Written Ministerial Statement

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Department of Health

MUCKAMORE ABBEY HOSPITAL INQUIRY REPORT RECOMMENDATIONS DEPARTMENTAL PROGRESS UPDATE

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Mr Butler (The Minister of Health): I wish to provide Members with an update on progress by my Department on its response to the Muckamore Abbey Hospital Inquiry report recommendations since the Oral Statement provided by my predecessor on 22 June 2026.

From the outset, I would like to confirm that I also share my predecessor's view that the Inquiry's report must be a watershed moment for the treatment of vulnerable people within our health and social care services and wider society. We owe it to patients, their families and carers not only to meet, but to exceed, their expectations when they come under our care.

As a first step, I wanted to meet in person with the families affected by the Muckamore Abbey Inquiry to hear directly their views, concerns and expectations on the delivery of the 106 recommendations contained within the Inquiry report. I felt this was a vital and necessary step, both for my own understanding and to help provide context, before I provided a further update on my Department's progress since June.

The meeting with the families took place on 16 September, and I thank those who took the time to come to the meeting and share their open and forthright views in person.

At the meeting, I emphasised that I wanted to listen carefully and openly, to accept that the system got it wrong and to reassure the families of my commitment to delivering change. I also acknowledged that some families may feel they are not seeing evidence of progress as quickly as they would like.

I understand that concern, and I have made clear to officials that the scale and complexity of this work cannot be allowed to become a reason for unnecessary or avoidable delay. Families have already waited too long for answers and accountability, and I expect the Department and the wider Health and Social Care (HSC) system to proceed with the urgency that the Inquiry's findings demand.

I appreciated the honest conversation in the room, and it was abundantly clear that, as colleagues would expect, there is a lot to be done to rebuild their trust in our HSC system. However, without going into all the detail of what was discussed, it was very clear to me that the families must be central to the work to implement the recommendations, and I have committed to ensuring they will have a key role in overseeing the developing work to deliver on the Inquiry's recommendations as we seek to rebuild their confidence and trust in the HSC system. One key action from that meeting was an agreement to establish an 'implementation consultation group', as detailed in R1, and my officials are working on progressing this at pace.

That involvement must be meaningful and continuing, rather than confined to individual meetings or consultation exercises, and the experience of patients and families must help shape how implementation is taken forward and how progress is assessed.

I also met with the Inquiry Chair, Mr Tom Kark KC, yesterday to discuss the Inquiry report and its recommendations. The meeting, which had been planned a number of weeks in advance, allowed me the opportunity to personally thank him for his commitment to the Inquiry and for the comprehensive report that he and his fellow panel members produced. We had a very constructive engagement. I

reiterated my commitment to ensuring that the delivery of the recommendations remained a key priority for the Department, and that I wanted to ensure the delivery structures were embedded for any future Health Minister to continue the transformation required.

The meeting also allowed me the opportunity to update him on progress to date and to discuss a number of specific recommendations. We also discussed ongoing support that the panel members may be able to provide, while recognising that the Inquiry Panel's formal role was timebound.

Since the initial response provided to the Assembly on 22 June, work on the implementation of the Inquiry recommendations has been ongoing, in line with the Departmental guidance on responding to public inquiries.

I believe the approach taken by my Department to date has been proportionate to the scale of what is required in terms of delivering the report's recommendations.

As an initial and vital first step, my predecessor held a Quality and Safety Summit on 30 June with HSC system leaders, including Trust Chairs, Chief Executives and Chairs of the newly established Patient Safety and Quality Committees, where expectations on the collective responsibility of the HSC system to strengthen patient safety, culture, governance and accountability were set out. The previous Minister wrote to attendees on 21 July with the feedback and outcomes from the summit.

In terms of work undertaken by my Department, a range of preparatory work has been completed. This includes an initial thematic analysis of the recommendations in liaison with relevant stakeholders, both within the Department and the wider HSC, to inform a response to the recommendations and that work is continuing.

This has included identifying any interfaces and alignment between the MAH Inquiry recommendations and other work that my Department already has in train. This is necessary to avoid duplication or confusion over who is responsible for taking forward the recommendations.

As part of this work, an independent assessment has been carried out to assess any crossover between the MAH Inquiry recommendations and the other inquiries whose recommendations the Department is also implementing.

The MAH Inquiry recommendations have also been considered and mapped against recommendations from a number of other key strategic initiatives relating to learning disability. These include the work on the new Learning Disability Service Model, the Adult Protection Bill currently progressing through the Assembly and the Equity of Access report on the future role of registered nurses in learning disabilities.

Furthermore, my Department has written to all Trusts asking them to provide an assessment of each recommendation, including the current position and any work already in progress to address it, while identifying any gaps and potential next steps for implementation.

Comprehensive responses have now been received from all Trusts and are being considered.

This work will help develop timescales for delivery and identify those recommendations that require further consideration and resources.

In addition, my Departmental officials have met with Directors of Learning Disability from all Trusts to ensure a coordinated response to implementation across HSC organisations and have agreed to hold monthly meetings to discuss the Inquiry report alongside wider learning disability issues.

The Chief Nursing Officer held a workshop on 18 August with Trust Executive Directors of Nursing, wider HSC learning disability leaders and representatives from my Department, the Northern Ireland Practice and Education Council for Nursing and Midwifery, and the Public Health Agency. The workshop discussed the Inquiry findings, key necessary actions, ownership, accountability and measures of success, and also considered work already commenced on the recommendations.

Drawing on this engagement, a proposal has been developed for an implementation oversight structure that involves grouping the recommendations thematically into 10 workstreams.
The preparatory work is necessary, but it cannot become an end in itself, and I have made clear that it must now translate into a structured programme of timely delivery against which the Department and the wider HSC system can be held to account.

Once this range of work has been completed, my Department will respond to recommendation R2, which requires my Department to indicate publicly within six months which recommendations it accepts, and an explanation of this decision. As outlined by the previous Minister, I expect that my Department will be in a position to provide this response well in advance of the six-month deadline set by the Inquiry.

I also expect the implementation arrangements that follow to clearly identify who is responsible for each accepted recommendation, the anticipated timescale for delivery and how progress and impact will be measured.

Separately, my officials have also carried out initial scoping work on recommendations R1, concerning the establishment of an Implementation Consultation Group, and R106, concerning the establishment of a Redress Working Party, including seeking independent assessment and advice on engagement.

As a result, and further to discussions with families on 16 September, I expect to receive advice on options for both of these recommendations imminently. We will, of course, engage with families and those representing people with learning disabilities on the proposed options before anything is agreed.

In addition, my Department has been considering those recommendations relevant to the Adult Protection Bill, including recommendations relating to CCTV in care settings, adult safeguarding, the introduction of a statutory duty of candour and amendments to the care offences in Part 3 of the Bill to reflect a reverse burden of proof. Advice has been sought from the Office of Legislative Counsel on whether amendments are required to address a number of recommendations in the report. Officials are also meeting with the Inquiry Chair later this week to discuss further a number of the recommendations relating to the Bill.

While discussions are ongoing, I remain committed to progressing the Adult Protection Bill without further delay, supporting its passage within the current Assembly mandate and delivering a statutory framework for the protection of adults at risk.

As Members are aware, there are also two recommendations that are outside the scope of my Department: R88, which relates to the PSNI process for reviewing live investigation files, and R89, which relates to a Department of Justice review of the timeliness of the prosecution system. I wrote to the Minister of Justice on 27 August requesting her assessment of these recommendations.

My Department will address recommendations quickly where possible. However, as Members would expect, some require further in-depth analysis, and there will inevitably be a number with resource implications that will need to be considered carefully in the current financial context in which my Department is operating.

There are also a number that may require legislative changes, and these will be finalised once we are at the stage of developing the required assurance frameworks to identify and underpin the work necessary to address each recommendation. Where legislative change is required, we will endeavour to facilitate the necessary changes by way of policy direction or circular, on an interim basis, to ensure the pace of delivery is not adversely affected by legislative timescales.

In terms of accountability and oversight, given the number of recent inquiries into services within Health and Social Care, my Department has established a directorate to ensure that any thematic issues arising from these reports are addressed and to oversee the implementation of all recommendations. The work on the MAH Inquiry response is now included prominently within these arrangements.

Oversight and accountability are provided through an Inquiries Implementation Programme Management Board, chaired by the Permanent Secretary. The Board ensures alignment and accountability across the Department and the wider Health and Social Care system for the delivery of inquiry recommendations.

The Muckamore Abbey Review Team within my Department is leading the response to the Inquiry report and its recommendations and is providing regular updates on activity and forthcoming work to the Inquiries Implementation Programme Management Board for its consideration.

In addition, as part of the Departmental oversight of work to progress the report's recommendations, a weekly meeting has been established, chaired by the Permanent Secretary. Attendees include representatives from the Departmental oversight directorate, the implementation team within the Department, the Strategic Planning and Performance Group, the Belfast Trust, the Regulation and Quality Improvement Authority and the Patient and Client Council. Independent members of the Inquiries Implementation Programme Management Board also have an open invitation to attend.

I also appreciate that, in line with Departmental oversight arrangements, it is important that patients, families, carers and the wider public have a role in holding us to account for progress. To enable this, my Department will provide public updates as the work moves forward, in a format and at intervals agreed with the families.

Members, I also reaffirm the previous commitment to provide regular updates to the Assembly and the Health Committee as we progress the work to implement the recommendations.

The scale of the work required should not be underestimated, but neither should it be used as a reason for delay. The ultimate measure of our response will not be the number of meetings held, structures established or reports produced, but whether patients and families can see and experience meaningful change in the safety, culture, governance and accountability of our health and social care services.

Robbie Butler MLA
Minister of Health