

 Belfast Health and Social Care Trust caring supporting improving together		Paper Ref. Num. 2026.08.27_TBP_AgendaITem7.1_P234-2026MAHI <i>Note:- To be completed by HQ meeting organiser</i>
Belfast Health & Social Care Trust Meeting Template Sheet (v050526)		
Title of paper (Maximum of 300 characters) Muckamore Abbey Hospital Inquiry & Related Workstreams Oversight Group – update as at 19.08.2026		
Purpose of paper		For Oversight
If other purpose please specify	Please enter text here	
Meeting TB Public		
If other meeting please specify	Please enter text here	
Rationale for confidential consideration (if applicable)		
Presenter	Peter Sloan	
Date of meeting	27 August 2026	
Background (Maximum of 1500 characters) Refer to attached paper.		
Date considered at Exec Team (If Applicable)	n/a	
Options for consideration (Maximum of 1500 characters) n/a		
Recommendations (Maximum of 1500 Characters) Trust Board are asked to note the update report		
Proposed Onward Consideration	Later Agenda	
If other		

Note:-

Any papers accompanying this template should not exceed 10 pages in length.

Please ensure when submitting papers that

- (1) Orientation of paper is set so that the content of the paper can be read*
- (2) Embedded documents should be [provided a separate attachments*
- (3) Append any papers to this coversheet starting on the next page*

Insert/Copy/Paste any additional information from this point

MEETING ASSURANCE REPORT

Report for:	Trust Board
Date of meeting:	27.08.2026

Report from:	MAH Inquiry & Related Workstreams Oversight Group
Report date:	19.08.2026 (meeting date: 18.08.2026)
Chair:	Chief Executive
Lead Officer / Author:	Co-Director Risk & Governance
Was the meeting quorate	Yes

Purpose: For Approval / Direction / Oversight / Other	Oversight
If 'Other' please specify:	n/a

Aligning to the Belfast Trust Corporate Priorities:

PATIENTS & SERVICE USERS	Being caring and open	X
PEOPLE	Being kind, professional, and respectful	X
POPULATION HEALTH & PARTNERS	Being collaborative and inclusive	X
PERFORMANCE	Being effective and safe	X
POTENTIAL	Being curious and embracing innovation	X

Background
Summarise Agenda items as bullet point list, to provide context
The purpose of this report is to provide Trust Board with assurance that the workstreams overseen by the MAH Inquiry and Related Workstreams Oversight Group are progressing and relevant risks and issues arising are being identified and managed. The MAH Inquiry & Related Workstreams Oversight Group comprises members of the Executive Team and the Directors with responsibility for each workstream. It was established on 02.12.2025, replacing the previous MAH Inquiry Oversight Group. At the meeting on 18.08.2026, reports from the following workstreams were considered: a) MAH Inquiry Report Recommendations – SPPG Tracker b) Liaison and engagement with patients, families, and carers c) MAH Resettlement d) Decommissioning & Closure of MAH

- e) Operation Turnstone (PSNI-led MAH 2017 CCTV Investigation) (ASG, Family Liaison)
- f) MAH 2017 CCTV HR Investigations
- g) MAH Inquiry-related correspondence, queries etc.
- h) Complex Subject Access Requests

Decisions and approvals made

Clarify any actions and next steps agreed

- Following the publication of the MAH Inquiry report on 18.06.2026, this Group's Terms of Reference is under review.
- At the meeting on 18.08.2026 there was detailed discussion of the Terms of Reference and the definition of the workstreams that will continue to report to the Group, and new workstreams that will require to be consolidated and begin to report to the Group as we move forward.
- It was agreed that additional workstreams that require consideration (in terms of which staff require to be involved and what work specifically they are required to deliver) and inclusion in the scope of this Oversight Group's remit include:
 - o *Managing requests to access CCTV* – consideration of the Trust's legal and particularly Data Protection obligations, practical implications and arrangements, and associated costs
 - o Acknowledging the BHSC's responsibilities as an employer: *Scoping staff (former and current) identified in the MAH Inquiry* – the work to consider criticisms and allegations of individuals contained in material published by the Inquiry, and steps that may help to address these (refer to update at 'Assure' section below)
 - o *Shared learning* – the establishment of an action plan to run in parallel to the regional tracking of the implementation of MAHI Report Recommendations, capturing learning that the Trust has identified in its work to manage issues related to MAH over the period 2017-present, and establishing pathways and measures to ensure this is shared and embedded, and makes a difference to patients and their outcomes, our services, and our teams
- It was also noted that a previous workstream, "DOH Oversight of Adult Safeguarding & Complaints at MAH", can be stood down, with the caveat that there is an open action on the Group's Action Log regarding open correspondence with the Department of Health on this theme. That action will be tracked and closed by the Group.
- On this basis, it was agreed the Terms of Reference requires further redrafting before it can be formally adopted by the Group. An update on this will be provided in September.

Important issues discussed

Using the 3-A Assurance Model (Alert, Advise, Assure): separate urgent issues, routine updates, and positive assurance to support decision making and assurance

Alert

Highlight matters requiring immediate attention or escalation

- **Resettlement and decommissioning:** one patient remains on the MAH site, with all Belfast Trust patients resettled. The remaining placement is subject to Judicial Review, with papers received on 11.08.2026 and affidavits being prepared. Next Court date likely November 2026.
- ID Services continue to manage the risks associated with the isolated care environment, staffing fragility, limited support services, security vulnerabilities on a largely decommissioned site, and continuing public and media sensitivity.
- **HR / criminal proceedings interface:** internal disciplinary investigations continue alongside PSNI/PPS processes. There is ongoing court activity, with former and current staff subject to criminal proceedings, cautions, convictions and pending arraignments. The Trust continues to manage patient safety, employment, regulatory, communication and reputational risks through established HR, safeguarding, legal and communications routes.
- As the criminal proceedings continue, **the acknowledged risk of divergence between outcomes secured in the criminal process and outcomes secured by Trust internal disciplinary processes is materialising.**
- HR is giving careful consideration to establishing a fair and consistent approach to next steps, where a current staff member accepts a caution or is convicted.

- **MAHI post-publication response:** the MAH Inquiry Report contains significant criticism of the Trust, including criticism of the Trust's engagement with the Inquiry process. Current mitigation relies on open and accountable communication, preparation for the September Health Committee, and prompt, transparent handling of MAHI-related correspondence, FOI and other requests.
- **Complex SARs:** the Trust continues to await the High Court decision following the most recent hearing on 15.06.2026. Delay may increase frustration among applicants awaiting records; mitigation continues through named single point of contact arrangements and written family updates. High Court decision anticipated in the autumn.

Assure

Confirm where the committee has received positive assurance

- **Liaison and engagement with patients, families, and carers:** as promised in the Trust's statement on receipt of the MAHI Report on 18.06.2026, the Chief Executive began reaching out to families in July to invite in-person meetings. More than 70 letters were issued. A process is in place to ensure responses are acknowledged and arrangements made in each case. One meeting has occurred to date, with several more scheduled in the coming weeks. Arrangements are in place to produce a reliable note of every meeting and ensure any agreed actions are captured and followed up.
- **Operation Turnstone (PSNI-led MAH 2017 CCTV Investigation) (ASG, Family Liaison):** three Family Liaison Social Work staff continue to offer support to 24 families, with 12 cases closed, five progressing to closure and 24 remaining open. Reports note that families have positively acknowledged the professionalism, care and advocacy of Family Liaison Social Workers.
- Senior managers facilitated 19 face-to-face meetings with affected patients and families between April and June 2026; the Adult Safeguarding Consultant attended all meetings and a Family Liaison Social Worker was present at each meeting to support families. An action log from the meetings is reviewed weekly at the sub-operational meeting.
- **HR oversight:** the HR dashboard tracking progress of cases continues to provide a structured basis for ongoing oversight of case progression, outcomes and risk controls.

- **MAH Inquiry-related correspondence, queries:** Considerable work has been completed in the 8 weeks since the publication of the Inquiry report, including specifically:
 - A line-by-line review of the MAHI Report (640 pages plus appendices) to extract all references to current and former staff identifiable by name, post, or MAHI cipher. Now that this is complete, it will enable the Trust to sift all references for specific criticisms, including allegations of harm, to determine whether, and if so what, further action may be needed. As noted above, this activity will be consolidated into a dedicated workstream *Scoping staff (former and current) identified in the MAH Inquiry*.
 - A first-pass draft redaction of the Corporate Warning Letter issued by MAHI to the Trust, and the Trust's letter of response. This work is being done to enable the Trust to respond to an FOI seeking disclosure of the Warning Letter. It is necessary, because the Warning Letter and the Trust's response made reference to materials disclosed to the Inquiry, or proposed for disclosure to the Inquiry but not received by it, that have not been published previously, and that include personal identifiable information relating to patients, families and carers, and former and current staff. The Trust is working hard to take an approach to responding to this FOI that is both proportionate in terms of resources dedicated to it and balances our commitment to openness and transparency with our confidentiality obligations to patients, families, and staff.

- **Complex SARs:** arrangements remain in place to provide consistent communication to affected applicants while the Trust awaits the High Court ruling.

- **Governance and reporting:** in establishing a revised Terms of Reference, this Group continues to set out a clear purpose for systematic and measurable oversight of MAH Inquiry learning and recommendations, aligned to Trust values and statutory obligations, with direct reporting to Trust Board.

Advise

Inform the receiving committee or board of matters that require awareness, but not immediate action

- **MAH Inquiry Report Recommendations – SPPG Tracker:** The Trust has provided its initial input to the SPPG Tracker which was circulated shortly after the publication of the MAHI Report, which seeks to consolidate the current position in respect of all 106 recommendations, known gaps, and potential next steps.

- While the Trust accepts the recommendations in principle, and has provided feedback in every area requested, the reality is that several recommendations will require regional discussion, Departmental direction, SPPG commissioning support and, in some areas, recurrent revenue and capital funding. These include future learning disability inpatient provision, intensive community support, restraint reduction infrastructure, workforce planning, safeguarding dashboards, CCTV policy, advocacy and aspects of Board-level governance.
- While the Trust will continue to cooperate with the SPPG in driving this regional tracker forward, it will not wait for regional progress on matters that can be addressed locally; having established the baseline position with the submission to SPPG, our next step is to develop a RAG-rated action plan and risk log to action and track progress on recommendations that we have identified are not yet implemented or require further work.
- **The next Oversight Group meeting is scheduled for 22.09.2026**, providing a further opportunity to review progress, risks and any matters requiring escalation to Trust Board.

New risks identified, including controls and mitigations discussed

Record any new risks identified or added to the risk register

No entirely new discrete corporate risk is identified in this report; however, as outlined above, the workstream updates describe several active and material risks requiring continued control and oversight.

Issues escalated or referred to another committee or group

Identify the name of the receiving forum and detail the issues escalated or referred

None at this time. However, the Group remains cognisant that:

- Matters requiring regional or Departmental direction should continue to be identified through the MAHI recommendations implementation process, particularly where recommendations sit outside the sole control of BHSCT or require regionally consistent policy, commissioning, workforce, funding or legislative decisions.
- Issues relating to the implementation of the MAHI recommendations should be aligned with the Trust's revised Integrated Governance and Assurance Framework, including the Patient Safety & Quality Committee and Social Care Committee where relevant.
- Any immediate safety, employment, legal, safeguarding or communications issues arising from Operation Turnstone, HR investigations, court proceedings, FOI or SAR

activity should continue to be escalated through the relevant executive and operational routes, with summary assurance to this Group and Trust Board.

Recommendations

Trust Board is asked to note this assurance update from the MAH Inquiry & Related Workstreams Oversight Group.

ENDS