ACTION FOR MUCKAMORE

Evidence response to the Adult Protection Bill public consultation

12/09/25

Prepared By :

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I am responding to this consultation as Chairman of **Action for Muckamore**, a family support and pressure group formed in response to the abuse and systemic failures uncovered at Muckamore Abbey Hospital. Our group represents families directly affected by those events, many of whom continue to suffer the devastating consequences of neglect, inadequate oversight, and institutional abuse.

Eight years after the abuse at Muckamore Abbey Hospital was discovered on CCTV, we have still not received justice, answers or accountability. Not one senior employee in the Belfast Health and Social Care Trust or in the NI Health Service was sacked. Not one senior employee resigned.

We take the view that the protection and safeguarding of adults with a learning disability in Northern Ireland is just as weak today as it was in 2017. In this statement we will explain why we hold this view.

In June 2023 the Northern Ireland Public Services Ombudsman Margaret Kelly made a statement to the BBC.

"**From a number of cases that have come into my office, I think it is clear that our adult safeguarding system is not fit for purpose. A lot of the time it is families who have had to draw the attention to healthcare staff about potential failings in care and that just isn't right."**

Dementia patient failed by safeguarding system in Northern Ireland - BBC News

We would like to begin with quoting Belfast Trust Social Worker Geraldine O'Hagan who appeared at the Muckamore Abbey Hospital Public Inquiry on the 15th of May 2024.

Transcript for Wednesday 15 May 2024_1.pdf

"I believe there are too many unnecessary obstacles for families in delivering services for people with learning disabilities within the system. In my experience, the main obstacles continue to be poor communication, poor investment in community services, and an imbalance of power between those who deliver care and those in receipt of care."

Families of adults with a learning disability who may not have capacity are often excluded from their loved one's care management process. In our opinion the failure to include families will increase the likelihood of abuse.

The Commissioner for Older People for Northern Ireland (COPNI) first called for dedicated adult safeguarding legislation in 2014.

https://copni.org/assets/general/resources/protecting_our_older_people_in_northern_ireland_report_1.pdf

In their call for adult safeguarding legislation, COPNI said;

"The Northern Ireland Adult Safeguarding Partnership (NIASP) has reported an increase in the number of cases of alleged abuse of older people, rising from 1715 in 2011-2012, to 3023 in 2013-14, marking a worrying trend. This recent increase in the number of referrals and the feedback I received through extensive engagement with older people and older people's organisations, who expressed concern and anger about the abuse of older people, convinced me that there was a lack of legal protection available to older people who experience abuse. As Commissioner for Older People, it is my responsibility to safeguard and promote the interests of older people, and so I commissioned a review of existing legislation in Northern Ireland in relation to protection for older people from abuse. My review identified clear gaps in the legislation which mean that there are some areas in which older people are not adequately protected from abuse. At present, the legislation is disjointed, and draws on several different laws, and whilst it offers protection to individuals who have been deemed to lack mental capacity, those with mental capacity are not afforded the same protections from abuse. This is compared to England, Scotland and Wales, all of which have dedicated adult safeguarding legislation. This report makes recommendations to Government which, taken together, culminate in a call for a single Adult Safeguarding Bill to be introduced to better protect older people in Northern Ireland. Older people in Northern Ireland must have confidence that they will be supported and protected. I am calling on the Minister of Health, Social Services and Public Safety and the Minister of Justice to introduce legislation which will give older people the certainty they need and deserve.

Despite the call by COPNI for adult safeguarding legislation in 2014, the Dunmurry Manor scandal broke in the media in 2016.

Dunmurry: Investigation into care at elderly residential home - BBC News

In February 2017 COPNI announced that they would be using their investigation powers for the first time by announcing an investigation into the care and treatment of residents at Dunmurry Manor Care Home.

Commissioner's investigation into Dunmurry Manor Care Home | Commissioner for Older People for Northern Ireland

The 2014 call by COPNI for adult safeguarding legislation was a result of the earlier scandal at Cherry Tree in Carrick Fergus.

Cherry Tree House nursing home review amid neglect allegations - BBC News

Health Minister Edwin Poots commissioned the RQIA to carry out a review of concerns raised by families, staff and whistleblowers at Cherry Tree Nursing Home. The report was released in July 2014.

1fc36cdd-154f-47a6-bd5d-366dcea2f3bf.pdf

Key extract from the Cherry Tree review report;

"The review team noted with concern that, in September 2006, a member of Trust staff was reported to have said to RQIA that her team was not investigating complaints in Homes due to time restraints. However, we found no evidence of such constraints from that time onwards."

"The review team's analysis of the whistleblowing events identified issues within 4 main areas of concern which are set out below.

(a) Allegations of the abuse of residents were mentioned at least 16 times.
(b) Standards of care delivered to residents were mentioned at least 25 times. The issues included the management of continence; abuse of residents by staff and by other residents; and the moving and handling of dependent residents.

(c) Other care issues were mentioned at least 15 times. These included the poor level of hygiene in the home, record keeping issues and the failure to implement procedures for the protection of vulnerable adults.
(d) Staffing was mentioned at least 16 times and included issues relating to shortages of staff; the lack of training for staff; poor communication between management and staff; and the lack of support for whistleblowers. Other concerns (which were mentioned at least 15 times) included the poor level of hygiene in Cherry Tree House; the standard of record keeping and removal of records; and failure to implement procedures for the protection of vulnerable adults.

The BBC reported the findings of the report which included criticism of the regulator RQIA.

Cherry Tree House nursing home report findings accepted by RQIA - BBC News
The RQIA Chief Executive gave a statement to the BBC's Marie Louise Connolly about the criticism of the RQIA.

"I accept that this report identifies a number of shortcomings for us and in sending copies of the report out yesterday to the whistleblower and the families, I indicated to them in my letter, an apology for those shortcomings. You're looking back over a period of perhaps almost ten years when there were different systems and structures in place. I think the structures we have in place now are much more robust and will make sure that we do not have a repeat of the situation."

The statement from the RQIA Chief Executive was made in 2014. Two years later there was a repeat of the situation. Dunmurry Manor happened.

The Dunmurry Manor COPNI report was released in June 2018

copni-home-truths-report-web-version.pdf

Key extracts from the report;

"Regrettably, this report outlines a disturbing picture where there were many significant failures in safeguarding, care and treatment which led to many of the residents not receiving adequate protection for prolonged periods of time. It reveals a system that is disjointed and failing in its duty to provide the care and protection that residents of Dunmurry Manor were entitled to. It shines a light on a home where despite multiple concerns being raised repeatedly by families, care home staff, Health

and Social Care (HSC) Trust employees and others, there was a slow and inadequate response from the authorities involved in ensuring that minimum standards of care were being met"

"My office previously issued a report in 2014, Changing the Culture of Care Provision, which made a number of recommendations to improve standards in care settings in Northern Ireland. These included recommendations to make the inspection process more rigorous, to introduce and implement clear sanctions, as well as specific adult safeguarding legislation and better protection for whistleblowers and improved complaints processes. In the same year, the independent review report on the Cherry Tree Nursing Home in Carrickfergus also revealed serious shortfalls in the standard of care and the inspection regime. At the time, there were a number of public commitments made to bring about change and to implement a series of recommendations to prevent a repeat of this happening in the future. Unfortunately, the response to these recommendations has been slow and disjointed, the result being that many of the failures identified in this investigation could have been prevented or at least managed better had the previous findings and recommendations been acted on more quickly and in full. It is vital that we can have confidence in our health and social care system and this must include care provision in later life. If the public are to be reassured that those who live in care homes are receiving good quality care, 24 hours a day and 365 days a year, then the findings of this investigation must be responded to as a matter of urgency. Not only that, but Government must advise which recommendations of this report it will implement and by when"

"The investigation findings are deeply concerning and reflect an environment of poor care and treatment, serious safeguarding issues and medicines management issues, compounded by a failure of responsible bodies (RAs) to act quickly and comprehensively. Evidence of physical and sexual assaults on female residents, residents leaving the home unnoticed and multiple instances of inhuman and degrading treatment were witnessed and reported. Despite Dunmurry Manor being regulated against care home standards within a regime of regulation and inspection, harm still occurred. It became clear as the investigation progressed that none of the organisations involved were aware of the full scale of the issues being experienced by residents in the home."

There has been a host of other care home scandals across Northern Ireland in the last 10 years;

-Clifton Nursing Home Belfast

https://copni.org/news/articles/statement-from-the-commissioner-for-older-people-for-northern-ireland-on-clifton-nursing-home

-Owen Mor Londonderry

https://www.bbc.co.uk/news/uk-northern-ireland-foyle-west-49405690

-Kingsway Dunmurry

RQIA highlights failings at Kingsway Private Nursing Home, Dunmurry - BBC News

- Rose Court Ballymena

-William Victor McLean: Dementia patient's care in Ballymena nursing home before death was "atrocious" | BelfastTelegraph.co.uk

-Glenabbey Manor Glengormley

https://audioboom.com/posts/7004362-the-health-safety-and-wellbeing-of-elderly-residents-could-have-been-compromised-once-again-at-a

-The Haven Dungannon

https://www.thedetail.tv/articles/financial-abuse

-Hebron House Markethill

https://www.belfasttelegraph.co.uk/news/health/nurse-accused-of-deplorable-overcharging-of-vulnerable-care-home-patients-struck-off/a1516604013.html

-Lisnisky Portadown

https://www.bbc.co.uk/news/uk-northern-ireland-39699348

-Colinvale Court Belfast

https://www.belfasttelegraph.co.uk/news/northern-ireland/dunmurry-boss-had-managed-separate-home-probed-by-psni/38625389.html

-Greenhaw Londonderry

https://www.belfasttelegraph.co.uk/news/northern-ireland/watchdog-finds-fresh-failings-at-derrys-greenhaw-lodge-care-home/39031011.html

The Learning disability area of our health service has had its own raft of failings, with of course the biggest adult safeguarding investigation in the UK being Muckamore Abbey Hospital.

In 2012 an adult safeguarding investigation commenced on the Ennis Ward at Muckamore Abbey Hospital because of serious concerns raised by in reach staff on the wards observing as a part of the resettlement of patients.

https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-11/Module%206b%20Ennis%20Bundle.pdf

In 2012 senior management decided to install CCTV on the wards at Muckamore. The CCTV was installed in April 2015. The CCTV did not become operational until after August 2017 when the family of a patient asked for the CCTV to be viewed after an allegation of abuse. The family was told that the CCTV was not operational and not recording. It turned out the CCTV was recording and by accident the biggest adult safeguarding investigation in the UK had commenced.

In 2012 an adult safeguarding investigation began at Ralphs Close in Derry. Ralphs Close is a care home situated on the grounds of the Waterside Hospital. Ralphs Close was the home of adults with a learning disability who had been resettled from long stay hospital wards at the Gransha site.

A review report for Ralphs Close was published by RQIA in August 2012.

https://www.rqia.org.uk/RQIA/files/53/53abe429-7bee-44c5-88de-af76f16e4b0c.pdf

The background to the RQIA Review report stated;

Ralphs Close Residential Care Home provides accommodation and support for adults with a learning disability. The home is situated at the rear of the Gransha Hospital site and was constructed in 2010 by Trinity Housing Association. The home provides single room accommodation for 16 adults and is divided into two separate, identical buildings, each containing two self-contained units for four residents. The home is managed by the Western Health and Social Care Trust (Western Trust) and the building is owned and maintained by Trinity Housing Association. Most of the residents who live in Ralphs Close moved there from long-stay learning disability wards on the Gransha site. Several residents have also been receiving inpatient care on the site since childhood. On 24 July 2012, an anonymous letter (undated) was received by the Western Trust in respect of allegations of physical and psychological abuse of vulnerable adults. The letter referred to Ralphs Close Residential Care Home. On 25 July 2012, a copy of the letter was forwarded to RQIA in line with reporting procedures for notifiable events. On 25 July 2012, in line with the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults , (Joint Protocol) the Western Trust convened a multi-agency strategy meeting to consider the allegations; to decide on the lead agency for the investigation and to develop an appropriate protection plan for service users. It was agreed that the Police Service of Northern Ireland (PSNI) would lead a single agency investigation into the allegations. It was also agreed that the Western Trust would initiate a protection plan in respect of residents living within the establishment. A further adult safeguarding meeting was held on 26 July 2012 at which the protection plan was reviewed. RQIA participated in both meetings by teleconference. On 27 July 2012, the RQIA Chief Executive wrote to the Western Trust Chief Executive to seek assurance "as to the robustness of the protection plans that have been put in place by the trust in light of these serious allegations". The Western Trust Chief Executive replied on 31 July 2012, stating: "the trust has collaborated closely with RQIA and PSNI colleagues to ensure that these anonymous allegations receive thorough investigation, and is a paramount concern to the trust that the safety of residents in Ralphs Close is protected on an ongoing basis throughout the investigative process."

On 6 August 2012, RQIA carried out an unannounced inspection of Ralphs Close. In view of the findings of the inspection, RQIA determined that action should be taken in relation to non-compliance with a number of regulations. This was subsequently taken forward separately and is not the subject of this report. Following this unannounced inspection, RQIA also determined that it should carry out a separate review of the safeguarding arrangements in place at Ralphs Close Residential Care Home. The RQIA Chief Executive wrote to the Western Trust Chief Executive on 8 August 2012 and stated: "RQIA intends to investigate the current safeguarding arrangements in place at

Ralphs Close as part of the protection plan for vulnerable adults residing at that facility"

The RQIA review report concluded with several recommendations including one relating to adult safeguarding.

7. The Western Trust should ensure there are arrangements in place to provide management oversight, support and training to the manager in Ralphs Close in making important decisions about the reporting of incidents, vulnerable adult investigations and restrictive practices.

In February 2014 the Health Minister Edwin Poots made a statement in the Assembly about Ralphs Close Residential Care Home

(Published at 5.00 pm on Wednesday 26 February 2014)

Mr Poots (The Minister of Health, Social Services and Public Safety): I wish to make a statement to the Assembly following the completion of the investigations into the allegations of abuse at Ralphs Close Residential Care Home and sign off of the Safeguarding Report by the Western HSC Trust Board.

Members will recall that following the initial allegations of abuse in July 2012, and in response to members questions, I informed the Assembly of the actions being taken by the Trust to protect and ensure the immediate safety and well-being of residents including the initiation of the Joint Protocol arrangements for the Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults which led to an investigation by the PSNI and a Safeguarding Investigation by the Trust. Both these investigations are now complete.

The outcome of the PSNI criminal investigation, which lasted nine months, concluded there was no evidence of wilful neglect and in the absence of witness evidence it was unlikely that the burden of proof threshold required in a court of law would be met. The Public Prosecution Service (PPS) has advised that in the absence of witness evidence there is no other evidence against identifiable individuals of any offences. This highlights the challenges we face in protecting the most vulnerable people in our society, people who cannot always speak for themselves and who rely on others for their care. There is no room in the health and social care family for those who exploit

their position of trust by inflicting suffering and harm, or indeed, standing by and ignoring others who do.

I welcome the assurance that the Trust has undertaken a very thorough safeguarding investigation, carried out by an experienced team of senior managers and professionals. As recommended by my Department, the senior team was assisted and advised by an independent external expert in Adult Learning Disability appointed by the Trust. The findings are disturbing, but it is always important that such issues are brought into the open so that we can take all appropriate action and secure improvements in services.

The report has concluded that on the balance of probability there has been abuse perpetrated by a number of staff in Ralphs Close over a period of time. The nature and type of abuse includes physical and psychological abuse and neglect by omission. Over 50% of allegations made have been substantiated and on the basis of these findings disciplinary proceedings are now progressing as well as investigations by the relevant regulatory bodies. Members will understand that I cannot say more on that subject at present, other than to say that individuals who abuse those in their care will be held to account for their actions.

I have already had an urgent meeting with the Chief Executive of the Western Trust and the Chair of the Trust Board to seek their assurance that individuals will be held to account for identified failings and that every effort has been made to ensure, as far as possible, that poor or abusive practice is not happening elsewhere in any setting within the Trust.

I am truly appalled and angered that anyone in a position of responsibility and trust, caring for vulnerable people, could in any way cause them hurt or distress. I deeply regret that individuals have suffered directly and their families. As a consequence I am hugely disappointed that vulnerable people and their families have been let down by the service. The Trust have apologised directly to those involved.

Members will be aware that this will have a personal resonance for many families who have loved ones being cared for in similar settings. I am aware that the findings in this case will impact on families' level of trust and confidence in our system.

As far as possible, I want to be assured and to assure the public that there is strong vigilance and proactive management in all health and social care settings in Northern Ireland, including private and voluntary sector settings where care is provided to vulnerable adults. I want to be assured that there is a determined and sustained focus

on promoting high standards of care and safety and on preventing, detecting and, where necessary, dealing robustly with poor or abusive practice at every level in the HSC system.

Consequently, I have sought assurance from the Chairs across all the Trusts that facilities, which are caring for vulnerable adults, have robust safeguarding arrangements in place, that they are confident these are being adhered to; and that a culture is promoted within those settings, and throughout the organisation, that has a zero tolerance of poor practice, negligence or deliberate harm of any kind.

It is important that we recognise and acknowledge that the vast majority of staff who care for our loved ones do so with compassion, kindness and a commitment to doing their best. I would acknowledge and thank those individuals who persisted in bringing the abuse in Ralphs Close to light. And, as I have said consistently in my role as Minister for Health, anyone who has a concern about the standard of care should not be afraid to come forward. Preventing abuse or neglect is the responsibility of all of us and none of us should tolerate vulnerable people being abused in any way.

My Department is in the process of developing new adult safeguarding policy, which I have instructed officials to finalise and issue as a matter of urgency. The policy will place a renewed emphasis on preventing harm to adults who are vulnerable and, at the same time, seek to ensure that effective protections are provided in circumstances where harm has occurred or is suspected. It will advocate a policy of zero-tolerance of adult abuse in any setting and make respect for their dignity and rights non negotiable. It will also make it clear that effective safeguarding of those who are vulnerable is the responsibility of us all.

At the same time, we are in the process of implementing new safeguarding legislation, the majority of which is already in operation. The aim of the legislation is to ensure that individuals found to have harmed adults who are vulnerable are removed from the workforce, added to barred lists where this is appropriate and, consequently, prevented from obtaining work with vulnerable adults in the future while they continue to remain on a barred list. The legislation will in future make it a requirement for employers and volunteer managers to check against the barred lists prior to permitting an individual to work or volunteer with vulnerable adults.

Trust can be abused in every sphere of care within our society. Some people are capable of terrible cruelty. There are corrupt and immoral individuals who, in spite of all our best efforts, will find ways to subvert the system and harm others. I am doing, I have done and I will continue to do all within my power to stamp out abuse and create

a system where there is no hiding place for those who abuse their position of trust. I cannot do this alone. It requires everyone to be vigilant and to take responsibility to protect those who are vulnerable.

People who use our services, their families and relatives, carers and members of staff or managers must feel confident and able to come forward to speak out and express any concerns they have about the quality or standard of care, whatever the context. Where individuals do not have the capacity or ability to do so themselves they must be supported to have a voice.

Creating a culture of openness and transparency within the health and social care system so that there is no hiding place for poor or abusive practices is my priority and it must be everyone's priority.
The movement of patients from an institutional setting to community based facilities is reflective of the strategic vision to de-institutionalise the care of individuals and to provide person-centred, community-based approaches which promote the rights of, respect for, choice and independence of individuals. The move to Ralphs Close had the potential to be a positive development for individuals who had previously resided in a hospital setting. Regrettably this was not the case.

The lessons from Ralphs Close highlight that the transition from institutional living to community based living requires careful planning and management. It is not simply about the transfer of location but requires a change in ethos and working practices. These lessons will need to inform the planning and implementation of the reform of the health and social care system, to ensure that the vision set out for Transforming Your Care is realised and that those responsible for implementing the reforms learn from this.

I have instructed the Health and Social Care Board to ensure that the lessons learned from this case are disseminated across all Trusts and service providers in the voluntary and private sectors who are commissioned to provide services by the HSC Board and/or Trusts.

Since the first allegations were made in July 2012 the Regulation and Quality Improvement Authority has undertaken more than ten announced and unannounced inspections of Ralphs Close. The most recent unannounced inspection was earlier this month and I can confirm to members there are currently no concerns regarding the standards of care in this facility. Indeed, there has been a transformation in the care provided to residents over the past 18 months.

I want to pay tribute to those staff in Ralphs Close who, in spite of the intense scrutiny and adverse publicity around this case, have continued to care for the residents and have worked tirelessly to create a new culture of person-centred care. We owe them our thanks and gratitude.

More than three years after Health Minister Poots made his Ralphs Close statement the revelations at Muckamore arose.

Health Minister Poots made two very important points within his 2014 Ralphs Close statement;

1- *"Consequently, I have sought assurance from the Chairs across all the Trusts that facilities, which are caring for vulnerable adults, have robust safeguarding arrangements in place, that they are confident these are being adhered to; and that a culture is promoted within those settings, and throughout the organisation, that has a zero tolerance of poor practice, negligence or deliberate harm of any kind."*

2- *"I have instructed the Health and Social Care Board to ensure that the lessons learned from this case are disseminated across all Trusts and service providers in the voluntary and private sectors who are commissioned to provide services by the HSC Board and/or Trusts."*

Given that Mr Poots wrote to all Chairs then the Belfast Trust Chair would have given assurances that Muckamore had "robust safeguarding arrangements in place".

If the HSCB was to ensure lessons from Ralphs Close were disseminated across all trusts, then how was it possible for CCTV at Muckamore in 2017 to record 1500 crimes in one ward?

Muckamore Abbey: CCTV reveals 1,500 crimes at hospital - BBC News

In **2014** the RQIA inspected three wards at Muckamore Abbey Hospital. The three wards were called;

-Killead Ward
-Donegore Ward
-Cranfield ICU

At Killead Ward the RQIA inspector stated that there were 133 substantiated adult safeguarding allegations.

At Donegore Ward the RQIA inspector stated that there were 32 substantiated adult safeguarding allegations.

At Cranfield ICU the RQIA inspector stated that there were 37 substantiated adult safeguarding allegations.

These figures were included in the RQIA inspection reports which are all available on the RQIA website. The Chief Executive office was required to sign off each RQIA inspection report.

Therefore, in a 12-month period between 2013-2014 there were 212 substantiated allegations of abuse at Muckamore. The RQIA inspection reports that contain the data are public record and were signed off by senior Belfast Trust officials.

In November 2014 Belfast Trust Chief Executive Michael McBride signed a RQIA inspection report as Chief Executive approving.

The report was for Donegore Ward.

https://www.rqia.org.uk/RQIA/media/CareServices/12048_Donegore_Care_18112014.pdf

The report states;

"Inspectors met with the hospital Safeguarding Vulnerable Adults Designated Officer (DO). The DO stated that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure. **Inspectors discussed the 32 substantiated allegations with the DO. The DO confirmed that that none of the 32 allegations were outstanding**. He advised that referrals for safeguarding investigation by ward staff had been promptly completed and that protection plans were put in place. The DO also advised that incidents had

been appropriately reviewed in accordance with the trust safeguarding policy and procedure."

The Margaret Flynn SAI Muckamore report concluded;

Between April 2012 and September 2017, the Hospital recorded 128 allegations concerning staff working on PICU, Six Mile, Killead, Ennis, Oldstone, Greenan, Cranfield, Mallow, Donegore, Moylena and Erne.

Over 92 of these allegations concerned "physical abuse," and 102 (80%) concerned physical abuse combined with "institutional abuse, psychological abuse, verbal abuse, verbal and psychological/emotional abuse."

Paragraph 55

Flynn, Margaret - Statement.pdf (mahinquiry.org.uk)

We would urge the Health Committee to read the Muckamore SAI report which is available in full by clicking the above link.

The revelations about abuse at Ralphs Close in Londonderry arose in 2012. This was at the same time as the investigation of allegations of abuse on the Ennis Ward at Muckamore.

The Designated Adult Protection Officer for the 2012 Ennis Ward investigation was Aine Morrison. Aine Morrison is currently the Northern Ireland Chief Social Worker.

At the Muckamore Abbey Hospital Public Inquiry, Aine Morrison set out her experience of being bullied whilst carrying out the role of Designated Adult Protection Officer.

Aine Morrison told the Muckamore Public Inquiry;

100. At the time, I believed that the reasons for the behaviour I experienced were attitudinal. I did not believe that there was any attempt to cover up or hide anything. I attributed the difficulties I experienced to a range of possible factors including professional defensiveness on the part of nursing and a reflection of some

community/hospital and social work/nursing tensions. Whilst some defensiveness is not unusual from services which are under investigation, this was beyond the normal. I also believed there was a reluctance, perhaps subconsciously, to accept the possibility of widespread abuse on Ennis Ward. The pressure from John Veitch was one of the most difficult parts of the investigation for me as it was repeated and coming from within my own line management hierarchy.

101. John Veitch's position as Co-Director for Learning Disability Services and subsequently as my line manager; Moira Mannion's position also as Co-Director and Esther Rafferty at Service Manager level were all more senior to me up until July 2013 when I took up a Service Manager post. This made the challenges I faced from them particularly difficult to handle. I believe that the behaviour of John Veitch, Moira Mannion and, to a lesser extent, Esther Rafferty was bullying in nature and it took a significant personal toll on me to have to maintain my own position and not give into the pressure and to carry out my professional responsibilities in the face of such opposition.

102. I also believed that I had withstood the pressure, had been able to carry out the investigation that I wanted to carry out and that the investigation report reflected what I felt able to say. The uncertainty of some of the conclusions was reflective of a lack of concrete evidence in some cases and not as a result of any pressure. Ultimately, I was not challenged on any aspects of the report.

https://www.mahinquiry.org.uk/files/mahinquiry/documents/2025-05/Morrison%2C%20Aine%20-%202nd%20Statement3.pdf

RQIA Chief Executive Briege Donaghy gave evidence relating to serious concerns meetings the RQIA had with the Belfast Trust in respect of Muckamore. (Pre 2017)
In the statement of Briege Donaghy, she set out the following;

- In 2011, there were three such serious concerns meetings; two relating to Moylena Ward and one relating to Finglass Ward. These followed from concerns identified during inspections.
- In 2013, there was one such meeting; relating to Ennis Ward. This followed on from concerns identified during an inspection.

- In August 2014 one such meeting and related to Moylena Ward. This meeting followed concerns identified during an inspection of Moylena ward on 8 July 2014.
- In 2015, there were two such meetings; relating to Killead and Moylena Wards. Both meetings followed concerns identified during inspections.
- In 2016, there were two such meetings; relating to Erne and Donegore Wards. Both meetings followed concerns identified during inspections.

Further in the evidence of Briege Donaghy, she explains what happens when a serious concerns meeting is called.

"A letter of invitation to meet the Assistant Director/Senior Inspector and/or relevant inspector/s (RQIA) will be issued to the Registered Person/Trust's Responsible Individual/s from the Assistant Director (RQIA) Contact with the Registered Person/Trust's Responsible Individual/s may also be made by telephone and followed up in a letter. A record of the telephone call will be retained. The purpose of the serious concerns meeting is to discuss with the Registered Person/Trust's Responsible Individual/s RQIA's concerns about the precise nature of the areas of potential noncompliance".

Recent reporting by BBC Northern Ireland in 2025 has highlighted ongoing serious concerns about the culture within the Belfast Health and Social Care Trust, particularly the cardiac surgery unit. Consultant cardiologist Dr. Kieran McManus has spoken publicly about bullying, intimidation, and a lack of transparency in the unit, warning that such behaviours compromise both patient safety and staff well-being. These issues underline that systemic cultural failings persist, showing that legislation alone is insufficient without accompanying measures to change culture, leadership, and accountability.

The current NI Chief Social Worker Aine Morrison reported bullying at the Belfast Trust in 2012. In 2025 there are still reports of bullying.

We think it is astonishing that there are still reports of bullying in the Belfast Trust in 2018 and 2018 after the Muckamore abuse was discovered on CCTV in 2017. That it is still going on in 2025 is truly extraordinary.

Action for Muckamore welcomes the intent behind the Adult Protection Bill. However, based on the lived experiences of families affected by institutional abuse and ongoing

failings, we are deeply concerned that the Bill in its current form may not prevent another tragedy like Muckamore Abbey. Legislation must be more than a framework — it must drive meaningful cultural change, enforce accountability, and embed robust protections across health and social care systems.

The Adult Protection Bill legislation as its current form will change nothing internally in the NI Health Service. The only change it will make will be externally in that the legislation will allow the PSNI/PPS to charge/prosecute employees and employers.

The well publicised failings internally in our health service will still make it very difficult for the PSNI to investigate and gather evidence and for the PPS to prosecute.

Northern Ireland faces serious challenges in protecting adults at risk of harm from abuse and neglect. At present Health and Social Care Trusts investigate their own services, while the Regulation and Quality Improvement Authority (RQIA) is funded by and accountable to the Department of Health. This lack of independence undermines the robustness, transparency, and credibility of safeguarding investigations.

At present the adherence to the NI Adult Safeguarding Operational Procedures is extremely poor in all the Trusts.

When the 2016 NI Adult Safeguarding Procedures were introduced, the Belfast Trust failed to migrate all the new adult protection documentation (APP forms) onto their system.

Key problems currently with adult protection/safeguarding across all the health trusts.

1. Trusts 'Marking Their Own Homework'

• Trust-employed social workers investigate abuse allegations within Trust services. The allegations being investigated may well relate to the service user that the social worker has key responsibility for.

• Conflict of interest: Investigators may be reluctant to expose systemic failings.

• Even fair investigations are perceived as biased, reducing public confidence.

2. Lack of Robustness and Consistency

• Investigations vary widely across Trusts, creating inequity.

• Organisational defensiveness prioritises reputation over truth.

• Families describe processes as adversarial, unfair, and retraumatising.

3. RQIA's Lack of Independence

• RQIA is funded by and accountable to the Department of Health.

• Creates a conflict of interest, weakening its ability to challenge systemic failings.

• Public confidence in RQIA has always been low; it is not seen as fully independent.

• Unlike England's Care Quality Commission (CQC), RQIA does not report directly to Parliament.

Consequences for Safeguarding

• Systemic failings go unchallenged.

• Confidence is eroded among families, victims, and staff.

• Opportunities for reform are missed, allowing harmful practices to persist.

• Vulnerable adults remain at risk of harm.

Pathways to Reform

The forthcoming Adult Protection Bill provides a critical opportunity to embed independence and accountability.

Reform should include:

1. Independent Investigations

• Establish a dedicated safeguarding body, separate from Trusts, with powers to investigate abuse/neglect.

2. Regulatory Reform

• Restructure RQIA's accountability so it reports directly to the Northern Ireland Assembly.

• Ensure RQIA functions as a truly independent arm's length body.

3. Transparency and Consistency

• Standardise safeguarding investigations across all Trusts.

• Publish clear findings and lessons learned to rebuild public trust.

Priority recommendations

• Establish an Independent Adult Safeguarding Commissioner with statutory powers to investigate, monitor, and hold organisations accountable.

• Ensure the Commissioner reports directly to the Northern Ireland Assembly, not the Department of Health, to safeguard independence.

• Mandatory Reporting Duties

• Introduce clear legal duties on all staff working with adults at risk to report concerns of abuse, neglect, or institutional failings.

• Protect whistleblowers from retaliation, ensuring that staff who raise concerns are supported rather than silenced.

• Cultural Change and Workforce Protection

• Require health and social care bodies to implement staff wellbeing and psychological safety frameworks, including protection against bullying and intimidation.

• Introduce mandatory safeguarding and professional conduct training for all staff, refreshed regularly.

• Link leadership performance and organisational inspections to evidence of a positive, transparent workplace culture.

• Stronger regulation and scrutiny of investigations and reviews within health trusts.

• Expand the powers of the Regulation and Quality Improvement Authority (RQIA) to conduct unannounced adult safeguarding related inspections, interview staff in confidence, and escalate concerns to the safeguarding commissioner.

• Ensure adult safeguarding inspection findings are made publicly available in full, not sanitised reports.

• Clear adult safeguarding language in policy and procedures that is easily understood by all.

• Provide a robust and inclusive definition of an “adult at risk,” ensuring coverage of all vulnerable groups, including those with learning disabilities, mental illness, dementia, or in institutional care.

• Define thresholds for intervention clearly to prevent inconsistencies in practice.

• Family and Service User involvement- A clear policy for the involvement of family where appropriate to include access to key documents, reports and information. Families are given choices and authority about whether CCTV is installed in cases where the service user does not have capacity.

• Mandate family involvement in safeguarding reviews, learning processes, and policy development. Have a clear set out staged approach to the whole adult safeguarding process from start to finish.

• Create statutory rights for families to receive timely, transparent information when safeguarding concerns arise.
• Regular review of the legislation and policy and procedures. There should be constant monitoring and oversight of the adherence by health trusts to the legislation and supporting policy and procedures.

• Build in a duty for the Department of Health to review the operation of the Act within three years of commencement, and at fixed intervals thereafter, to ensure it remains effective and responsive.

There needs to be an urgent independent investigation (Scotland, England or Wales) into the culture within our whole health and social care service. There can be no delay.

Glynn Brown

Chair, Action for Muckamore.