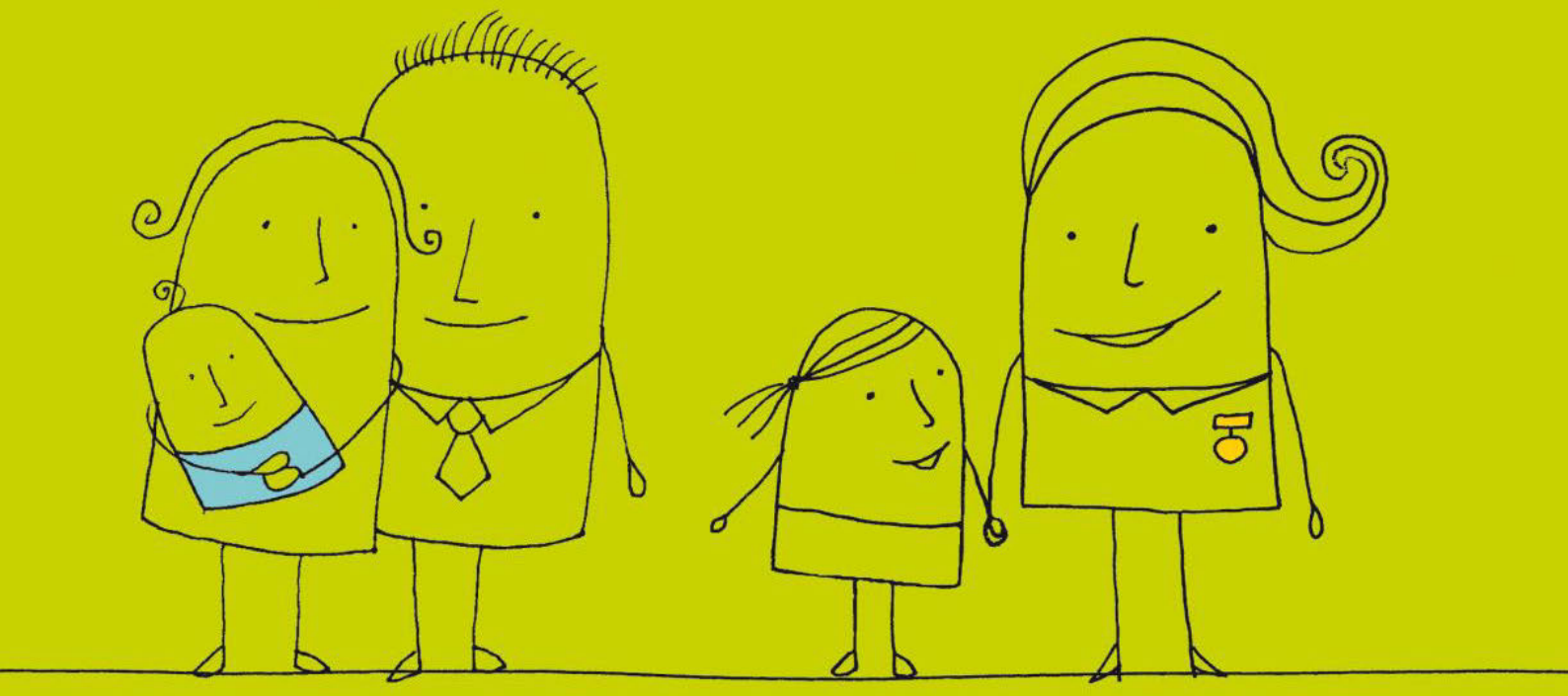
Patient and Client Council

# Report on the Engagement with current and former patients, families, and carers

## Regarding

## The Terms of Reference of the Public Inquiry into Muckamore Abbey Hospital

**March 2021**



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## List of terms and abbreviations used in this report

- **DSO**- Departmental Solicitor's Office. This is a branch of the Department of Finance which provides legal services to Northern Ireland's government departments.
- **DoH or 'The Department**' – This refers to the **Department of Health** for Northern Ireland, which is the Government department responsible for Health and Social Care, Public Health, and Public Safety.
- **FOI Requests**- Freedom of Information Requests. Formal requests under which an individual is exercising their legal right to access information.
- **HSC** - Health and Social Care. This abbreviation may refer to a number of different bodies under the Health and Social Care umbrella of statutory bodies and agencies.
    - The **Health and Social Care Board** is the statutory body responsible for arranging health and social care services in Northern Ireland.
    - There are also five **HSC Trusts** in Northern Ireland, which are responsible for providing health and social care services in their respective areas. These are:
        - **BHSCT** The Belfast Health and Social Care Trust. It is responsible for Muckamore Abbey Hospital.
        - **SEHSCT** The South Eastern Heath and Social Care Trust
        - **NHSCT** The Northern Health and Social Care Trust
        - **SHCST** The Southern Health and Social Care Trust
        - **WHSCT** The Western Health and Social Care Trust
- **HSE(NI)**-The Health and Safety Executive for Northern Ireland is a non-departmental public body sponsored by the Department for the Economy. It is responsible for regulating health and safety at work in Northern Ireland.
- **RQIA-** Regulation and Quality Improvement Authority. The RQIA is an independent statutory body established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland.
- **MAH** – Muckamore Abbey Hospital
- **MDT-** Multi-Disciplinary Team. This is a healthcare team comprised of individuals from multiple healthcare disciplines (such as doctors, psychiatrists, psychologists, nurses, and occupational therapists[1])
- **PCC**- The Patient and Client Council. The Patient and Client Council (PCC) was created on the 1st April 2009 as part of the reform of Health and Social Care in Northern Ireland for the purposes of acting as an independent, informed and influential voice that advocates for people across Northern Ireland on Health and Social Care.
- **PSNI-** the Police Service of Northern Ireland.
- **SAI-** Serious Adverse Incident. This is an incident that, due to its serious nature, must be reported to the Health and Social Care Board under the current safeguarding protocols.

[1] When a draft report on our December Terms of Reference engagement events was sent out for review, one respondent noted that it is best practice for MDTs in the field of learning disability to include families.

- **SAR**- Subject Access Request**.** This is a request made to an organisation or company under UK data protection law for personal information it holds about the requester.
- **ALBs –** Arm's Length Bodies, These are bodies situated inside or outside the health and social care family with input to regulations and standards, such as the RQIA, the HSC Trusts, and the Health and Social Care Board.

## INTRODUCTION

1. On 8th September 2020, the Minister for Health, Robin Swann MLA, announced his intention to invoke his powers under the Inquiries Act 2005 to call a Public Inquiry into abuse at Muckamore Abbey Hospital.

2. Minister Swann committed to consult with families, carers, and current and former patients on the Inquiry's Terms of Reference and the identity of its Chair. He asked the Patient and Client Council (PCC) to carry out these consultations on his behalf.

3. The Patient and Client Council held three engagement events in December 2020 in which families and carers met with representatives from the Department of Health, the Inquiry team, and the Patient and Client Council to learn more about the Public Inquiry and discuss their views on its Chair and Terms of Reference. These events were conducted remotely due to public health guidance and were attended by over 47 individuals.

4. In addition to these public events, Patient and Client Council staff members have spoken privately with current and former patients, carers, families, and advocates from November 2020-February 2021 to discuss their views of the Terms of Reference and Inquiry Chair. They also met with current patients in person on the hospital site, visited former Muckamore Abbey Hospital patients in supported housing, and spoke to small groups of former patients in day centres and self-advocacy groups. These facilitated formal conversations occurred with 59 individuals, including 22 current or former patients. The Patient and Client Council also received 29 written submissions via email and post in which patients, families, and carers shared their views on the Inquiry. Throughout this process, many respondents shared their personal experience of Muckamore Abbey Hospital, and we would like to thank them for entrusting us with this sensitive information. We appreciate the time, thought, and courage that respondents have invested in this process.

5. The PCC's consultation sought views on the following topics, which were agreed in advance with the Inquiry Team. These were not exhaustive:
    5.1. The purpose of the Inquiry (what people want the Inquiry to achieve)
    5.2. The substantive scope of the Inquiry (what people think the Inquiry should investigate)
    5.3. The time frame of the Inquiry (which years the Inquiry should consider in its investigation)
    5.4. Whether the Inquiry should have the power to make recommendations
    5.5. The types of evidence the Inquiry should consider
    5.6. The background the Inquiry Chair
    5.7. The types of support that should be offered to patients and their families, carers, and friends throughout the Inquiry process.

6. All contributions to group discussions, individual responses, and group submissions were considered in full, and a wide range of topics were covered.

**The following report summarises the views that patients, families and carers shared with the Patient and Client Council. It does not lay out the specific details of each response, but rather outlines the key themes that emerged from patient, family, and carer responses on the whole.**

7. Given that the majority of the PCC's engagement took the form of group discussions, the following report does not quantify the number of respondents who agreed on particular topics, with a few exceptions. Instead, the language used below indicates whether or not respondents agreed on particular points of discussion.

8. Where feedback from patients, families, or carer representatives diverged on key themes or areas, this has been noted.

9. Copies of the materials that the PCC used throughout their engagement process can be found in the appendix to this report.

10. **A note on language:** This report is intended to serve as a factual reflection of all information provided by respondents. The words "allegations" and "alleged" are used throughout. These terms are not intended to suggest that any claims made by respondents are illegitimate or made in bad faith; they simply refer to any facts that have not been tested in and proven by a court of law.

## KEY THEMES

### The purpose of the Inquiry

11. As part of the PCC's engagement and consultation process, we asked current and former patients and their carers or families what they want the Inquiry to achieve. It was challenging to quantify responses in this area given the divergence in viewpoints. Responses indicated that the Inquiry should serve two main purposes:

    11.1. **Acknowledgement**

        11.1.1. On the one hand, there was a general consensus amongst former patients that there is a historical element to the Inquiry. A large proportion of families, carers, and friends also agreed on this point. Former patients, particularly those who were in Muckamore in the 1960s-80s, allege that they experienced physical, emotional, financial, material, and/or sexual abuse at the hospital.[2] They view the Inquiry as a long-awaited opportunity to tell their stories. Individuals view the Inquiry as their chance to gain closure, and they remarked that at the end of the Inquiry, they hope to walk away with the knowledge that officials finally listened to them, as well as a formal apology.

        11.1.2. This sentiment was echoed by other former patients, who reported feeling that because they have learning disabilities, they were not believed when they disclosed allegations of abuse. These individuals stated that at the end of the Inquiry, they hope to receive formal recognition of the abuses they suffered, and the feeling that they experienced disability-based discrimination, when trying to be heard.

        11.1.3. The PCC also spoke to relatives of former patients who suspect that their loved one experienced abuse, but they do not know if this was the case because their relative is non-verbal or has passed away. While some of these individuals told the PCC that they do not know if they will ever uncover the specific details of their loved one's time in Muckamore, they view the Inquiry as a chance to develop a better understanding of patients' experience in the hospital and gain closure.

[2] All allegations were reported to the relevant authorities.

11.1.4. On a related note, respondents agreed that they expect that any perpetrators of abuse who are identified by the Public Inquiry, including individuals who are in leadership or management positions, will face censure, criminal prosecution and/or professional disciplinary action if malpractice is evidenced and proven. Although respondents understood that the Inquiry cannot produce such outcomes itself, they hope to see definitive legal and/or disciplinary action taken in response to the Inquiry's factual findings. In light of these considerations, one group submission stated that "The Inquiry should also [sic] have the power to refer matters to the criminal authorities."

11.1.5. Respondents also expressed hope that the Inquiry would open up pathways for victims to seek redress—either financial or in the form of services—for the abuse and neglect they experienced at the hospital. It was noted that this was made available to victims connected to the Historical Institutional Abuse Inquiry.[3]

11.2. **Recognition**

11.2.1. On the other hand, virtually all current patients who spoke to the PCC stated that this must be more than a historical abuse Inquiry. Families and carers who attended the PCC's December engagement events generally agreed on this point, as well. In fact, some relatives of former patients noted that they do not see value in a historical investigation and felt that the Inquiry should focus solely or primarily on the present-day issues that impact Muckamore Abbey Hospital and Northern Ireland's wider adult social care system. Respondents were largely of the view that the abuse and neglect that took place on the grounds of Muckamore Abbey Hospital is the consequence of widespread deficiencies in Northern Ireland's Health and Social Care system. These individuals suggested that abuse and neglect is able to occur because there are not enough legal protections for the rights of persons with learning disabilities and mental health conditions under Northern Ireland's existing legislative framework. To this end, one respondent stated that they believe that people with learning disabilities are "treated like second-class citizens" in Northern Ireland.

[3] The HIA Inquiry's Terms of Reference stipulate that the Inquiry's report "will make recommendations and findings on…The requirement or desirability for redress [financial or the provision of services] to be provided…to meet the particular needs of victims." (see https://www.hiainquiry.org/terms-reference) A redress scheme for victims was subsequently established under The Historical Institutional Abuse (Northern Ireland) Act 2019

11.2.2. Respondents expressed their belief that the authorities' default response when they encounter a person with learning disabilities and challenging behaviour is to institutionalise them in Muckamore Abbey Hospital. Families, carers, and advocates allege that this happens because they believe that there are inadequate financial resources or adequately trained staff to cater to the needs of individuals with complex needs and challenging behaviour in community settings in Northern Ireland (several family members of former Muckamore patients noted that Northern Ireland spends significantly less per capita on support for people with learning disabilities than the other UK jurisdictions.) They feel that many of the failings of Muckamore Abbey Hospital are a result of this under-investment.[4] Several respondents told the Patient and Client Council that they believe that individuals with challenging behaviours are sent to Muckamore to disguise this reality.

11.2.3. Respondents remarked that they do not believe that abuse and neglect of the kind that was uncovered in Muckamore Abbey Hospital will be prevented from happening again until its underlying causes are addressed. ***They hope that this inquiry will function as a paradigm shift for adult social care in Northern Ireland—they view the Inquiry as an opportunity to call attention to the need for increased investment in learning disability support services, as well as policy changes to improve accountability for abuse and neglect in adult social care settings and legal reforms that will better safeguard the human rights of persons with learning disabilities throughout the jurisdiction.***

12. Overall, respondents were generally in agreement that the Inquiry should aim to:

12.1. **Reveal the whole truth** of what happened at Muckamore Abbey Hospital.

12.2. **Identify the parties who are at fault for patient abuse and neglect and hold them to account**. Respondents made it clear that they consider "parties at fault" to be any individuals who were directly responsible for abuse and neglect, as well as those who did not intervene to prevent it, particularly if the latter individuals occupied positions in which they owed a duty of care to the patients of Muckamore Abbey Hospital. Respondents believe that responsibility for the failure to act over the years points to systemic failures to hear the voice of the patients, families and carers.

[4] "NI per capita spend on mental health and learning disability was less than half of spend in England." Betts and Thompson, "Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS, and Barriers to Accessing Services" (24th January 2016, NI Assembly NIAR 412-16) p. 43

12.3. **Improve policies, legislation, systems and processes** both within Muckamore Abbey Hospital and across the HSCNI/ the broader adult social care sector. Respondents expressed hope that the Inquiry would lead to the development of improved models of care for Northern Ireland's learning disability population, and increased investment in learning disability support. They also called for improvements to staff recruitment and training, governance, safeguarding, and accountability mechanisms throughout Northern Ireland's adult social care services.

## Period of time to be Considered by the Inquiry

The PCC's engagement process sought views on the timeframe on which the Inquiry should focus.

13. Patients, families, and carers were made aware that the Inquiries Act 2005 prevents the Minister of Health from including events that occurred when devolution was suspended in the Inquiry's Terms of Reference without the permission of the Secretary of State for Northern Ireland. Respondents were unanimous in their view that the Minister should ask the Secretary of State for an extension of this time frame. An overwhelming majority of respondents were of the opinion that the Inquiry would be incapable of uncovering the truth if it were to be confined to the periods in which devolution was in effect.

14. Respondents generally agreed that the Inquiry should cover the entire history of Muckamore Abbey Hospital, from when it first admitted patients in 1949 until the present day. Families and carers added that the period of time considered by the Inquiry should extend several years into the future, up until the point at which the Inquiry concludes, so that the experiences of current patients are included in its remit.

15. This time frame was broadly deemed necessary for two reasons:
    15.1. Respondents' experience of Muckamore Abbey Hospital ranges from the present day to as early as the 1960s. The overwhelming majority of respondents were of the opinion that the experience of all living current and former Muckamore Abbey Hospital patients should be included in the Inquiry. However, because of concerns related to the availability of accurate, comprehensive records of Muckamore Abbey Hospital patients, concerns related to the possibility of determining the earliest date at which a living former patient was admitted to the hospital. Furthermore, several respondents who were patients in the 1980s or earlier noted that it was the norm at that time for patients to spend decades in the hospital. One respondent alleged that, historically, the hospital was "cradle to grave" and that "people were born, lived, and were buried" on its grounds. Another respondent, who is a former patient of Muckamore Abbey Hospital, believed that some of his fellow patients had been in the hospital since it opened. He felt that the Inquiry would do these individuals a disservice if their experiences were excluded from its scope.

15.2. Respondents agreed that the Inquiry should uncover "what went wrong" at Muckamore Abbey Hospital. However, they did not agree upon the point at which things started to go wrong. On the one hand, many individuals who are either long-term patients of the hospital, or who attended the hospital on multiple occasions over the years, believe that the hospital and the treatment of patients therein, have improved over the years. On the other hand, a number of current patients and their families stated that the hospital has declined over the years, and point to different dates or events as the point at which this decline began. Some current patients allege that the hospital's problems started with the 2002 Bamford Review and the subsequent introduction of the Muckamore Abbey Hospital Resettlement plan, while several current patients allege that the hospital's problems began with the introduction of the CCTV cameras in 2016. A longer time frame will allow the Inquiry to gather the information it needs to determine when and why problems occurred in Muckamore Abbey Hospital.

Avoiding unnecessary delays

16. Although respondents acknowledge that it is important for the time frame of the Inquiry to be broad enough so as not to exclude any patients or their loved ones, respondents were in agreement that they do not want the Inquiry to "drag on" for an unnecessary length of time. They expressed concern that the greater the period of time covered by the Inquiry, the longer it would take to conclude. It was suggested that one way to balance the competing needs for promptness and comprehensiveness is for the Inquiry to release periodic progress reports rather than waiting until the end of the investigation to release information. This approach has been taken by several other Public Inquiries.[5]

## Substantive Scope of the Inquiry

17. The majority of the PCC's engagement with patients, carers, and families connected to Muckamore Abbey Hospital took the form of discussions about what they believe the Inquiry should investigate. These discussions revealed that patients, families and carers would like the Inquiry to answer the following key questions:

17.1. ***What is the scale of the abuse and neglect of the patients of Muckamore Abbey Hospital?*** Respondents asked the Inquiry to determine how long patient abuse and neglect has occurred in the hospital.

[5] e.g. Taylor LJ, Chair of the Inquiry into the Hillsborough Stadium Disaster, released an interim report and a final report. More recently, the ongoing Grenfell Tower Inquiry, which commenced in 2017, is releasing its findings in "phases."

They also ask the Inquiry to reveal the nature of abuse and neglect and the frequency with which incidents of abuse and neglect took place.

17.2. ***Who is responsible for patient abuse and neglect?*** Respondents felt strongly that the Inquiry should identify all individual actors who played a part in the abuse and neglect of patients.

17.3. ***Why did patient abuse and neglect occur?*** Respondents asked the Inquiry to identify the factors that allowed the abuse and neglect of Muckamore Abbey Hospital patients to occur. They queried whether systems, policies, individuals, or a combination of the three created an environment in which they perceived that abuse was normalised and neglect was tolerated. One group submission stated that the Inquiry should take particular care to identify:

> *systemic failures [within the Department of Health, and other such bodies or agencies as are identified and appropriate], in the treatment of patients at Muckamore Abbey Hospital which permitted or led to abuse, including both direct physical or psychological abuse, provision of inappropriate care or care of insufficient quality to meet patient's needs*

17.4. ***Why did nobody intervene to prevent patient abuse and neglect or hold those responsible for wrongdoing to account?*** Patients and their families, friends, and carers spoke about the lengths they took to call attention to abuse and neglect in Muckamore Abbey Hospital. Respondents told the PCC that they contacted multiple agencies and departments within the HSC system and beyond, alerted the police, contacted the press, and took legal action in response to events in Muckamore, oftentimes to no avail. Respondents expressed frustration that their continual strive to be heard failed and that the systems and individuals that were put in place to protect patients failed to do so. They ask the Inquiry to determine why this happened.

17.5. One group of respondents alleged that this lack of accountability is the result of deliberate cover-ups, and they view the Inquiry as an opportunity to bring this to light. They alleged that frontline staff, hospital managers and high-level actors within the HSC system deliberately covered up the abuse and neglect that took place in Muckamore Abbey Hospital. They ask the Inquiry to determine if this did happen, and if so, identify and censure any individuals who actively worked to disguise, downplay or enable patient abuse and neglect.

17.6. Other respondents were of the opinion that the Inquiry should not be confined to a search for deliberate cover-ups alone, but that it should seek to identify *all* factors that allowed abuse and neglect to continue unchecked, including but not limited to:

- bureaucratic constraints,

- deficiencies in staff training
- a lack of candour,
- inadequate cooperation between the various bodies and agencies that had oversight of the hospital, and
- deficiencies in the laws, policies, and regulations that govern both Muckamore Abbey Hospital and Northern Ireland's adult social care sector at large.

18. ***In light of these concerns, respondents were almost unanimous in their view that the Inquiry will only be able to uncover the scale and root causes of the abuse and neglect of patients in Muckamore Abbey Hospital if it is afforded an exceptionally broad investigative remit.***

*What is the scale of the abuse and neglect in Muckamore Abbey Hospital?*

While individual respondents' experiences of Muckamore Abbey Hospital varied in nature, they felt that the Inquiry's investigation into allegations of abuse and neglect should cover the following:

19. Over the course of our engagement process, patients and their relatives, carers, and/or friends disclosed allegations of patient **neglect**,[6] **inappropriate care**, **negligence**,[7] and **physical,[8] emotional, sexual, financial,**[9] and **material**[10] **abuse**.[11] Respondents urge the Inquiry to investigate all such allegations.

20. Respondents alleged that patients were **overmedicated** in Muckamore Abbey Hospital, and that medication was over-used as a response to patients' emotions. In light of these concerns, they ask the Inquiry to assess whether the use of PRN (or 'as needed') medication was accurately documented by care staff and whether the use of medication at Muckamore has complied with medical standards and norms. Respondents also ask the Inquiry to scrutinise how treatment decisions are/were made and reviewed at the Hospital. One former patient stated that he does not feel that front-line care staff got to know patients or their needs, and he questioned how they would have been able to give accurate information about patients' wellbeing to their treatment teams. Other respondents asked the Inquiry

[6] Respondents alleged that patients were left unsupervised in the wards for hours, and that patients were left unkempt.
[7] Respondents disclosed allegations in which they allege that errors or inadequacies in patient care led to serious illness, injury, or death.
[8] In addition to the ongoing PSNI investigation into suspected incidents of physical abuse that were discovered on the hospital's CCTV footage, the relatives of current and former patients repeatedly alleged that their loved one exhibited unexplained marks, cuts, and bruising.
[9] Respondents repeatedly alleged that patients' money disappeared, and one former patient alleged that staff coerced her into spending all of her money on food for them in the on-site shop and café.
[10] Respondents repeatedly alleged that patients' personal belongings disappeared when they were in Muckamore Abbey Hospital or that patients' belongings were returned to them poor condition. They also allege that patients were not dressed in their own clothing.
[11] The PCC developed a safeguarding protocol under which all allegations were reported to the relevant authorities.

to determine whether treatment decisions relating to patients' physical and mental health were reviewed on a regular basis, both internally and by outside bodies. Another respondent noted that Northern Ireland has a small population of medical professionals who specialise in learning disability and questioned whether this impacted the independence of second opinions.

21. It was reported in three separate engagements that electroconvulsive therapy (ECT) was widely used in the hospital in earlier decades, and respondents asked the Inquiry to uncover the extent to which it was used at the hospital. They ask the inquiry to investigate the history of these practices at Muckamore Abbey Hospital, determine when they ceased, and scrutinise the extent to which these practices complied with domestic and international law at the time they were carried out. The PCC also heard two separate accounts, from the 1960s and 1970s, respectively, in which it was alleged that staff removed patients' teeth in order to prevent them from biting staff.

22. Respondents also alleged that **physical restraint and seclusion** were over-used in the hospital, and that this resulted in harm to patients.[12] Respondents felt that staff automatically resorted to restraint and seclusion as a response to patient distress, rather than using alternative strategies to de-escalate patient behaviour. In light of these concerns, they ask the Inquiry to investigate whether staff kept accurate records of the use of restraint and seclusion at the hospital. They also queried whether these methods are/were used more frequently in Muckamore Abbey Hospital than in other comparable settings. They queried whether restraint and seclusion were used in a manner that was unsafe and/or violated patients' human rights, and whether it was a proportionate response to patient behaviour. Furthermore, respondents were largely of the opinion that the seclusion room should never have existed in the first place. They queried why its use was approved by hospital management, the Belfast Trust, the RQIA and the HSE. Respondents proposed that patients who present challenging behaviour should be given the chance to calm down in their room or a sensory room rather than being subjected to further agitation in the seclusion room, which one respondent described as "draconian."

23. In recognition of respondents' concerns around patients treatment and care, one group submission stated that the Inquiry should identify:

> *the extent to which the care in Muckamore Abbey Hospital corresponded to relevant statutory obligations, regulatory framework[s] and policy framework[s.]*

24. Although current and former patients agreed that living conditions have improved in the hospital in recent years, former and long-term patients of Muckamore Abbey Hospital alleged that the hospital has a history of **poor living conditions and**

[12] Respondents alleged that the staffs' use of restraint caused patients to incur injuries and severe bruising. Four separate accounts were also submitted to the PCC in which it was alleged that patients were left unsupervised in the seclusion room for hours without food, drink, or access to a toilet.

**practices** that they believe amount to **institutional abuse**. They questioned the extent to which the following conditions interfered with their human rights:

24.1. Former patients who were in Muckamore as recently as the 2010s alleged that many patients slept in communal dormitories, and that those patients who slept in private rooms were forced to leave the door open so that their bedroom was never dark or quiet and they never had any privacy.

24.2. Patients noted that some wards had bars on the windows as recently as the 2010s.

24.3. Former patients alleged that they did not have choice over bed times or meal times and that they often spent their days "locked in the ward with nothing to do." One former patient alleged that patients would only be taken out for activities if "good" members of staff were on duty that day, otherwise they would spend their days idle.

24.4. Former patients who were in Muckamore in the 1970s-1980s stated that the paid staff viewed themselves as "prison guards" rather than carers, and they allege that staff did not tend to patients' care needs. One former Muckamore patient alleged that staff instructed her to help bathe and dress patients who were unable to do so themselves.

24.5. Former patients who were in Muckamore in the 1970s-1980s allege that they were not addressed by their names.

24.6. Former patients who were in Muckamore in the 1970s-1980s allege that they spent their time at Muckamore Abbey Hospital working in the onsite laundry, shop, kitchen, and as groundskeepers for no pay. They allege that they were denied food or sent to "early bed" if they refused to work. One former patient alleges that she was told she would be paid for her labour when she left the hospital, but she never received wages. She stated that she would like the Inquiry to find out whether patients were lied to about receiving pay, or if the wages they were promised were misappropriated for another use.

<u>Staff Conduct</u>

25. Respondents asked the Inquiry to find out how many allegations of abuse and neglect were raised against Muckamore Abbey Hospital staff, what the nature of these allegations were, and what was done in response to said allegations.

26. Some respondents told the PCC that they did not report incidents of abuse or neglect out of fear, intimidation, or because they did not know who to go to with their concerns. These individuals noted that it is important for the Inquiry to look beyond reported incidents and historic allegations—they expect it to cast a wide search for signs of abuse and neglect. Furthermore, respondents proposed that the Inquiry should provide patients and their families with the opportunity to come forward with allegations that they have not previously disclosed. They expect that such allegations will be investigated by the Inquiry.

27. Respondents alleged that staff did not intervene to prevent patients from physical or sexual assaults by other patients, and one former patient alleged that staff left

patients unsupervised in the wards for extended periods of time. They ask the Inquiry to determine how frequently this happened and why this was the case.

*Who is responsible for patient abuse and neglect?*

An all-systems approach

28. The majority of respondents attributed Muckamore Abbey Hospital's problems to high-level and widespread failings within the Health and Social Care system. They therefore urge the Inquiry to investigate the extent to which the entire Health and Social Care (HSC) system and the actors therein are responsible for the abuse and neglect of Muckamore Abbey Hospital patients**.** Respondents proposed that the Inquiry should have the power to investigate all wards and units of Muckamore Abbey Hospital and all branches and Arms-Length Bodies of Northern Ireland's Health and Social Care system, including but not limited to: the Department of Health, the Health and Social Care Board (HSCB), the HSC Trusts, the Regulation and Quality Improvement Authority (RQIA), and the Patient and Client Council (PCC), as well as the agencies that acted as predecessors to these bodies prior to the introduction of the Health and Social Care (Reform) Act (Northern Ireland) 2009. Respondents agreed that the Inquiry should have the power to investigate all current and former HSC employees and contractors who have connections to Muckamore, including those who are or were employed through agencies.

29. Respondents also generally agreed that the Inquiry's investigation should extend beyond the HSC system. They recounted that they attempted to alert outside bodies about patient abuse and neglect in Muckamore Abbey Hospital, but they allege that appropriate actions were not taken to address their concerns. These respondents would therefore ask the Inquiry to investigate the actions taken by advocacy organisations that had contracts with the hospital,[13] professional regulatory bodies,[14] elected representatives,[15] and non-HSC public bodies such as the PSNI, the Health and Safety Executive (HSE), and the Northern Ireland Public Service Ombudsman. In particular, respondents ask the Inquiry to find out why the relevant bodies, agencies, and authorities did not investigate or report allegations of abuse and neglect or declined to hold perpetrators to account.

Front-line hospital staff

30. The vast majority of respondents agreed that the Inquiry should investigate the conduct of all medical professionals (including student or trainee professionals) and operational staff who were involved in the care of Muckamore Abbey Hospital

[13] Including private and charitable advocacy organisations and the Patient and Client Council
[14] i.e. the Nursing and Midwifery Council (NMC), the General Medical Council (GMC), and the Northern Ireland Social Care Council (NISCC)
[15] i.e. MPs, MLAs, and Government Ministers

patients, including but not limited to: care assistants, nurses, consultant psychiatrists, doctors, psychologists, and social workers, in order to identify those who are directly responsible for patient abuse and neglect. Although respondents stressed that there are many "excellent" individual members of staff at Muckamore Abbey Hospital who promote good practice, all respondents agreed that those who are responsible for wrongdoing should be held to account.

Leadership and Management at the Hospital and HSC levels

31. Respondents generally agreed that the Inquiry should look beyond the actions of front-line staff and investigate the actions of those in leadership and managerial roles. A significant proportion of patients, and some families, expressed concern about a disproportionate focus on the actions of front-line staff, potentially exacerbated by the nature of media coverage, to the exclusion of those in managerial and leadership positions. These respondents stated that it is important for the Inquiry to investigate and emphasize the extent to which management at the hospital, Trust, Board, and Department levels are responsible for the abuse and neglect of Muckamore Abbey Hospital patients.

32. Respondents raised concerns that those who may have been responsible for abuse and neglect in Muckamore might still occupy positions of influence and/or roles in which they are responsible for the care of vulnerable adults. Several respondents voiced their concern that responsible parties have simply moved jobs, were re-appointed to new posts, or entered early retirement.

33. Respondents were of the impression that management were often absent from the hospital, and it was pointed out that the 2020 report entitled '*A Review of Leadership and Governance at Muckamore Abbey Hospital'* described leadership and management at the hospital, Trust, and Director levels as 'dysfunctional' and 'wanting'. Respondents therefore ask the Inquiry to investigate the extent to which management held frontline staff to account for adherence to professional standards, poor performance and/or abusive behaviour, as they noted that it is management's responsibility to set and enforce standards for staff conduct and performance.

34. Respondents were also in agreement that the Inquiry should investigate the conduct of any elected officials who had responsibility for Muckamore Abbey Hospital, as well as political, non-Executive Directors at the HSCB and Department levels. Respondents noted that it is the senior leaders of the Health and Social Care system who are "are ultimately accountable when things go wrong."

*Why did patient abuse and neglect occur?*

35. As continually stated, respondents generally agreed that the Inquiry should investigate the extent to which the abuse and neglect of Muckamore Abbey

Hospital patients is the result of systemic failures. One group submission urged the Inquiry to pay particular attention to the extent to which "systemic failures in respect of management, training, support, protective and oversight systems within the hospital or the Department [of Health]" led to the abuse and neglect of Muckamore Abbey Hospital patients.

36. One respondent noted that:

> *There will always be individuals who seek to manipulate and abuse the poor and vulnerable in our society so there needs to be robust safeguards, regular inspections, transparency, and a willingness to listen, watch and act on your instincts if you feel something is not right.*

The overwhelming majority of respondents alleged that the safeguards were not in place in Muckamore Abbey Hospital or the wider HSC system, and that this led to the widespread abuse and neglect of patients.

<u>Staff recruitment, retention, and training</u>

37. Respondents request the Inquiry explore the belief that Muckamore Abbey Hospital has faced understaffing issues for years, and they alleged that staffing shortages have undermined care quality at the hospital. Current patients also alleged that at present, there are not enough staff who are trained to respond to distressed patients in an appropriate manner, and this has placed both patients and staff at risk of harm. Current patients allege that at present, there is such a severe shortage of staff trained to address challenging behaviours, that patients feel that they have to intervene to protect members of staff from being attacked by patients. These patients stated that this has turned the hospital into a stressful environment. Two respondents asked the Inquiry to determine whether there is a correlation between insufficient staffing and the number of incidents that occur on the wards, and they queried whether more incidents happen on days when the wards are short-staffed.

38. In light of these concerns, respondents ask the Inquiry to investigate why the Belfast Trust and the Department have allowed severe understaffing to persist at the hospital for so long. Respondents allege that staff shortages have been a long-standing problem throughout Northern Ireland's learning disability support services, and they urge the Inquiry to find out what steps are being taken to develop a workforce of medical and care professionals who are trained to support the needs of people with learning disabilities and/or mental health conditions, particularly those who present challenging behaviour. One respondent pointed out that the staff suspensions connected to the ongoing PSNI investigation into the hospital have made this shortage even worse.

39. Respondents also agreed that they would like the Inquiry to look into the extent to which each staff member has been trained and vetted to work with the patients of Muckamore Abbey Hospital. Respondents allege that at present, most Muckamore staff are trained in mental health rather than learning disability, and they question the impact that this has on patient care. Queries of this nature were summarised by one respondent, who asked the Inquiry to assess:

39.1. the qualifications required for the various posts within the hospital,
39.2. whether staff possess these qualifications,
39.3. where staff were trained,
39.4. the induction process for new staff,
39.5. how often staff training was reviewed,
39.6. and the type of background checks that staff members were expected to undergo before they assumed their posts.

40. Respondents also stated that they would like the Inquiry to scrutinise recruitment and interviewing procedures for the hospital. In particular, one respondent asked how job opportunities were presented, what recruitment criteria was used, and who sat on interview and recruitment panels for posts connected to the hospital.

Lack of Resources

41. Respondents alleged that Muckamore Abbey Hospital does not possess the facilities or trained professionals required to address patients' acute care needs. They query why this is the case, and they call upon the Inquiry to examine the extent to which the absence of acute care facilities at the hospital has resulted in poor health outcomes and the neglect of patients' physical health.

42. Respondents also questioned the extent to which decision-making in relation to Muckamore Abbey Hospital were guided by a desire to minimise costs, and whether the hospital's deficiencies are a consequence of it not being considered a spending priority.

Organisational Culture

43. Respondents shared that they believe Muckamore Abbey Hospital's problems to be a consequence of its organisational culture. Respondents allege that they often witnessed frontline nursing and care staff exhibit behaviours that fell below professional conduct standards, and that they experienced a general lack of professionalism at the hospital. The relatives of one former patient stated that they often could not distinguish staff from patients when they visited the wards because they allege that staff did not wear uniforms and "often wandered around looking lost." The relative of another former patient alleged that "there were a number of findings of maladministration" in relation to patient care in Muckamore, such as poor record-keeping amongst frontline staff. These individuals ask the Inquiry to investigate the extent to which past and present members of the hospital's leadership and management teams have tolerated abuse, neglect, and poor adherence to professional standards.

44. Patients, carers, and families allege that many members of staff displayed "cold" or "aggressive" attitudes. Respondents report that this left them afraid to self-advocate or raise concerns about patient care. One former patient who was in

Muckamore on a voluntary basis alleged that staff threatened to "section"[16] him if he complained or "didn't do what [he] was told." Another respondent alleged that staff in community settings would threaten to send service users to Muckamore if they "misbehaved". Respondents allege that there was a culture of secrecy amongst Muckamore staff. Families and carers allege that it was incredibly difficult to maintain communication with hospital staff, and that they were often left "in the dark" about their loved ones' care. Multiple respondents allege that the hospital staff and treatment teams have been reluctant to include families in treatment decisions and they described being "talked down" to or ignored when they tried to provide input into their loved one's care.

45. Respondents queried whether the perceived "secrecy" of Muckamore staff was deliberate, or if it was the result of breakdowns in communication throughout the hospital. Respondents questioned why mechanisms were not in place to encourage collaboration between patients, their families/carers, and treatment teams (or if such mechanisms existed, why they were not utilised in an effective manner). Regardless of cause, respondents ask the Inquiry to determine why open communication channels were not maintained between the hospital and patients' next of kin. Many respondents noted that they felt unable to trust the hospital staff due to their lack of candour about patient care.

Legal protection

46. Respondents were largely of the opinion that abuse and neglect was able to take place in Muckamore Abbey Hospital because Northern Ireland affords inadequate legal protections to the rights of persons with learning disabilities and their carers'. They therefore ask the Inquiry to compare the legal framework that is in place to safeguard the rights of persons with learning disabilities in Northern Ireland to those of Scotland, the Republic of Ireland, England and Wales in order to identify where there are gaps in legal protection for people with learning disabilities in this jurisdiction. Two former patients said that they would like the Inquiry to determine why the Mental Capacity Act (Northern Ireland) 2016 has not been fully commenced, as they felt that this legislation would give them more power to speak up for themselves, which would serve as additional protection against abuse.

Policies and procedures

47. Respondents have asked the Inquiry to determine the extent to which the neglect and abuse in Muckamore Abbey Hospital is a consequence of inadequate or poorly implemented policies and procedures. Questions about policy were summarised by one respondent, who asked:

[16] i.e. detain them under the Mental Health (Northern Ireland) Order 1986

*Who drafted and approved the policies and procedures that regulate Muckamore Abbey Hospital? What evidence did they use to inform their decisions? How often were policies and procedures reviewed in order to ensure that they reflected best practice?*

48. Two relatives of former patients expressed concern that policies and procedures that regulate professional practice had prevented frontline care staff from getting to know their patients on a personal level or from administering high-quality care. These individuals noted that they would like the Inquiry to investigate the extent to which constraints, perceived as bureaucratic, which govern medical professionals, prevented staff from providing quality, person-centred care to the patients of Muckamore Abbey Hospital.

49. To this end, respondents generally agreed that they would like the Inquiry to assess how the policies and practices pertaining to Muckamore Abbey Hospital compare to those of similar facilities in other jurisdictions. One group submission stated that the Inquiry should identify "the extent to which any gaps or omissions in the relevant statutory obligations, regulatory framework and policy framework, permitted or led the abuse perpetrated in Muckamore Abbey Hospital to occur, and/or led to a failure to promptly hold those responsible for the abuse to account."

*Why did nobody intervene to prevent patient abuse and neglect or hold those responsible for wrongdoing to account?*

<u>Failure to act</u>

50. Respondents repeatedly described situations in which they felt that they were ignored when they attempted to alert hospital staff, regulatory agencies, and other authorities about their concerns regarding patient care and treatment in Muckamore Abbey Hospital. These respondents felt that it was important for the Inquiry to investigate how complaints, concerns, incidents, regulatory reviews and inspection outcomes/recommendations were monitored and acted upon.

<u>Safeguarding</u>

51. Respondents generally agreed that they do not consider the safeguarding systems in Muckamore Abbey Hospital or Northern Ireland to be fit for purpose. They view current adult safeguarding policies and processes as incapable of producing outcomes that are able to help patients or hold parties at fault to account. They do not perceive Northern Ireland's current safeguarding system to be transparent, and they do not know whether their safeguarding concerns are or were handled appropriately.

52. Respondents therefore ask the Inquiry to determine whether those who are responsible for the care and safety of Muckamore Abbey Hospital patients have

complied with safeguarding policies and procedures. Respondents alleged that staff at the hospital and Trust levels were reluctant to escalate safeguarding concerns or initiate safeguarding investigations, that safeguarding concerns were downplayed or misrepresented by those responsible for their escalation or investigation, and that safeguarding investigations were not thorough or carried out in accordance with the correct procedures. One particular respondent recalled that he had to "fight" for an adverse incident involving his son, a former patient, to be investigated as an SAI (serious adverse incident).

RQIA Inspections and Complaints

53. Respondents repeatedly alleged that "a performance was put on" for RQIA inspections, and that the RQIA did not adequately uncover or address concerns at the hospital. Respondents ask the Inquiry to investigate the role and responsibility of RQIA as a regulator in monitoring and quality assuring practices in Muckamore. If, as believed by the families, RQIA failed in its duties, they ask that the Inquiry determine the extent to which the powers and practice of RQIA, in comparison to its counterparts in England, Scotland and Wales, prevented it from addressing problems in Muckamore Abbey Hospital.

A lack of cooperation between agencies

54. The Protocol for the Joint Investigation of Alleged Suspected Cases of Abuse of Vulnerable Adults was introduced in 2009 in the interest of ensuring that the HSC Trusts, the PSNI, and the RQIA work together to investigate and address allegations of the abuse and neglect of vulnerable adults. Respondents were largely of the sentiment that they have "lost faith" in this system, as they do not believe that organisations have cooperated in a manner that has allowed them to uncover abuse. Respondents alleged that agencies simply "passed problems around" in order to avoid taking action. Respondents ask the Inquiry to determine what action can be taken to improve inter-agency cooperation in response to allegations of the abuse or neglect of adults in need of protection.

Whistleblowing

55. Respondents agreed that they would ask the Inquiry to assess the way in which whistle-blower allegations were handled. On three occasions, the relatives of patients who had been identified as the subjects of whistleblowing concerns told the PCC that they did not feel that whistle-blower allegations were taken seriously by those responsible for investigation or enforcement.

Access to formal advocacy and/or peer support

56. Respondents ask that the Inquiry determine whether advocacy and/or peer support was deliberately withheld from patients and families, and the role that this may have played in preventing abuse and neglect from being uncovered or addressed. Several families of former patients reported that they were not made aware that formal advocacy or peer support services were available to hospital patients or their families. One respondent alleged that the South Eastern Health and Social Care Trust did not have a tender in place for advocacy services at

Muckamore Abbey Hospital until 2020. Respondents also alleged that the hospital restricts advocates' access to client meetings and their presence on hospital wards, which prevents advocates from fulfilling the responsibilities of their posts.

The impact of personal relationships on accountability

57. Respondents repeatedly alleged that a large number of the Muckamore Abbey Hospital staff were related to one another. Respondents alleged that staff "acted like a large family" in the sense that even those who were not related to one another were exceptionally close. In light of this information, respondents ask the inquiry to uncover the scope of nepotism within the hospital. Concern was raised about the extent to which relationships between hospital staff prevented individuals from being held accountable for poor performance or misconduct.

58. Respondents noted that because Northern Ireland has a small population, "everyone knows each other." They therefore believe that there is a possibility that personal relationships between professionals in the learning disability support sector and the Health and Social Care system have prevented actors from being held to account for their actions in relation to Muckamore Abbey Hospital. It was therefore proposed that the Inquiry should explore the extent to which personal relationships undermined accountability at the operational and managerial levels, both within the hospital and within the wider HSC system.

Previous investigations and reports

59. Families who attended the PCC's December engagement events expressed frustration that little has changed despite the fact that a number of large-scale investigations have already been conducted into Muckamore and the wider HSC system. Representatives from one action group connected to Muckamore Abbey Hospital suggested that the Public Inquiry's line of investigation should be guided by and build upon the findings of the 2020 report *'A Review of Leadership and Governance at Muckamore Abbey Hospital' and* Dr Margaret Flynn's 2019 report, *'A Review of Safeguarding at Muckamore Abbey Hospital- A Way to Go.'* They call for the Inquiry to determine what steps have been taken to act upon both reports' recommendations, or, alternatively, why actions have not been taken. One respondent also noted that they would like the Inquiry to determine whether disciplinary action has been taken against individuals who were identified by the authors of the aforementioned reports as guilty of misconduct.

60. However, representatives of another action group urged the Inquiry to scrutinise the work of the aforementioned reports. They queried whether the investigations were thorough, whether the investigators were independent from the HSC system, as well as why it took so long for the investigations to commence and their findings to be released.

61. Respondents also queried why the recommendations of investigations, reviews, and inquiries into the broader Health and Social Care system have not been adopted in Northern Ireland. They called particular attention to the following:

61.1. A statutory duty of candour has not been enacted in Northern Ireland, despite the fact that this was recommended by Justice O'Hara, the Chair of the Inquiry into Hyponatraemia-related deaths.[17]

61.2. The recommendations of the Government Response to Winterbourne View Hospital were not adopted in Northern Ireland, and respondents allege that that the report was not taken into account by those responsible for health and social care policy in the region.

61.3. Northern Ireland has not introduced adult safeguarding legislation, as recommended by the Commissioner for Older People following their investigation into Dunmurry Manor Care Home.[18]

*Other areas of concern*

Detention under the Mental Health (Northern Ireland) Order 1986

62. Respondents alleged that it appeared to be "standard practice" to detain patients in Muckamore Abbey Hospital under the Mental Health Order rather than admitting them as voluntary patients. Furthermore, families alleged that their loved one's period of detention was extended for longer than originally agreed or that their discharge was delayed. In light of these concerns, respondents ask the Inquiry to find out what type of review systems were in place to make sure that patients were not in the hospital for longer than necessary.

Use of CCTV

63. CCTV was frequently discussed by respondents, and opinions on the topic diverged.
    63.1. Respondents generally agreed that it is important to ask the Inquiry to investigate why the hospital's CCTV cameras were activated without anyone's knowledge before the hospital's CCTV policy was finalised. While many current and former patients believe that CCTV helps keep people safe, they also feel that the cameras intrude upon their privacy, and several patients were of the opinion that the decision to turn on CCTV cameras before a policy was drafted amounted to a betrayal of their trust.

    63.2. A significant proportion of families and carers asked why CCTV cameras had not been installed or activated earlier than they were.

[17] O'Hara J, Report of the Inquiry into Hyponetraemia related Deaths (January 2018) p. 84
[18] Commissioner for Older People for Northern Ireland*, Home Truths: A Report on the Commisisoner's Investigation into Dunmurry Manor Care Home* (2019) p. 153

63.3. Respondents who are connected to the PSNI's investigation into the hospital's CCTV footage expressed concern about the fact that they have been told that some of the footage has been lost or overwritten, and they noted that they would like the Inquiry to determine what steps are being taken to secure and archive the hospital's CCTV footage.

63.4. A significant subset of families and carers asked whether CCTV will be introduced in residential settings for people with learning disabilities throughout Northern Ireland, as many of the relatives of current and former Muckamore patients stated that they consider the installation of CCTV a necessary measure to protect the safety of their loved ones.

Patient Resettlement and Discharge

64. The families and carers of patients who have gone through the resettlement process request that the Inquiry covers issues relating to the discharge or resettlement of patients out of Muckamore Abbey Hospital, including:

*Resettlement policies and plans*

65. The families of current and former Muckamore patients stated that they do not believe that the Muckamore resettlement plan has considered patients' best interests. Rather, they view resettlement as a "box-ticking exercise" that was introduced in response to political pressure and changes to funding structures. The loved ones of patients who went through the resettlement process alleged that neither patients nor their families had the opportunity to provide input into resettlement. Instead, respondents report that they were told that a new care arrangement was found for their loved one, and the patient was moved with little notice. One former patient alleged that he was not told that he was leaving Muckamore until the morning of his discharge. Another respondent, whose sister was a former Muckamore patient, alleged that his sister was moved into a community placement without the family's knowledge or approval.

66. Families of former patients alleged that their loved one was placed in a setting that did not align with the wishes of the patient or their family, and that staff in the new setting were not trained to address their relative's needs. They attributed this to the lack of collaboration between patients, families, and the resettlement team. These respondents felt that resettlement arrangements were put in place in order to fulfil contractual obligations between private care providers and the Trust, and they urged the Inquiry to investigate the role that commercial and financial interests played in the resettlement process.

*Mishandled or failed resettlements*

67. Respondents alleged that a large number of attempted resettlements have failed. They ask the Inquiry to determine how many attempted resettlements have failed

and why, as well as how many patients are currently in Muckamore as a result of a failed resettlement or community placement.

68. A number of respondents alleged that while Muckamore Abbey Hospital used to be “the place they would send people with challenging behaviours,” they now believe that the Health and Social Care Trusts have started sending people with learning disabilities and high support needs to long-term residential placements outside of the jurisdiction. Respondents urge the Inquiry to uncover the extent to which this phenomenon is occurring**,** as they fear that it violates the human rights of the individuals concerned.

69. Respondents ask that the Inquiry consider these matters within its investigative scope because they fear that the problems with resettlement are an indication of larger issues in Northern Ireland’s adult social care system. The families and carers of former patients noted that their loved ones are dealing with significant distress connected to their experience in Muckamore Abbey Hospital, and that this manifests in the form of challenging behaviours. Respondents were generally of the view that Northern Ireland’s social care system does not have the capacity to support individuals with challenging behaviours and high support needs.

*Risk of harm*

70. Respondents stated that they would like the Inquiry to assess the extent to which resettlement has placed former Muckamore Abbey Hospital patients at risk of harm.

    70.1. Several former patients allege that they ended up homeless or in hostels after they left Muckamore Abbey Hospital, and they allege that they were exposed to harm in these settings.

    70.2. Several families alleged that the abuse and neglect their loved one experienced in Muckamore continued or intensified in residential settings in the community.

    70.3. The relatives of a number of former patients stated that their loved one died or suffered a significant health decline shortly after resettlement. One respondent told the PCC that a local news article claimed that at least 22 former Muckamore patients died shortly after resettlement. These respondents would ask the Inquiry to investigate the extent to which these deaths were connected to resettlement**.**

71. Families of former Muckamore patients who have tried to call attention to problems in community settings allege that Adult Safeguarding, the Trusts, the RQIA, and the PSNI have again failed to address their concerns, as was the case in Muckamore.

72. Respondents noted that resettlement is an important topic for the Inquiry to address, because officials have repeatedly announced that resettlement is the long-term goal for all Muckamore patients.

## Power of the Inquiry to Make Recommendations

73. The PCC's engagement process sought views on whether the Inquiry's Terms of Reference should provide the Chair with the power to make recommendations. Respondents were unanimous in their view that this should be the case. Respondents stated that they would not consider the Public Inquiry to be worthwhile if it focused on fact-finding alone.

74. Respondents stated that recommendations should:

    74.1. Lay out the steps that the relevant authorities should take to ensure that the abuse and neglect that took place in Muckamore Abbey Hospital will never reoccur. Respondents also asked the Inquiry Chair to go beyond simply issuing a list of recommendations; they would ask the Inquiry Chari to produce an action plan for reform with clear objectives and deadlines.

    74.2. Determine whether additional responses, including but not limited to: an apology, an acknowledgement forum, or a compensation scheme, are required or desirable.

75. One group submission also suggested that in the interest of timeliness, the Inquiry should have the power to make interim recommendations. This submission added that the power and responsibility for implementing the Inquiry's recommendations should fall upon the Department of Health in the event that the Executive is not functioning.

## Evidence to be considered by the Inquiry

The PCC's engagement process sought views on the type of evidence that should be considered by the Inquiry. Respondents suggested that the Inquiry should consider the following:

76. **CCTV footage**

77. **Testimony from patients, families, carers, and staff**. Respondents noted that it is important for the Chair or panel to exercise their power to compel testimony from those suspected of wrongdoing. This is critical given that it was alleged that several members of Muckamore Abbey Hospital and HSC staff refused to cooperate with earlier investigations into the hospital. Several respondents also noted that they would ask the Inquiry to obtain testimony from agency or locum staff and student doctors and nurses who completed training rotations at Muckamore Abbey Hospital, as these individuals would have had a fresh perspective on practices at the hospital.

78. **Written records and documents** from Muckamore Abbey Hospital, the HSC Trusts, external care providers, the RQIA, the HSE, and the PSNI, such as:

    78.1. **Medical records** (including records of care and treatment delivered in Muckamore Abbey Hospital, records of injuries, records from acute care hospitals, GP records, and any records of patients being referred to Muckamore Abbey Hospital);
    78.2. **Psychology and psychiatry notes**
    78.3. **Social work reports**
    78.4. **Incident reports and safeguarding records**
    78.5. **Records of concerns, FOI requests, SAR requests, and formal and informal complaints, as well as** correspondence in relation to how these were handled.
    78.6. **Records of RQIA and HSE inspections, investigations, and/or assessments**
    78.7. **Records of disciplinary procedures** taken by professional regulatory bodies
    78.8. **Records of legal cases** brought against the hospital
    78.9. **Police reports** in relation to events in the hospital
    78.10. **Records of complaints to and investigations conducted by the Police Ombudsman and the Northern Ireland Public Service Ombudsman**
    78.11. **Records of the use of the seclusion room**
    78.12. **Minutes** from staff meetings, Multi-Disciplinary Team meetings, etc.
    78.13. Formal and informal **notes and memorandums**
    78.14. **Emails and written correspondence**

*This list is non-exhaustive.*

79. Respondents raised concern about the quality of official records from the hospital. They urge the Inquiry to **'look for what's missing'** and consider why records may not exist in relation to certain patients, practices, or incidents. Many relatives of current and former patients noted that they have extensive personal photographic and written records of their concerns relating to Muckamore Abbey Hospital, and others noted that they have worked with solicitors or advocates to address their concerns at the hospital. They stated that they would ask the Inquiry to consider these records as evidence. It was also recommended that the Inquiry secures its own team of independent researchers who are responsible for obtaining evidence.

80. Respondents expressed concern that evidence may be tampered with or destroyed, and they urged the Inquiry to make it a priority to secure evidence.

## The Inquiry Chair or Panel

The engagement process sought views on the background of an Inquiry Chair.

Professional background of the chair

81. An overwhelming majority of respondents agreed that an individual with a strong legal background, such as a judge or experienced barrister, should chair the Inquiry. The majority of families, carers, and patients felt that a Chair with a legal background would have more professional impartiality than an individual from a professional health or social care background. They also noted that a Chair with strong legal knowledge would be best-positioned to ensure that the Public Inquiry does not interfere with the PSNI's ongoing investigation into the hospital's CCTV footage and staff. It was also suggested that the Chair should have a strong litigation background, as this would allow them to effectively question hostile or reluctant witnesses. One group submission added that the Chair or panel members "would need to have a strong understanding of public administration, significant experience with governmental or health bodies and proven experience of addressing/investigating disputes at high level."

82. Respondents agreed that they would also like the Chair to have some knowledge or expertise in learning disability. A minority of respondents stated that they would like the Chair to be an individual with a professional background in the field of learning disability or mental health, as they believed that such an individual would have a better understanding of the challenges that patients, families, and professionals faced in Muckamore Abbey Hospital.

83. A significant proportion of respondents proposed that the Inquiry should be run by a panel composed of a legal professional *and* a learning disability professional, such as a nurse or social worker. Some respondents added that the panel should also include at least one lay person, as this would add an additional layer of objectivity. A number of respondents stated that they would like patients' families to have the opportunity to sit on the panel.

Personal background of the Chair or panel members

84. A small minority of respondents stated that they would like the Chair or panel members to come from Northern Ireland. The vast majority of respondents stated that they would like the Chair or panel members to hail from outside of Northern Ireland, as they felt that this would ensure a greater degree of impartiality. Respondents also stated that they would like the Chair or panel members to be empathetic individuals who are not afraid to take an aggressive approach to their investigation. One group submission also stated that the Chair or panel members should be individuals who are "widely respected" in their field(s).

## Support for those Impacted by the Inquiry

85. As part of the engagement process, respondents were asked what type of support they would like to see for current and former patients and their families, carers, and friends during the Public Inquiry. Respondents generally agreed that they would like the following:

Open communication and regular updates throughout the Inquiry.

86. Respondents generally agreed that the best way to support them during the Inquiry is to maintain open and transparent communication channels between families and the Inquiry. Respondents stated that they found it distressing to learn about developments in relation to Muckamore through the media, and they would prefer direct communication that came to them first. They also want to have the opportunity to ask questions about what new developments mean for them and their loved ones.

87. Respondents asserted that in the interest of accessibility, information should be made available in a range of formats, including email, physical documents, audio recordings, and via phone, according to each individual's preferences. It was also noted that information should be made available in Easy Read format, and a large number of respondents noted that information should be available in jargon-free plain English. Respondents shared several further points about communication:
    87.1. Updates on the Inquiry should be available on an opt-in basis, because some individuals would find it distressing to receive constant updates.
    87.2. Respondents would like the Inquiry to designate an individual who is able to act as a single point of contact between patients, families, carers, and the Inquiry Team. This individual should also be available to explain the proceedings and guide them through the Inquiry process.
    87.3. There should be a centralised location for all information connected to the Inquiry, such as a website.

Access to the Inquiry's proceedings and evidence

88. The families of Muckamore Abbey Hospital patients stated that they would like to have full access to the Inquiry proceedings, including the opportunity to attend hearings. They would also ask to have access to the evidence considered by the Inquiry Chair.

Support to provide evidence

89. Respondents agreed that patients, families, and carers should have the opportunity to submit written or verbal testimony to the Inquiry. Respondents also suggested that they should have the option to provide evidence anonymously, and/ or to submit evidence or testimony as part of a group of other families or patients.

90. Many current and former patients stated that they would like to provide testimony, but that they will need support to do so. To this end, they stated that they would like to have the option to give evidence in private, behind a screen, via video-link, or with the assistance of a nominated support person.

91. The relatives of patients who are non-verbal also noted that they would ask the Inquiry to hire specialists who are able to help their loved one give evidence.

Legal Counsel

92. Relatives of current former patients felt strongly that patients and their families or carers should be entitled to legal representation throughout the Inquiry process, and a number of families stated that they would expect to have access to legal aid. One group submission stated:

> *We accept that this does not mean that each family would require a separate and publicly funded legal team. We consider that this could be done through a very small number (between 1-3 legal teams consisting of Solicitor, Junior and Senior Counsel) who could be approved by the Inquiry to represent their interests.*

Other advocacy support

93. Families who have pre-existing relationships with advocacy services stated that they would like their advocates to support them during the Inquiry.

94. Respondents who are connected to the PSNI investigation into Muckamore Abbey Hospital noted that they have found the support of their Family Liaison Officer (FLO) helpful. They questioned whether it would be possible to designate FLOs for the Inquiry, as well.

Acknowledgement

95. Many respondents stated that they would like to have the opportunity to make a statement to the Inquiry about their personal experience of Muckamore Abbey Hospital and the impact that this has had upon their lives. Respondents proposed that the Inquiry should introduce a mechanism under which victims of abuse and their families will be able to receive formal acknowledgement for their experience.

Psychological Support

96. The PCC met with former patients who had traumatic experiences in Muckamore Abbey Hospital, and spoke to their treatment teams. In some of these cases, patients expressed a wish to speak about their experience at Muckamore and their treatment teams agreed that it would be of therapeutic benefit for them to do so. However, in other cases, it was determined that the risk of harm from re-traumatization could outweigh the benefits of participating in the Inquiry process.

97. In light of these concerns, respondents stated that they would ask that psychological support services be made available to those impacted by the Inquiry. Several respondents noted that talking therapy will not suit the needs of all patients, and that a range of therapeutic options should be made available to suit the varying needs and preferences of patients and their families.

Peer support

98. Respondents noted that they would like peer support groups to be set up for families and patients.

APPENDIX I

**FROM THE MINISTER OF HEALTH**

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email: private.office@health-ni.gov.uk

Our ref – SUB-2124-2020

Date: 10th November 2020

Dear

**Muckamore Abbey Hospital- Public Inquiry**

I wrote to you 12 November to let you know that I have asked the Patient and Client Council (PCC) to arrange a number of events to allow you to give your views on the arrangements for the Public Inquiry into the abuse at Muckamore Abbey Hospital. These will help shape the draft Terms of Reference and identify an appropriate Chair for the Public Inquiry. The PCC is acting as an Independent Public Advocate in relation to the Inquiry. An explanation of this role can be found in Appendix 1 of this letter. An explanation of the roles of the Department of Health as the sponsoring department, and also the role of the Secretariat to the Inquiry is set out in Appendix 2. I have also included a Quick Read Guide to Public Inquiries; a more detailed version of this is available and can be requested from [redacted]

After consultation with the PCC, I have decided to host 3 meetings initially, in which you will have the opportunity to hear from me and my officials. I want to hear directly from families and carers to ensure your views are fully reflected upon before I take the important decisions I need to make regarding the Inquiry. I have also asked my officials to use this opportunity to explain the inquiry process in detail.

These meetings will take place remotely on Monday 7 December at 6pm, Wednesday 9 December at 1.30pm, and Thursday 10 December at 9.30am. If you wish to attend, please contact [redacted] for further details.

I am pleased to be able to host these meetings as I see them as critical to ensuring that the Inquiry starts on the correct footing. I hope these meetings will be a two-way discussion. I will begin by outlining my expectations for both the meeting and the Inquiry itself, followed by my officials explaining how Public Inquiries are set up and operate. This will include the ways in which family members, carers, current and former patients will have the chance to share opinions on what shape the Inquiry should take. This section of the meeting will be recorded for those of you who are unable to attend, and will be made available upon request.

After my opening remarks and the presentation by my officials, there will be a discussion facilitated by the PCC. During this you will have the opportunity to ask questions and express your views. Prior to the meeting, you may wish to consider the following:

- What do you want the Inquiry to achieve?
- What issues do you think the Inquiry should investigate?
- What time period do you think the Inquiry should cover?
- Is there any particular evidence you think the Inquiry should obtain?
- Who would you like to see appointed as chair of the Inquiry? Should they have a legal or professional expert background?

Next steps and ongoing communications will also be agreed at this stage.
At present, there are three ways in which you can contribute to the process of shaping the Public Inquiry:

1. **Attend a consultation meeting** and share your views.
    a. In line with public health recommendations, our initial consultation meetings will take place remotely via Zoom. Please contact the PCC for the Zoom login details.
    b. If you do not have access to Zoom, we will arrange for you to join the meeting via telephone. The PCC will provide the details to dial-in.

2. **One-on-one discussion**: If you would prefer to share your views in relation to the Inquiry on a private, one-on-one basis, please contact [redacted]

3. **In writing**: If you would prefer to submit your views in writing, please see appendix 4, the attached guide on written submissions. Once you complete the form, please post to the PCC in the stamped addressed envelope provided.

Following these initial discussions we shall facilitate a conversation with current and former residents. The PCC is currently in the process of developing a separate series of accessible engagement processes to which current and former patients will be invited to express their views. These will take place in January 2021.

Yours sincerely

**Robin Swann MLA**
**Minister for Health**

**Appendix 1**

## Explanation of PCC's role as an Independent Public Advocate

The Patient and Client Council (PCC) was created 1 April 2009 as part of the reform of Health and Social Care in Northern Ireland. We are an independent, informed and influential voice that advocates for people across Northern Ireland on Health and Social Care.

The Patient and Client Council has been asked to act as an Independent Public Advocate in relation to the Public Inquiry into the abuse at Muckamore Abbey Hospital. In the context of public inquiries, Independent Public Advocates are responsible for supporting families, carers, and current and former patients by:

- Understanding their needs and their interests.
- Providing support to ensure that families, carers, and patients can understand the purpose and proceedings of the public inquiry.
- Supporting families, carers, and patients to be able to be fully involved in the inquiry process.
- Providing support to those families, family members, and patients who want it.
- Engaging with other public bodies that are responsible for the inquiry in the best interests of families, carers, and patients.

The PCC cannot provide legal advice to individuals involved in the Inquiry.

In order to fulfil its duties as an Independent Public Advocate, the PCC is independent of the other bodies involved in the Inquiry (e.g.: the Department of Health, the Health and Social Care Trusts). However, the PCC works closely with these bodies in order to communicate the views of families, carers, and current and former patients.

**Patient and Client Council**

[redacted]

**Freephone :** **0800 917 0222**

## Appendix 2 – Role of the sponsoring Department and Secretariat to the Inquiry

### The sponsoring department

*Pre-inquiry*

- Preparation of business case for inquiry (staffing, accommodation, IT, security);
- Secure appropriate funding;
- Identification of chair[s] of inquiry (and panellists) and recommendation to Minister for decision;
- Preparation of Terms of Reference for Ministerial approval following consultation with families (in conjunction with Chair) and appropriate legal advice; and
- Record management.

*During the Inquiry*

- Collection of financial information relating to the Inquiry;
- Regular monitoring of spending and progress; and
- Scrutiny of propriety and regularity.

*Post-Inquiry*

- Supervision of the timely destruction of departmental records that are no longer required;
- Co-ordination of the Government's response to the report and ensuring that work is taken forward to implement any recommendations in it; and
- Oversight of transfer of Inquiry records for archiving.

### Role of the Secretariat

The secretariat of the public inquiry works for the Inquiry and not the sponsoring Department.

### Role

*Pre-Inquiry*

- Securing accommodation, IT, security and staff
- Establishing appropriate Information management requirements

- Ensuring design of Website and inquiry logo
- Overseeing the development of a Communication plan

*During Inquiry*

- General administration and management of the inquiry;
- Budgetary control
- Intermediary for all information requests relating to the inquiry;
- Control and monitor the transfer of information to the inquiry and to witnesses;
- Agree policies and processes for information management;
- Ensure safeguarding and maintaining adequate records of the inquiry work;
- Handling receipt and possibly publication of the final inquiry report;

*Post-Inquiry*

- Identification of records for archiving and destruction and ensuring this is completed on a timely basis; and
- Lessons learned document.

## Appendix 3 - Quick Guide to Public Inquiries

### What is a Public Inquiry?

A Public Inquiry is a way for Government to openly and transparently investigate a matter of public concern. The Minister of Health, Robin Swann, MLA intends to establish a Public Inquiry, in line with the legislation set out in the Inquiries Act 2005 to investigate allegations of abuse of patients at Muckamore Abbey Hospital (MAH). A Public Inquiry can only be set up under the Inquiries Act 2005 by a Government Minister; however, once established, it is independent of the Government.

Public Inquiries examine issues of serious public concern. The Inquiry Chair will look at decisions and events that led or contributed to the issues being investigated. A Public Inquiry typically answers at least the following questions:

- What happened?
- Who is responsible?
- What can we learn from this?

The criminal investigation led by the PSNI into the allegations of abuse of patients will continue and be unaffected by the Public Inquiry. The Public Inquiry cannot make any findings of guilt; its role is to provide facts and recommendations to Government and other authorities, if appropriate.

### How a Public Inquiry operates

The Inquiries Act 2005 sets down how a public inquiry is run. It covers:

- The setting up of inquiries;
- The appointment of people to run them;
- Their procedures and powers, and
- The submission and publication of inquiry reports.

A Public Inquiry can look and feel like a court case as it can involve a judge, legal representatives, witnesses and evidence. Minister Swann will wish to ensure that whilst the Public Inquiry conforms to the Inquiries Act it will be accessible to all those who wish to be involved. The Public Inquiry will serve the wider public interest by seeking to find out what happened and to make recommendations to prevent it from happening again.

If a witness is called to give evidence at a Public Inquiry, or produce documents for it, they must do so, as it is a criminal offence not to. Public Inquiries are also usually held in open view to the public, unless there is a good reason for the Chair to ask for it not to

be. A Public Inquiry may produce a written report with their findings and recommendations if this is set out in its terms of reference; this must be made public.

**Appointment of a Chair**

Under the terms of the Act, appointments are solely at the discretion of the responsible Minister. The Chair may be from a judicial background, like a judge or barrister, or they may be an expert in the field of the Inquiry.

Judges are:

- Politically independent;
- Experienced at running hearings;
- Able to analyse information and uncover facts;
- Legally experienced in instances when an inquiry is running at the same time as criminal proceedings (as is the case with the MAH Public Inquiry), and
- Able to understand legal and procedural complexity.

An expert Chair is able to:

- Incorporate specialist knowledge and expertise within the role of the Chair, such as an understanding of the particular issues of relevance to the inquiry, or experience of policy making, and
- Potentially develop detailed implementation plans for the Inquiry's recommendations.

Whoever is chosen as Chair they will be supported by a dedicated team.

**Terms of Reference**

The Terms of Reference (ToR) will set out the purpose and scope of the Inquiry. The Inquiry will have to stick to the ToR through all their work. The ToR is decided by the relevant Minister in consultation with the Chair. The ToR will be carefully worded to ensure that all matters that should be investigated are investigated. If the Inquiry is to make recommendations this must be stated in the ToR.

In Northern Ireland the ToR should not include anything which would require the Inquiry to examine events occurring prior to 2 December 1999, or during any period when devolution is suspended, unless the consent of the Secretary of State is sought and confirmed. Devolution was suspended from 11 February 2000 until 30 May 2000, and again from 14 October 2002 until 8 May 2007.

# Appendix 4 - Guide for written submissions

If you wish to express your views on the Inquiry in writing, through a written submission, please use the following questions as a guide.

**What is a Public Inquiry?**

A Public Inquiry is a way for Government to openly and transparently investigate a matter of public concern. The Minister of Health, Robin Swann, MLA intends to establish a Public Inquiry, in line with the legislation set out in the Inquiries Act 2005 to investigate allegations of abuse of patients at Muckamore Abbey Hospital (MAH). A Public Inquiry can only be set up under the Inquiries Act 2005 by a Government Minister; however, once established, it is independent of the Government.

Public Inquiries examine issues of serious public concern. The Inquiry Chair will look at decisions and events that led or contributed to the issues being investigated. A Public Inquiry typically answers at least the following questions:

- What happened?
- Who is responsible?
- What can we learn from this?

The criminal investigation led by the PSNI into the allegations of abuse of patients will continue and be unaffected by the Public Inquiry. The Public Inquiry cannot make any findings of guilt; its role is to provide facts and recommendations to Government and other authorities, if appropriate.

**Question 1:**

**Time frame of the Inquiry (what period in time should the Inquiry cover?)**

The Inquiries Act 2005 specifies that in Northern Ireland, Public Inquiries can only cover periods in which the Northern Ireland Assembly was in session unless the Minister seeks the Secretary of State's consent to extend the period outside these timeframes. This means that events prior to 2 December 1999 cannot be examined and also the periods 11 February 2000 to 30 May 2000 and 14 October 2002 to 8 May 2007 without the permission of the Secretary of State.

***In your response you might want to consider:***

- ***What period of time do you think the Inquiry should focus on?***

***In your response you might want to consider:***

- ***Do you think that the time frames outlined above in the Inquiry Act 2005 are enough? Or do you think the Minister should request an extension of this time frame from the Secretary of State?***

**Question 2:**

**Substantive scope of the Inquiry**

This is the detail of what the Inquiry will look into. Thinking about your family's experience of Muckamore Abbey Hospital, what do you want the Inquiry to explore?

***In your response you might want to consider:***

- ***What do you want the Inquiry to achieve?***

- ***What issues do you think the Inquiry should investigate?***

**Question 3:**

**Evidence (what should the Inquiry look at?)**

Think about the reports, documents and communication that your family had with Muckamore Abbey Hospital.

***In your response you might want to consider:***

- ***Is there any type of evidence, such as documents, communications, or reports that you think it is essential for the Inquiry to obtain?***

***Examples of evidence could include documents, communications, video footage, recordings or reports***

**Question 4:**

**Power of Inquiry to make recommendations (what should the Inquiry do?)**

A Public Inquiry typically answers at least the following questions; What happened? Who is responsible? What can we learn from this? The Inquiry will seek to establish responsibility for the abuse at Muckamore Abbey Hospital. It should also make recommendations to prevent future occurrences.

***In your response you might want to consider:***

- ***Do you agree that this is what the Inquiry should do?***

- ***Are there any other functions you think the Inquiry should have?***

**Question 5:**

**The Inquiry Chair (what sort of background should the person who is running the Inquiry have?)**

Public Inquiry chairs may have a strong legal background, and can be former judges. This ensures that they are able to manage the legal complexities associated with running a Public Inquiry. When chairs are from a non-legal background, they tend to be drawn from professions that the public trust, such as social workers, nurses and doctors. Chairs that are from a non-legal, relevant professional expert backgrounds may have a higher level of expertise in the subject areas related to the Inquiry.

***In your response you might want to consider:***

***Do you think the Chair of the Inquiry should have a legal or a professional expert background?***

**Question 6:**

**Additional views (do you have anything else to add?)**

***In your response you might want to consider:***

- **Do you have any other views or information that you would like the Inquiry to consider?**

Thank you for taking the time to complete this written submission. Please return this form in the stamped addressed envelope provided to:

**Patient and Client Council**

[redacted]

**Freephone : 0800 917 0222**

# Muckamore Abbey Hospital Public Inquiry



The Government is planning a Public Inquiry.

It will look into abuse at Muckamore Abbey Hospital.

Sometimes people do bad things to other people, this is called **Abuse.**

The Public Inquiry will look at

- What happened?
- Who made it happen?
- What can we do to stop it happening again?

Patient and Client Council

**Your voice** in health and social care

The Patient and Client Council have been asked to help you get your voice heard.

We want to hear from you, if you are a patient at Muckamore or you used to be a patient.


We want to find out what you think about the inquiry.

- What should the inquiry look at?
- Who should be in charge of the inquiry?

# How to tell us what you think

## 1. you can go to a meeting


There will be meetings in February 2021. These are for patients and people who used to be patients and their key workers.

At the meetings you will learn about the inquiry and you can tell us what you think.

These meetings may be done by video call. Video calls let you see other people in the meeting and they can see you. It will be just the same as a normal meeting but you stay at home.


## 2. You can talk to us on the phone or we can meet.

To plan a meeting or talk on the phone please call [redacted].

## 3. You can write to us

Fill in the form that came with this letter.

Post it using the stamped addressed envelope.

It is okay to get help to fill out the form.

# What is a Public Inquiry

## How do Public Inquiries work?

Public Inquiries are like a court case. There can be lawyers, witnesses and evidence.


Public Inquiries are not part of police investigations.

The police investigate to see if a crime happened. They look at who did it and they might go to court to see if they are guilty.


Public Inquiries look at what happened.

They say what should be done to stop it from happening again.


Public Inquiries are open to everyone.

Any reports can be read by anyone.

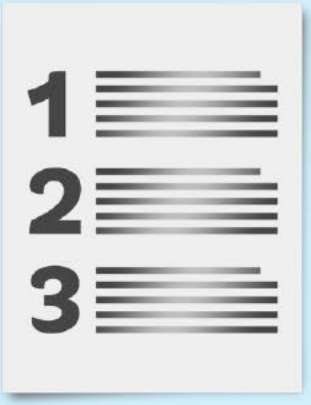
Family and patient names are kept private

# Who should be in charge of the Public Inquiry?


The Minister of Health from the Government, Robin Swann, will choose who will be in charge of the inquiry.

The person in charge can be someone who works in law like a judge or a barrister.

Or they may be an expert, like a doctor or social worker.




Everyone will agree on a list of important things that the inquiry should look at.

The inquiry will only look at what is on the list.

We want you to tell us what should be on the list.

# Muckamore Abbey Hospital
# Public Inquiry Feedback Form

**1. What do you think the inquiry should look into?**

Think about your experience of Muckamore. Is there anything you want to learn more about?

For example

- How was your information used to make decisions about your treatment?
- What training was offered to nurses?
- How were complaints looked into?


## 2. How far back in time should the inquiry look?

Should the inquiry only look at the last few years? Or how far back should it look?


**3. Is there any evidence you think the inquiry should look at?** For example, medical reports, safeguarding reports, inspection reports or camera footage.

**Evidence** is anything that you see, experience, read, or are told that helps you find out if something is true or has really happened.

**4. Who would you like to be in charge of the inquiry? Someone with a legal background or an expert in Learning Disability and Mental Health?**

If they have a legal background they have worked in law, like a judge

If they are a judge they will

- not support one side or another
- have experience of running meetings
- have an understanding of the law and how things are done legally.

If the chair is an expert then they will know about Learning Disability and Mental Health.


5. At the moment the inquiry will look at

Who is responsible for the abuse at Muckamore

And say what it thinks should happen to make the hospital better.

**Do you agree this is what the inquiry should do?**

**6: Please tell us anything more you would like the inquiry to look at.**

# The Patient and Client Council Our Job

Patient and Client Council
Your voice in health and social care

The Patient and Client Council gives patients, clients, carers and communities in Northern Ireland a voice.

We help you speak up, or speak up for you on anything that is important to your Health and Social Care.

For this inquiry we will support families, carers, patients and people who were patients.

We will do this by understanding your needs and interests and providing support to those who want it.

We can help you understand the reason for the inquiry and what will happen.

We can help you to take part in the inquiry.


We can talk to the Government and other groups about what is best for families, carers, and patients. We can let them know what families, carers, and patients think.

The Patient and Client Council cannot give legal advice.

The Patient and Client Council is independent. We do not speak for Muckamore, the Government or any other group.

# Get in touch with us

Patient and Client Council
Your voice in health and social care

Here is all the information you need if you want to get in touch with us.

Patient and Client Council

[redacted]

Phone

[redacted]

e-mail

[redacted]

## How to find us


[redacted]

[redacted]

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