MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON, WEDNESDAY, 5TH MARCH 2025 - DAY 123

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

123

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INDEX

PAGE

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

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

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

CLOSING SUBMISSION OF MR AIKEN

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

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

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

10:02

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

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The Trust repeated its previous personal and public apologies to those MAH patients who had been abused at the hospital whilst in the care of the Belfast Trust, and to their families.

10:03

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

10:03

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

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

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

the fact of those systems failures.

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

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

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

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

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

The Belfast Trust also recognises that what has occurred at Muckamore Abbey Hospital has contributed to an already highly damaging lack of Trust that exists between many families and health and social care professionals in the area of learning disability care. The Belfast Trust also apologises for the damage its failures connected to the hospital have had on that important issue of Trust between families and the necessary public service providers of care for their loved ones.

Having had a brief opportunity to consider the written closing submissions on behalf of the family groups and then to hear the oral closing submissions being delivered on their behalf, it's evident to the Belfast Trust that there is much work to be done in this area of Trust and that a way must be found to re-set those very damaged but vitally important relationships between families and those individuals who, by necessity, provide vital care for their loved ones. Its care that is not always easy to provide. There may well be failures that occur with it but in many cases, there will have to be a life-long relationship between staff in the health and social care system and in mental health and learning disability in particular and the families of their highly vulnerable loved ones that the health and social care system must care for. 10:09 10:10 10:10

Whilst it's perhaps entirely understandable, given how let down those families feel, that they should at present see no good or nothing positive in the care provided to their loved ones by the health and social care system. It is a dreadful indictment. 10:11

It's our respectful submission that a way must be found to try to rebuild those vitally important relationships which must endure long after the public Inquiry has completed its work. Perhaps the MAH Inquiry will give consideration to what form of recommendations it could make that might facilitate trust-building mechanisms 10:11

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

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

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

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

Whilst it is again understandable that when things go wrong in the health and social care system, calls are made for resignations and dismissals at all levels, it is hoped that the MAH Inquiry Panel, which includes professionals who have worked in health and social care, will appreciate and accept that most health and social care staff, including those involved in learning disability care, do not get up in the morning with the intention of making mistakes in their work or of letting down the people they care for or frustrating or upsetting the families of their patients. 10:13 10:14

Further, that being accountable for failures that occur doesn't necessarily mean losing your job, it can mean rolling up your sleeves and trying to make things better. 10:14

Also present from the Belfast Trust is Ms Templar, the Belfast Trust Service Manager in relation to the Inquiry. I know that Ms Templer will not thank me for saying so because she regards it simply as part of her public service, but over the course of the last three years often in the evenings and weekends, and during times when she was notionally on leave, Ms Templar and her team, along with my instructing solicitors and the Directorate of Legal Services and the counsel team, who as well as assisting many witnesses who found the Inquiry process unnecessarily difficult in their view and some tried to explain that to the Inquiry, have 10:14 10:14

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

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

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

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

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

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

10:19

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

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

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

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

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

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

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

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

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

lower than that.

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

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

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

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

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

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

something I'll hopefully return to later.

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

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

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

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

10:29

This is particularly important when considering events or incidents at Muckamore prior to 2017 and what has, through CCTV, subsequently become known to have occurred in 2017. It's an obvious fact as set out by Anthony Hidden QC as he was then, in his 1989 Inquiry report into the Clapham Rail Disaster that: 10:29

"There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself constantly aware of that fact." 10:30

That is, we respectfully say, particularly important to bear in mind when identifying what are said to be missed opportunities or previous events that can be identified genuinely missed opportunities based on what was known at the time those events were being dealt with, or are they only a missed opportunity when viewed through the prism of subsequent events, the nature of which will always cause you to look for something previous that might have alerted you to or been seen to be a sign of things to come. 10:30 10:30

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

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

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

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

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

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

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

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

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

10:35

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

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

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

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

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

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

valid perspective, and in some cases, perhaps a right to be heard in their own defence where they have been criticised by a colleague in respect of the same event, then you should exercise caution in relation to making any findings in relation to that event. 10:39

I want to address the topic of the awareness of abuse generally and then in particular relating to the abuse that was subsequently found on CCTV from 2017. I want to be clear on behalf of the Belfast Trust, that in 10:39 considering this topic, which is a difficult topic, the Belfast Trust is not seeking to minimise or excuse the abuse suffered by patients, nor any systems failures for which the Belfast Trust can be reasonably and legitimately criticised. The fact vulnerable patients 10:39 could be abused by health and social care staff is a known longstanding problem, that it could occur notwithstanding the vocation and professional responsibilities of staff, was known to the North and West Belfast Health and Social Services Trust and later 10:40 the Belfast Trust, it was known to the Mental Health Commission and later the Regulation and Quality Improvement Authority. It was known to the then Health and Social Care Board, the Public Health Agency and the Department of Health, Social Services and Public 10:40 Safety, later the Department of Health.

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

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

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

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

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

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

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

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

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

10:44

The material demonstrates that the nature and extent of how matters were investigated changed over time. The available investigative mechanisms and disciplinary processes and learning mechanisms also changed over time. They were generally regionally designed 10:44
processes that had to be followed across the health and social care system. The processes can be said, generally speaking, to have over time become more detailed and generated more and more paperwork, whether ultimately on reflection that also means they improved 10:45
or were more effective may be a matter of debate.

That may speak to why, as you will probably be now aware, there are major changes to come in adult safeguarding, I'll hopefully say a little more about 10:45
that later, that an overhaul of the SAI process is now well advanced. You heard counsel from the Department yesterday that the intention is to simplify that system which is supposed to be a learning tool. The Minister for Health has now indicated, which you also heard 10:45
about yesterday, that there will be legislation brought forward, if time permits, in the mandate in respect of an organisational duty of candour within health and social care. So there will be much forthcoming change

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

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

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

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

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

10:48

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

10:48

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

10:48

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

10:48

10:49

hospital as a whole at any point in time.

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

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

I make the submission recognising that, in fairness to the staff I mention shortly for illustrative purposes, there has been no evidence adduced nor suggestion put to any member of staff who gave evidence to the MAH Inquiry that they were actually aware that patients onwards at MAH were being abused in 2017 by the staff who were supposed to be caring for them. 10:51

It has been said that: 10:51

"Where there is a small group of devious staff who deliberately mislead both those engaged in inspection and regulation processes, as well as MDT members, advocates and carers, it is very difficult to detect their actions, especially when service users are very vulnerable and have limited communication skills." 10:52

If we can bring up page 67 of the bundle, that is a quote to be found on page 56 of Professor Murphy's 67-page, 18th of March '2020 initial report on the adequacy of the CQC inspections at Whorlton Hall in County Durham following a Panorama programme that reported on 38 days of undercover filming on a 17 bed unit. The undercover filming recorded abuse by staff at the facility. The independent review was asked to: 10:52 10:52

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

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

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

While the question being asked and answered, specifically related to the regulatory or inspection process, the conclusion reached has, respectfully, arguably much wider import. The question is posed and the report says: 10:53 10:54

"This question was central to the regulatory review conducted. It is clear from..."

And it refers back to Section 9: 10:54

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

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

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

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

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

In hindsight, after the Panorama programme..."

And it is important that we remember this is 2019:

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

That is exhibited at Appendix 3 of the report: 10:56

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

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

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

In this case Whorlton hall:

"...once they were no longer employed by the provider. Much more careful interviews with service users in conditions of privacy where they felt safe, preferably with the use of alternatives and augmentative communication tools, such as talking mats, more thorough interviews with all family carers; frequently inspectors were simply given the contact details for a small sample of chosen carers." 10:57 10:58

Interestingly, you may consider, as the section of the report that I've read from says, it was not until after May 2019 that the Regulator in England and Wales, through its Head of Mental Health, developed some specific guidance for inspectors to try to identify closed cultures which it was considered would have a greater risk of abuse occurring and going undetected. 10:58

Albeit the guidance indicated that the presence of one or more inherent risk factor is not proof that there is an abusive or punitive culture, but could be a sign that there is an increased chance of one developing. 10:58 10:59

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

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

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

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

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

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

11:01

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

11:01

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

11:02

11:02

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Maxwell then asked:

"Q: This was November 2017?
A: Yes, as soon as we came became aware of the situation. Prior to that we had no knowledge that there was any concerns.

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

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

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

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

Professor Fitzsimmons is then asked:

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

The answer cuts across:

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

That is the review, the engagement: 11:09

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

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

Professor Murphy then asked:

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

And the answer that the Professor gave:

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

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

Dr Maxwell the is recorded as saying: 11:11

"Q: I was just going say, were any of those students working as healthcare assistants on the bank, so were they in Muckamore on two roles?
A: I do not know that to be a fact, but it may well be 11:11
the case."

Professor Murphy asked:

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

The answer from Professor Fitzsimons: 11:11

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

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

The Professor asks again: 11:12

"they could have been on any wards. Could they have been there at any time of the week, so you know, possibly weekends would have been more difficult times but might they be there over weekends as well?." 11:12

The answer:

"So I genuinely wouldn't, there were small numbers of our students in Muckamore at any given time. You then 11:12 sir, asked, that's what I wanted to ask how many students, you may have given the information somewhere. single figures at anyone placement."

She describes five or six students possibly at a time 11:12 but using a range of different facilities and over what sort of period? They were placements that were six or 12 weeks. Dr Maxwell asked about whether they working shifts and the answer was:

"They worked shifts right across the entire roster."

Scroll on further down, please. There is a discussion then about the extent of the duties, does it cover

night duty and the answer was yes:

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

And then further down there is a question asked about:

"And as far as you recall none of the wards were excluded by the placement audit?
A: No, none were deemed unsuitable." 11:13

And then Dr Maxwell asked a question:

"So they could have been on the Intensive Care PICU Ward?" 11:13

And the answer from Professor Fitzsimons was:

"So the audits that were conducted after the 1st November 2017 didn't indicate concerns in any of the placement areas, so that would have included the more acute facilities as well." 11:13

And then she refers to it being a conundrum that she does not perfectly understand herself. Then it goes on to explain, slightly further down, the discussions that were engaged in thereafter. 11:14

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

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

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

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

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

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

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

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

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

CHAIRPERSON: Thank you. Yes.

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

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

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

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

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

MR. AIKEN: We'll keep going. Thank you, I'm sorry. So there's reference to patients involved with the multidisciplinary team, including nursing staff and the consultant psychiatrist, the forensic psychologist, social worker, day services staff, the occupational therapist and the behavioural therapist. 11:36 11:36

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

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

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

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

staff and new Ward Manager. These changes were seen as positive and it was good to note that patients who met with the inspectors felt the changes had been well managed and the high quality of care provided in the ward had been maintained. Patients reported no concerns regarding the care and treatment they received in the ward. Patients also stated that when they had a concern or difficulty regarding their care they could discuss these with the MDT and/or their advocate and informed inspectors that they knew who to talk to if they were not happy or had a concern. It was positive to note that patients understood their rights and a number of patients had previously attended the mental health review tribunals." 11:38 11:39

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

"They stopped the hospital gardening programme without telling us."

Someone else saying "I'm treated well":

11:39

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

recreational and creative activity programme."

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

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

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

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

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

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

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

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

"The ward's atmosphere was positive. Patients stated

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

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

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

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

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

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

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

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

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

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

"It is important to note that the ward provided care and treatment to newly admitted patients who presented as very unwell. At the same time the ward also continued to care for patients who no longer required treatment." 11:46

So again, I'm drawing to your attention that that's a report that's coming in to the Belfast Trust and moving down to the management of the hospital as to what the patients were saying to the inspectors who are not there employed by the Belfast Trust. 11:47

The third one I want to look at, please, begins at page 205 of the bundle. It's also in May. So the report we were briefly looking at was the 16th to the 18th of May. This inspection is the 17th and 18th May, different inspectors, and it is, if we just scroll down please, it is the Donegore Ward, you did hear from one of those inspectors I believe, although this report wasn't opened with her. 11:47 11:47

If we move down please to page 207 and just the bottom half of the page on 207 you'll see, again, sorry, it is in the top half this time, the detail of the ward itself. It's a nine bedded ward. The purpose of the ward is to provide care and treatment to female patients with a learning disability who present with behaviours that challenge. There were nine patients 11:48

present on that day.

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

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

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

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

I draw your attention to:

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

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

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

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

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

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

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

"Considerate to the patients presenting needs and staff

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

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

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

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

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

11:54

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

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

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

reflect, as the necessary caveat, that the ward circumstances on the day of the inspection. So you can see the first concern that would have been expressed was that patients were unable to access Allied Health Professionals: 11:55

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

Patients told the Inspector they had no concerns regarding their ability to access services, including podiatry, speech and language services, social work, a dentist or an optician. Patient care records evidenced that patient needs were comprehensively assessed and a 11:56 corresponding care and treatment plan had been agreed. The Inspector found no evidence that patients had been unable to access any professional that might be required to support their care and treatment.

11:56

Staff who met with the Inspector demonstrated understanding of AHP within the hospital. This included referral pathways to AHPs and the Inspector reviewed the referral pathways with the Ward Manager and discussed contingency planning in circumstances 11:56 where there might be a delay; for example, in accessing a podiatrist or an optician.

The Ward Manager assured the Inspector that the

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

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

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

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

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

patient who remained acutely unwell. Care records reviewed by the Inspector evidenced that the ward's multidisciplinary team continued to provide contemporaneous records of each patient's progress. Patient care plans, risk assessments, physical healthcare assessments were up-to-date. Nursing continuing care records evidenced that patients were closely monitored and their care and treatment patient centred. 11:58

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

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

11:59

But, again, this is a report this time specifically about a concern that prompted the Inspector to go there. That report is then coming back in to the Belfast Trust and moving down to the relevant individuals who see it and that is the context of information as matters take a totally different turn as the CCTV review subsequently reveals. 11:59

But those are, again, external individuals whose

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

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

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

You heard from Dr Milliken, highly experienced

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

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

"Shock, anger and despair."

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

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

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

"...who where as shocked as he was when the allegations came to light." 12:04

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

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

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

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

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

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

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

He replied:

"I believe now that they were, yes."

You asked then:

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

He said: 12:07

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

Sir, you then refer him to and the evidence given: 12:07

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

And his answer to that is:

"Yes, it shocks me."

You then ask, Chairman: 12:07

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

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

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

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

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

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

Dr Milliken answered:

"Yes, in Six Mile, yes."

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

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

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

The answer is:

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

12:09

You then ask, sir:

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

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

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

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

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

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

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

CHAIRPERSON: Yes. 12:11

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

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

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

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

"So in relation to that..."

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

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

And the answer that H223 gave to you was:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This is talking about the post-August 2017:

"But ultimately we know that it was more than just one and you continued to be Head of Learning Disability Services until 2019 and you've described various measures that you implemented to try and address issues at Muckamore." 12:23

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

"But in becoming aware of the issues that were captured on CCTV, did you or have you since reflected on how that could have happened in a situation where you were implementing the measures that you have described to us?." 12:23

And the reply is:

"How the incident could have happened?"
Q: Yes, how the number, the number of incidents and the level of abuse that took place at Muckamore?." 12:23

The answer is:

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

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

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

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

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

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

"So you were a mentor to student nurses at Muckamore from the 1990s until your retirement in 2020, is that correct?
A: Yeah. 12:27

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

And his answer was "no":

"Q: Elsewhere in your statement you say, and you'll pull up paragraph 61, thank you, you're here, third 12:27
line down?
A: I don't recall any incidents where I witnessed poor care. I would have felt confident to report anything I was uncomfortable with to my line managers, but I

cannot recall any specific occasion when I needed to.

Q: So you didn't personally witness any incidents that you were uncomfortable with?
A: Yeah. 12:27

I think, again, when the question was asked to me, the question was specifically, had I witnessed poor care, it wasn't 'was anything ever reported to me', so there would have been..." 12:28

And he then recalls two incidents where things were reported to him and what he did about those. And then one incident was to do with his time working on Movilla and another was do with his time working on Cranfield 12:28 in 2015 and he explains the various processes that were engaged in:

"So those are two occasions when something was reported to me which you had to act on immediately like, the 12:28 first one, you know, we didn't know whether it was believable or not, but you had to take it that it was and follow procedures.

The second one was different where it was a member of 12:28 staff reporting another member of staff and there was a second staff witness."

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

"Q: But you were always clear about what your responsibilities were?
A: Yes, you know, you couldn't have something like that happening on your ward and if it did happen, it had to be reported." 12:29

Then he is asked:

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

And he then he said: 12:29

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

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

And he said:

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

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

12:30

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

12:30

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

12:31

12:31

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

sought and I'm not going to be able to do this subject justice in the time that's available, but I want to say something briefly about the response to the developing and growing problem that was found on the CCTV review and the response that followed to it. 12:32

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

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

A significant and extensive problem of abusive

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

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

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

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

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

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

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

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

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

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

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

are set out.

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

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

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

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

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

And then within a short time of that you had the service of the three Improvement Notices from the RQIA which are very significant events in respect of the operation of a Health Trust, Health and Social Care Trust. And you then have very significant steps taken in management to try to deal with those Improvement Notices which occurred.

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

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

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

having replied:

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

He's recorded as having:

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

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

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

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

being managed.

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

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

12:47

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

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

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

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

This is Ms Hopkins from RQIA: 12:49

"There has been an increase in adult safeguarding referrals but we see that as a positive increased recognition with staff being proactive. We do not believe this represents a deteriorating position and we 12:49 feel it's only fair that we congratulate the Trust on what it has achieved in the last two years."

Now the Trust is not looking for congratulations, there are all sorts of problems and difficulties as I have 12:49 acknowledged and you will be able to identify those, but it's in a context of recognising at least the effort that was going in to try to manage a very difficult situation. And that included being asked to admit more people to Muckamore which is an indication 12:49 of the difficulty with the system. Dr Jack wrote to the Permanent Secretary about that on the 10th of December 2021 and you'll find that at STM-287-439.

I had recorded that I was going to say, I have moved 12:50 very quickly through, but I have actually moved much more quickly through than I had intended.

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

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

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

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

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

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

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

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

12:54

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

12:55

12:55

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

12:56

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

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

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

CHAIRPERSON: Just for context, this was in 2020.

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

that, so yes January 2020.

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

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

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

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

significantly longer period. But if you want to think about what your concluding remarks should be, I will give you that time, even though others might complain.

MR. AIKEN: I hope they won't. What I may do sir, with your leave, I am not going to be deal with it in the way that you're envisaging, so it might be that we provide it to you in writing and then you will be aware of it and can make of it what you will. 13:00

CHAIRPERSON: All right.

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

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

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

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

THE INQUIRY RESUMED AFTER A SHORT BREAK, AS FOLLOWS:

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

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

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

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

CHAIRPERSON: It is, we understand, all right.

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

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

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

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

[redacted] A witness [redacted] that you heard from and this is in the context of the provision of day care services, [redacted], was the

mother of a patient and the mother of the patient is a core participant. As I say, nothing I am saying is intended as a criticism of the mother of the patient

The patient was a patient in the hospital [redacted] 13:12
[redacted], and I will just deal with it in very summary form. The recollection of the mother of the patient was that in the context of day care there was no help at all, nothing to do. There was one person was seen who 13:13
came onto the ward but other than that, no exercise, nothing. And you'll see that [redacted]
[redacted] the patient's mother explained that she had enjoyed walking with her daughter elsewhere but that wasn't the 13:13
kind of thing that occurred in Muckamore.

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

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

records about those sessions, how shortly they began after [the patient] went into Muckamore, so just short of a month after the admission and various trips out that are recorded in the records. A walking schedule, that you will find in the records drawn up by Behaviour Services [redacted]. Part of what's recorded as "assessing the need for structure" and attendance at the swimming pool. Cookery sessions and work skills with peers. And it included on one occasion, a complaint from [the patient] that she didn't like the new timetable because it didn't allow her to see her friends the way the previous version had.

13:14

13:15

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

13:15

13:16

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

13:16

it.

But at least on this theme, and it may well be, we respectfully say it actually applies the across the themes, that what actually happened may have been considerably different from what the person believed and recollected it to be in terms of what they explained to you in their evidence. And so, you respectfully need to look at the notes and records, particularly on subjects that there is not really debate to do with veracity or anything else, to understand what was believed to be the position or what recollection evidence that was given to you, the extent to which that is in fact accurate. And that applies, there are lots of examples in day care but the same issue arises in respect of other themes. 13:16 13:17 13:17

And it is an issue about the care in making factual findings or determinations on general themes where the evidence has not been tested in that way. It's uncorrected belief evidence which may not be consistent with what's in the material and that that material shows that the belief, however genuinely held, may in fact be mistaken. And in fact the person could benefit potentially from being aware that there was much more activity with their loved one than they believe now was the case. 13:17 13:18

There are other illustrative examples of the same type,

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

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

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

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

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

13:20

And you'll see, the memo wasn't opened during evidence with Ms Hynds or anyone else, and it's important we say it is examined. It gives you a snapshot of information that perhaps isn't available to you elsewhere, for what may no longer be remembered by those who were trying to 13:20
give evidence about the matters at many years remove.

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

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

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

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

Very briefly in open, sir, and I am again just going to deal with this in summary form and ask you to consider it. In paragraphs 12 and 13 of the PSNI closing submission, and it was repeated to you yesterday during the oral closing, I don't know if you have that to hand? But it appeared to be based on a mistaken premise or to misunderstand what the issue was or the difficulty that was being described to you in evidence. The issue wasn't about whether the Belfast Trust and its staff had information about any particular incident identified on CCTV. It obviously had that information. The issue was the extent to which officials within the Belfast Trust involved with the investigation, so that kept that information tight and who obviously did have it, the extent to which they were in a position to share that information or convey the detail of it to staff who were on the ground, such as the individual who became subject of some form of supervision and training, or the person acting as the supervisor of that person. 13:24 13:24 13:24 13:25

So the submission seemed to be suggesting the Belfast Trust was giving evidence that it was not being given the information, that is not the issue that was being addressed in the evidence. There is an obvious tension, and it's important I recognise that on behalf of the Trust, arising from concern not do anything to prejudice a criminal process in tightly controlling the 13:25

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

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

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

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

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

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

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

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

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

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

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

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

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

THE HEARING ENTERS RESTRICTED SESSION

OPEN SESSION

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

CHAIRPERSON: That's the job of Ms King.

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

CHAIRPERSON: Tell us what it is. 13:45

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

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

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