 So, Panel, setting the apologies aside, how and why was 15:54
21 this inadequate and deficient care system for learning
22 disability permitted and sustained? How and why was a
23 culture of abuse allowed to develop and be maintained
24 at Muckamore? How and why were so many opportunities
25 to identify abuse and take action to stop it missed? 15:54
26
27 Prior to CCTV footage being viewed in mid 2017, who in
28 senior positions knew about the abuse, even if not the
29 extent of it, and what measures did they take or fail

1 to take to stop it? And if they didn't know about the
2 abuse were they curious enough or critical enough? Did
3 they scrutinise enough? We say the only conclusion to
4 be reached on the evidence is no.
5 15:55
6 So what of the Department of Health at the top end of
7 the governance pyramid? Andrew McCormick was Permanent
8 Secretary between 2005 and 2014. And whilst it was a
9 common view among senior Belfast Trust witnesses that
10 the size of the organisation was not an excuse for 15:55
11 failure to ensure patients at Muckamore were safe, Mr.
12 McCormick referring to his time the Department
13 acknowledged that:
14
15 "Getting a governance structure and organisational 15:55
16 structure that was going to be effective was a
17 challenge."
18
19 And he concluded:
20
21 "But I think it's undeniable that it leaves mental
22 health and learning disability struggling to get
23 attention. I think that's, you know, a simple fact."
24
25 Well it should haven't been a simple fact. 15:56
26 Mairead Mitchell, head of Learning Disability Services
27 between December 2016 and 2019, put it in starker
28 terms. She said:
29

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1 "So Muckamore and Learning Disability Services I felt
2 and a lot of staff felt were at the bottom of the pile
3 and it wouldn't have been seen as a priority."
4
5 And we ask, why not? 15:56
6
7 We know from Mr. McCormick's evidence that significant
8 concerns about Muckamore were known about by the
9 Department as early as 2007. In January of that year
10 Mr. McCormick was interviewed on BBC Radio Ulster about 15:57
11 issues at the hospital. In that interview he said
12 vulnerable people at Muckamore were not being forgotten
13 about, not being forgotten about, although he
14 acknowledged he said:
15
16 "It is an immensely challenging agenda, there is a lot
17 do here."
18
19 And talking about amongst other things delayed
20 discharge, Mr. McCormick said: 15:57
21
22 "The particular issue of people being in a totally
23 inappropriate environment is something we only knew
24 about in the last few days."
25
26 So this is early 2007. But he then declared the
27 Department was committed to making a difference and he
28 said "things are getting better."
29

1 We now know from the evidence that things did not get
2 better. Indeed we say, and the Panel may readily
3 conclude having heard the evidence, that things got
4 worse, a lot worse. Mr. McCormick agreed with the
5 radio interviewer that certain patients in Muckamore 15:58
6 were the least likely to stick up for themselves and he
7 said:
8
9 "These people need advocacy, they need support."
10
11 But who was giving them advocacy, who was supporting
12 them?
13
14 Mr. Richard Pengelly who was Permanent Secretary at the
15 Department of Health between 2014 and 202 led it 15:58
16 through the CCTV allegations in Autumn 2017. And
17 because there was no assembly and no regional
18 government he issued a formal apology to the patient
19 victim of abuse and to their families. In evidence to
20 the Inquiry he too confirmed the Department's view that 15:59
21 the size of the Belfast Trust didn't cause difficulties
22 in terms of oversight function and he said there was:
23
24 "No evidence during my time in post to indicate these
25 oversight arrangements were not effective." 15:59
26
27 The responsibility to escalate concerns and the
28 effectiveness of arrangements, according to
29 Mr. Pengelly is dependent on all stakeholders

1 recognising their obligations and taking appropriate
2 steps to assure themselves that they have appropriate
3 and proportionate measures in place to meet these
4 obligations. He said:
5
6 "I think it's a point that came out in the leadership
7 and governance review that in shorthand terms the
8 architecture seemed sound but may be the practical
9 application of that was less than it should have been."
10 15:59
11 He repeated this view when he was asked about abuse
12 disclosed in CCTV footage and whether that brought into
13 question dramatically the effectiveness of oversight
14 arrangements. His answer was as follows:
15
16 "Absolutely, clearly unequivocally something was
17 happening that should not have been happening and
18 should have been detected. But I think I'm just trying
19 to differentiate between the arrangements and the
20 practical application of the arrangements. My sense is 16:00
21 that it was a practical application of the arrangements
22 where the greater issue arose."
23
24 We ask is it possible that for any governance or
25 oversight system to work effectively, one can 16:00
26 differentiate between the arrangements per se and the
27 application of those arrangements? We say, Panel, it
28 is not because to do so is not only to delegate the
29 arrangements but to delegate responsibility for those

1 arrangements.
2
3 That something went wrong with the system between the
4 Department at the top of the pyramid and the frontline
5 staff at the lower end is undeniable. In essence 16:01
6 though, from the Department's perspective, it seemed
7 that it was the responsibility of others to practically
8 apply the arrangements. No longer in their view was it
9 the responsibility of the Department of Health.
10
11 So what of the Belfast Trust? Prior to CCTV footage
12 being viewed in Autumn 2017, who in senior positions
13 there knew about the abuse? What measures did they
14 take or fail to take to stop it? And if they didn't
15 know where they curious enough or critical enough? Did 16:01
16 they in the Belfast Trust scrutinise enough?
17
18 In evidence Peter McNaney, who was Chair of the Board
19 of the Belfast Trust from 2014 to 2023, said of the
20 Trust's system of governance: 16:02
21
22 "I genuinely thought we had a decent governance
23 system".
24
25 He went on to say: 16:02
26
27 "But you know the bottom line is unacceptable abuse was
28 happening, we didn't pick it up. The system was there
29 to prevent it, didn't prevent it, I regret that

1 deeply."
2
3 Dr. Cathy Jack, former Chief Executive of the Belfast
4 Trust and also a long standing Board member said,
5 albeit the Panel may agree using a rather unusual 16:02
6 analogy, she said:
7
8 "I mean, you know, what we need in an organisation the
9 size of Belfast Trust is to get a sense not just from
10 the balcony but from the stairs and the dance floor." 16:02
11
12 She said:
13
14 "I mean, you know, you need to be able to go the mile
15 deep as well as have the mile wide." 16:03
16
17 But it is others, she said, that had to go the mile
18 deep. And on the failure of others to escalate issues
19 to Board level she accepted the Trust Board should have
20 been more curious. 16:03
21
22 We were given some insight into how the Department of
23 Health could or should have acted. Profession or
24 Charlotte McArdle, former Chief Nursing Officer said in
25 evidence: 16:03
26
27 "we have to use our data to do those deep dives to
28 understand how we can improve services and not rely on
29 inspection because it is only a moment in time, it's on

1 a day. We need a high level dashboard that gives us
2 all the data that we can all use at whatever level to
3 identify trends and analysis."
4
5 Notably though, returning to Dr. Jack, she confirmed 16:03
6 that Muckamore was only discussed three times, three
7 times at Board level between 2012 and 2017 when the
8 abuse was uncovered through CCTV footage. Dr. Jack
9 said:
10
11 "It is the case that up until September 2017 Muckamore
12 was not a place of concern for the Trust Board or the
13 Executive Team."
14
15 But it should have been. And but for CCTV footage 16:04
16 coming to light we say it is likely to have remained
17 the case, even now in March 2025, that Muckamore would
18 not be a place of concern for the Trust Board or the
19 Executive Team because the evidence doesn't take us
20 there. 16:04
21
22 The previous Chief Executive of Belfast Trust, Martin
23 Dillon, Chief Executive between February 2017 and
24 February 2020, talked about needing a robust system of
25 delegated and distributed leadership throughout the 16:05
26 organisation given its size. On accountability of the
27 Chief Executive, he did accept that delegated
28 leadership didn't diminish it and that he was
29 responsible for ensuring the system of delegation was

1 effective. In his view however, prior to 2017, he:
2
3 "Had no reason to believe that the structures and
4 processes for the management and oversight of Muckamore
5 at Directorate level were other than effective." 16:05
6
7 clearly we say, on the evidence they were not.
8 Mr. Dillon was asked:
9
10 "Are you saying, Mr. Dillon, then that the structures 16:05
11 themselves were fine but the issues that arose in
12 Muckamore in 2017 where a result of staff at Muckamore
13 Abbey Hospital not using the structures effectively?"
14
15 He answered: 16:05
16
17 "As I said earlier on, no system of governance is
18 perfect and any system of governance is only as strong
19 as its weakest link which is the staff who use it."
20
21 When asked whether a system of governance ought to be
22 detect difficulties Mr. Dillon replied:
23
24 "Yes but staff working together who collude together
25 can defeat any system of governance." 16:06
26
27 Dr. Cathy Jack put it somewhat differently. She said:
28
29 "Any governance system, no matter how well developed

1 and comprehensive, relies on individuals doing the
2 right thing."
3
4 This, we say, is demonstrative of the Trust's mindset,
5 it's back to the first line of defence. And we say 16:06
6 that while an isolated incident involving a determined
7 and secretive abuser may not be readily detectable, we
8 say the Inquiry should not accept where there is
9 widespread abuse as part of a culture governance
10 systems cannot and should not pick it up. 16:07
11
12 We now know, Panel, from the evidence, that the abuse
13 perpetrated by staff on patients, and I'm using "abuse"
14 in its most general sense there, was widespread and in
15 the open. 16:07
16
17 In an unrestricted evidence session Esther Rafferty,
18 who was a former Service Manager at Muckamore, she was
19 an Associate Director of Learning Disability Nursing
20 and then the Divisional Nurse for Learning Disability, 16:07
21 she said of CCTV footage she watched as follows:
22
23 "If some of the incidences that I viewed had been in
24 areas that were isolated you could understand how some
25 of that was hidden. Unfortunately what I was viewing 16:08
26 on CCTV was instances of people abusing or staff
27 abusing patients in full view of registrants and
28 non-registrants and the disregard that I witnessed was
29 unbelievable because it seemed to be in the open."

1
2 Professor Sir Michael McBride confirmed:
3
4 "The robustness of governance arrangements were
5 dependents on matters that required Muckamore staff, 16:08
6 clinical and managerial, including at director level,
7 to escalate concerns and to ensure appropriate
8 intervention and action."
9
10 Albeit the Professor accepted that good governance 16:08
11 required the Board to apply what he referred to as
12 downward curiosity.
13
14 There is no evidence, we say, that the Trust Board or
15 its senior executives applied any, let alone sufficient 16:09
16 downward curiosity to Muckamore such that abuse was
17 detected or detectable. The facts, Panel, we say speak
18 for themselves. Until CCTV exposed abuse of patients
19 by staff in September 2017 the Trust appeared to be
20 ignorant of the abusive conduct and it appeared to be 16:09
21 blind to the inadequacies of the circumstances that
22 facilitated and sustained that abuse.
23
24 Professor McBride did acknowledge the Trust's failings.
25 He said: 16:09
26
27 "It is absolutely the fact that they did not detect the
28 abuse and the systematic failings that were clearly
29 occurring within Muckamore Abbey Hospital, I mean, and

1 I deeply regret that."
2
3 He goes on to say:
4
5 "They singularly failed to identify, to detect and 16:10
6 escalate the abuse that was going on and that was a
7 fundamental failure."
8
9 When he was pressed on whether any system of
10 governance, no matter how good, could have detected the 16:10
11 abuse at Muckamore the Professor said:
12
13 "One cannot conclude that the systems of governance and
14 oversight were sufficient when such abuse took place.
15 It was not identified, was not escalated and was not 16:10
16 acted upon. So, I mean, ultimately it's a matter for
17 the Inquiry to determine but I can only conclude that
18 those systems were not adequate."
19
20 We say demonstrably they were not adequate, but, with 16:10
21 dire, severe, grave consequences for the patients and
22 their families.
23
24 Professor Sir Michael McBride said when asked by you,
25 Chair, whether he was sufficiently probing or 16:11
26 challenging:
27
28 "I don't think any of us at any level were and I think
29 we are all diminished by that and I include myself in

that. I think, you know, it is not possible to conclude otherwise."

But, for both the Trust and the Department of Health prior to CCTV footage coming to light and subsequent reports, there were significant missed opportunities to identify and address concerns over abuse at the hospital. These included the EHSSB, NWBHSST review of 2005 into safeguarding at Muckamore. They included the Ennis Investigation which related to multiple allegations of abuse of a number of patients by staff with a report produced in October 2013 about which the Inquiry has heard considerable evidence.

The report, notwithstanding some having issues about the substance of the investigation and subsequent report, was an important document. It was a missed opportunity to identify and address issues of abuse within the hospital environment. The Belfast Trust failed to heed repeated advice to escalate concerns to the level of a serious adverse incident. The report got lost to the upper echelons of the Trust and the Department of Health. Dr. Cathy Jack gave evidence that she only became aware of it in 2019. Professor Sir Michael McBride said he didn't recollect receiving a briefing on it and expressed surprise that it hadn't been escalated to the Executive Team and the Board. And he, himself, described Ennis as a missed opportunity. There is no doubt about it, he said.

1
2 Mr. Pengelly said the Department of Health only became
3 aware of the report following media reports in October
4 2019.
5 16:13
6 And we say it is at least conceivable from the evidence
7 given to the Inquiry that had the recommendations of
8 the Bamford Review been implemented, those patients
9 subsequently abused in Muckamore wouldn't even have
10 been there in that most inappropriate environment. 16:13
11
12 On the Bamford vision and delayed discharge, Mr cecil
13 Worthington, who was a former Direct of Social Work in
14 the Trust said:
15
16 "Let's be very clear, if those recommendations from the
17 Bamford Review had been delivered in a timely way,
18 Muckamore would not have existed in that format, in the
19 format it did in 2014. All those resettled patients,
20 the delayed discharges should have been discharged much 16:14
21 earlier. So this was very much a chronic problem and
22 the whole system, myself, the director, Trust Board,
23 HSCB and the Department were well aware of it and
24 indeed the Department adjusted their targets year on
25 year about resettlement because they knew they weren't 16:14
26 delivering."
27
28 Professor Roy McClelland, on Bamford, giving evidence
29 in March 2023, said:

1
2 "If the proposals from the Bamford Review had been
3 implemented then Muckamore would not have existed in
4 2017 other than as a potentially small acute assessment
5 and treatment facility." 16:15
6
7 In any event, we say, and notwithstanding the lack of
8 implementation of the Bamford recommendations there
9 were other non-Muckamore specific opportunities that
10 should have alerted the leadership of the Belfast Trust 16:15
11 and the Department about, at the very least, the
12 potential of abuse being an issue at Muckamore and that
13 included the review into abuse at Winterbourne View.
14 About which Professor Michael McBride said:
15
16 "But with the benefit of hindsight and subsequent
17 events I think we have to ask ourselves whether we were
18 sufficiently probing or sufficiently exacting in the
19 questions that we were asking or the challenge function
20 that was being used to actually inquire." 16:15
21
22 But, there were other potential red flags when
23 relatives of patients spoke with managers or wrote to
24 directors.
25 16:16
26 At a meeting in Muckamore in 2015 Antoinette, P1's
27 sister, Martin's sister recalled her mother raising
28 concerns at a multidisciplinary meeting that there was
29 systematic abuse at Muckamore only for her mother to be

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1 told by a consultant psychiatrist:
2
3 "Och come on now missus, och come on now".
4
5 Antoinette said her family was brushed off at every 16:16
6 turn and constantly being browbeaten and that is
7 evidence similar to the evidence you've heard from
8 other of our clients.
9
10 Where the Department and Belfast Trust put leadership 16:17
11 and governance structures in place for the safe running
12 of Muckamore and Learning Disability Services more
13 generally, other agencies, like the PCC and the PHA
14 were there to provide external advocacy oversight
15 assistance and regulation. They unfortunately were 16:17
16 weak and ineffective and, despite their remit, abuse
17 persisted at Muckamore Abbey Hospital.
18
19 Most significantly, though, the RQIA was an independent
20 body set up to regulate and inspect the quality and 16:17
21 availability of Northern Ireland's health and social
22 care services. And Muckamore was within its remit from
23 the 1st April 2009 when the functions of the former
24 Mental Health Commission were transferred to it. Since
25 that date the RQIA has had a specific responsibility 16:18
26 for keeping under review the care and treatment of
27 patients with a mental disorder or learning disability.
28 Mr Ruck Keane KC told the Inquiry:
29

1 "The RQIA is a hugely, hugely important role."
2
3 But we say, and we say the evidence will take the Panel
4 to this conclusion, the RQIA just wasn't strong or
5 effective enough or, to adopt terminology used by 16:18
6 Andrew McCormick in his evidence:
7
8 "It just wasn't scary enough to adequately oversee care
9 provision at Muckamore and uncover the widespread abuse
10 that took place there." 16:19
11
12 Counsel for the authority acknowledged that in his
13 opening statement where he said:
14
15 "The RQIA recognises failings in the oversight of the 16:19
16 care provided to patients in Muckamore and apologises
17 to the victims and their families that it did not
18 uncover the abuse they suffered."
19
20 So despite the involvement of these agencies, despite 16:19
21 all of the structures and processes of the Department
22 of Health and the Belfast Trust, it wasn't until CCTV
23 footage came to light in Autumn 2017 that a culture of
24 abuse in all its forms was uncovered and subsequently
25 we learned it pervaded the system in Muckamore. 16:19
26
27 So what of the CCTV recordings? The PSNI appreciated
28 the import of CCTV footage, both for safeguarding
29 purposes and in identifying alleged perpetrators of

1 abuse. Detective Chief Inspector Gill Duffy in charge
2 of Operation Turnstone said it was concerning to police
3 that from the 18th December 2018 DAPOs were not
4 permitted on-site at Muckamore to carry out reviews of
5 viewing sheets. She said: 16:20
6
7 "Essentially this meant there was a pause on
8 safeguarding."
9
10 So the police view, the police view was this meant 16:20
11 there was a pause on safeguarding and the Trust were
12 therefore, arguably, not fulfilling their statutory
13 obligations in respect of safeguarding. DCI Duffy
14 attended at Muckamore for a meeting at which it was
15 confirmed as follows: 16:21
16
17 "The Trust had not viewed as much CCTV as had been
18 previously communicated to police. DCI Duffy said she
19 seized the CCTV hard drives because she was unable to
20 rely on the assurances from Belfast Health and Social 16:21
21 Care Trust that all footage had been viewed."
22
23 When this was a safeguarding issue. In a
24 contemporaneous note DCI Duffy recorded on the 1st of
25 February 2019 as follows: 16:21
26
27 "I cannot have faith in the Trust viewing of the
28 footage and I have made the decision that the CCTV must
29 now be copied and moved to police premises to allow us

1 to view the footage in its entirety."
2
3 She went on:
4
5 "To maintain public confidence in the investigation." 16:21
6
7 In a sad indictment, we say, of the Belfast Trust, a
8 commonly held view among our clients expressed to us
9 was that the Trust could not be trusted. Now we learn
10 on evidence even the PSNI it seems couldn't trust the 16:22
11 Trust.
12
13 What was clear, though, from evidence consistent with
14 the early view expressed by our clients, and indeed
15 referenced in our opening statement to this Inquiry and 16:22
16 ultimately acknowledged by the Trust, was that CCTV was
17 a game changer. We say it was the only effective
18 change that led to the uncovering of widespread abusive
19 practices and ultimately led to further reports and to
20 this Inquiry. On that we agree with the observations 16:22
21 of Professor Sir Michael McBride regarding the other
22 arrangements. He admitted:
23
24 "They singularly failed to detect, to identify, to
25 detect and escalate the abuse that was going on and 16:23
26 that was a fundamental failure."
27
28 All seem to agree and the Panel may therefore readily
29 conclude that but for CCTV, widespread abusive

1 practices most likely would have continued unabated at
2 Muckamore.
3
4 The Inquiry has heard how the patients and their
5 families who we represent have been traumatised by 16:23
6 their experiences at Muckamore and how many still have
7 a feeling of guilt for what happened to their loved
8 ones there. That evidence, unlike many public
9 inquiries, was not about a single traumatic event or an
10 experience over a short time, it was their lived 16:24
11 experience of our clients' lives before, during and
12 after Muckamore. It was their journey battling, often
13 alone, for their loved learning disabled sons and
14 daughters. It was their account but this is our
15 collective story because we, as a community, owe a duty 16:24
16 of care to these vulnerable people and their families.
17 We entrusted our leaders, the government ministers and
18 their Permanent Secretaries. We entrusted the Chief
19 Executives and Board Directors of the Belfast Trust to
20 ensure that that duty of care was fulfilled, but it was 16:25
21 not and the patients were left exposed to abuse over
22 many years and suffered harm as a result.
23
24 Whatever was the state of the health and social care
25 system more generally, for learning disability and 16:25
26 mental health there was a broken system, we say, from
27 top to bottom and that broken system caused terrible
28 damage for which if justice is to be served among
29 recommendations to protect the interests of the

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1 learning disability and mental health communities in
2 the future, we say patients and their families should
3 receive appropriate redress for Muckamore was not an
4 environment in which our clients' loved but vulnerable
5 learning disabled relatives should have been placed for 16:26
6 anything but specialist treatment. All have agreed
7 that hospital should never have been their home. But
8 where it was their home they should have been, as a
9 matter of course, safe, and properly cared for by well
10 trained, experienced and learning disabled qualified 16:26
11 staff, but they weren't. We reflect on the evidence,
12 expert evidence of Mr Ruck Keane KC who provided a
13 helpful analysis of the human rights model of
14 disability, highlighting the basic principle that it is
15 not the disability or impairment that is the problem, 16:26
16 rather it is society's failure to respond to the
17 impairment which creates the problem. We agree.
18
19
20 Our clients and their relatives have too often been 16:27
21 viewed as the problem. Their common view is that there
22 was little desire within the walls of Muckamore or
23 little desire within the offices of the Trust or little
24 desire within the Committee rooms of the Department of
25 Health to understand their loved ones and what lay 16:27
26 behind their, at times, challenging behaviours.
27 Rather, in keeping with the patient as the problem
28 approach, which our clients say prevailed at Muckamore,
29 there was a hasty, even immediate and inappropriate

1 move to nuclear options of PRN, seclusion, and MAPA to
2 the grave detriment of patients and utter disregard for
3 their basic human rights. And of course, patients were
4 deliberately mistreated and abused.
5 16:28
6 We pause there to consider the approaches of the
7 Department of Health and the Belfast Trust. If the
8 Inquiry accepts the evidence, a summary of which I have
9 just referenced, at least that evidence up until 2017,
10 the Department of Health had sound governance 16:28
11 arrangements in place, but it relied on the Belfast
12 Trust to carry them out. The Belfast Trust had, they
13 believed, at the time effective structures and
14 processes in place, but they were dependent on
15 management and staff. So we're back to the first line 16:28
16 of defence.
17
18 As professional witnesses have acknowledged, neither
19 the Trust nor the Department of Health nor the RQIA
20 were curious enough or scrutinised enough. And that we 16:29
21 say is a grave detriment on the leaders and managers in
22 those organisations, but it is also to over simplify
23 and understate the issue. The reality, of course, was
24 very different. The Trust and the Department were, we
25 say, at the very least blind to the abuse, if not 16:29
26 indifferent to it. There were lots of warning signs
27 that abuse was occurring at Muckamore Abbey Hospital.
28 Department and Trust leaders should have known and
29 should have acted to stop the abuse. But they all

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1 fiddled like Nero whilst Rome burned. They fiddled
2 with their meetings and committees and groups and
3 agendas, but all the while they failed to see the smoke
4 of the many missed opportunities and it wasn't until
5 the flames of abuse uncovered by CCTV engulfed them 16:30
6 that they acted to put out this fire of abuse.
7
8 But even then, even then, Panel, as we learned from the
9 PSNI, the fire was not completely or sufficiently
10 extinguished. CCTV, as we have heard, was a game 16:30
11 change and the Inquiry is aware of our view that but
12 for it it is likely abusive practices would not have
13 been curtailed. But whilst we say CCTV must be an
14 integral part of the protective regime within any
15 hospital or community placement, it is not a panacea. 16:31
16 Because, whilst it may be a deterrent, of necessity it
17 can only evidence abuse after the event. Instead there
18 must be a system in place to ensure issues are
19 identified and addressed before they become
20 problematic. 16:31
21
22 Sean Holland, Chief Social Worker from 2010 to 2012
23 referenced this succinctly in concluding remarks of his
24 evidence. He said:
25
26 "Systems that catch are no replacement for care that
27 prevents."
28
29 So looking to the future and consideration of

1 recommendations, the learning disability and mental
2 health community needs to be embraced by a wrap around
3 service with families being integral to decision making
4 and being utilised as a valuable resource.
5
6 Learning disability and Mental Health Services must be
7 properly resourced with a focus on assisting families
8 to care for their learning disabled relatives at home
9 for as long as possible and, where that is not
10 possible, in well managed but appropriate community 16:32
11 placements, all the time with the focus on the person
12 for whom the service is required and their family.
13
14 Our clients and their loved ones to whom they have
15 given voice have been at the front and centre of this 16:32
16 Inquiry and will be, we hope, as you consider your
17 findings and make recommendations.
18
19 But what is a successful outcome for them? Yes, it's
20 about adequate and appropriate resources for learning 16:32
21 disability and Mental Health Services. Yes, it's about
22 health and emotional wellbeing. Yes, it's about being
23 safe and well cared for, but it's also ensuring that in
24 every decision relevant to their care the person is at
25 the front and centre of their thinking. From the care 16:33
26 assistant to the social worker, from the nurse to the
27 doctor, from the care manager to the care funder, from
28 the director to the Chief Executive and from the
29 Permanent Secretary to the Minister. Only then will

1 our clients feel they are not the problem. Only then
2 will they truly feel they and their loved relatives are
3 fully part of our community, at the centre of that
4 community where they should be. Anything less, we say,
5 is not good enough. 16:33
6
7 Panel, those are my submissions, subject to a
8 restricted session.
9 CHAIRPERSON: Do you now want to refer to evidence
10 which has previously been under a Restriction Order. 16:34
11 MR. MAGUIRE: I do.
12 CHAIRPERSON: Okay. Well in order to preserve the
13 sanctity of the original Restriction Orders I will
14 direct now that we must go into restricted session.
15 You were told you could do this and you have taken your 16:34
16 opportunity to do so. How long do you think you'll be?
17 MR. MAGUIRE: 15 minutes.
18 CHAIRPERSON: Okay.
19 MS. ANYADIKE-DANES: Sorry, I have had some exchanges
20 with your senior counsel about that, I don't think my 16:34
21 clients have realise that there would be in any event a
22 closed session in relation to Group 3. I have
23 explained to them there is a paragraph that we took out
24 of ours because it is subject to a restriction order.
25 It would make maybe less than 15 minutes and I would 16:34
26 ask you, Sir, if we may refer to that since you're
27 going to have a closed session in any event.
28 CHAIRPERSON: I am a bit surprised about that, I mean
29 there has been three months to prepare these

1 submissions and it was made clear originally there
2 could be a restricted --
3 MS. ANYADIKE-DANES: I understand that, sir. It was
4 something we took out this morning when we went through
5 with the PSNI. The reasons for it, I think your Senior 16:35
6 Counsel appreciates, it took a while to appreciate that
7 the particular section was indeed covered by a
8 Restriction Order because some part of that evidence
9 was actually in open session and some part of it is in
10 a transcript, but when we tracked down into the 16:35
11 restricted transcripts we realised that actually that
12 part was specifically referred to. That's obviously my
13 responsibility and my fault for not tracking that
14 through. I can assure you sir it won't take more than
15 10 minutes. I think I have been faithful to the time 16:35
16 you have allowed me.
17 CHAIRPERSON: Well first of all I think the right thing
18 to do is to allow Mr Maguire to complete his address.
19 I don't think it's right to interrupt him, so take a
20 seat. Mr Maguire, we will now go into restricted 16:36
21 session. I'll hear that part that you want to address
22 me about and then I'll consider Ms. Anyadike-Danes'
23 application. Do you want to say anything Mr. Doran?
24 MR DORAN: No, Chair, I understand the statements are
25 to be fairly short in restricted session and therefore, 16:36
26 it would certainly be my submission that we should
27 proceed with them if at all possible this afternoon in
28 order to complete the families' closing statements.
29 CHAIRPERSON: Let's get on as best we can now, see what

1 time we get to and then I'll make a decision, okay.
2 INQUIRY SECRETARY: Chair, some people may have to
3 leave.
4 CHAIRPERSON: I'm just about to deal with that. We
5 will now go into restricted session. So only Core 16:37
6 Participants who have signed confidentiality agreements
7 may remain in this room and I'm sorry to ask everyone
8 else who will have to leave and the feed to Hearing
9 Room B will now have to be cut. And of course the live
10 feed is cut. 16:37
11
12 THE HEARING ENTERED RESTRICTED SESSSION
13
14 THE HEARING RESUMED IN OPEN SESSION
15
16 CHAIRPERSON: That does conclude the hearing today. I
17 think tomorrow is likely to be a shorter day, if that's
18 a relief to anybody, but we will see because we have
19 three addresses from Mr Robinson, Mr Neeson and Mr
20 McGuinness so we can look forward to those. So thank 17:07
21 you, 10 o'clock tomorrow morning.
22
23 THE INQUIRY ADJOURNED UNTIL 10.00 ON TUESDAY, 4TH MARCH
24 2025
25
26
27
28
29