Executive Summary – Muckamore Abbey Hospital Inquiry (June 2026)

Purpose of the Inquiry
Established following 2017 revelations of abuse at Muckamore Abbey Hospital. The Inquiry examined what happened, why it happened, and what must change, focusing on systemic failures rather than individual blame.

Key Findings
Abuse occurred including physical, emotional abuse and neglect. While not all staff were involved, systemic failures enabled harm to persist.

Vulnerability of Patients
Patients were highly vulnerable, many non-verbal with learning disabilities or autism, leading to significant power imbalance.

Systemic Failures
Failures in staffing, governance, safeguarding, training and oversight created an environment where poor practice was not challenged.

Failure to Recognise Warning Signs
Long-standing warning signs such as complaints, violence and staffing shortages were not connected or escalated.

Role of CCTV
CCTV footage in 2017 exposed abuse occurring openly and triggered safeguarding responses and the public inquiry.

Culture
A culture of normalisation of poor practice developed, with lack of challenge and reduced accountability.

Impact on Patients and Families
Patients experienced distress and harm; families suffered trauma and loss of trust in services.

Conclusions
The Inquiry found a fundamental system failure involving leadership, governance and organisational culture.

Purpose of Recommendations
106 recommendations aim to address systemic issues through measurable, achievable and time-bound actions.

Final Message
Urgent system reform is required to ensure safety, dignity and prevent recurrence of such failures.