TONY M'GLEENAN

You have been commissioned by the Human Rights Commission to look at death in hospitals here what exactly was your remit and what exactly have you come up with.

Well the Human Rights Commission were interested in seeing whether or not our current system of looking at health care fatalities complied with human rights obligations and those are international human rights obligations and also the new domestic law in human rights under the Human Rights Act 1998 does the investigation process that we have adequately measure up to the requirements of the law that's what the Commission wanted to know and that's what I have been exploring.

And does it.

Well in short the requirement imposed on the State whenever there has been a fatality in which they have been involved is to hold a prompt public effective and independent investigation and it must adequately involve the next of kin in that process that's the bench mark standard and what I have done is I have explored and examined the existing investigation mechanisms to see does it comply with that is it prompt is it effective are the public involved are the family involved and does it effectively lead to accountability in the event of an accident.

And what is the answer you come up with.

Well if we look in the rounded the different means that are existing for investigation health care fatalities you'll see that ultimately in my view they fall short of the requirements of Article 2 of the European Convention of Human Rights and the Human Rights Act.

So that's what we're saying what really we're saying here is if someone dies in hospital there is an obligation on the hospital and the authorities to carry out a prompt investigation open and independent and in our hospitals today that is not happening I mean lets look first of all at the hospital the hospital would say that it carries out immediate internal review if we look at that what is that how is that constituted and does how far short of Article 2 does that fall.

Well when there is a health care fatality in a hospital setting there are two investigations which can take place an internal clinical audit where the clinicians involved will get together and discuss the outcome of the particular case which is laudable in itself however its plainly not independent in that those individuals work for the hospital there in the institution its not public there's no involvement with the public the next of kin are clearly not involved they're not part of the audit meeting therefore it falls short on a number of grounds so while clinical audit may identify errors it doesn't have the degree of public accountability which the law now requires. The second mechanism which may be triggered in the case of a fatality would be an internal review held by the Chief Executive the Medical Director and again that may involve some expert independent report being commissioned once again that's institutional the Chief Executive is inducting internal enquiry there's no external oversight no objectivity there necessarily and again the family members aren't involved the public aren't involved and it will not necessarily happen unless the family make a complaint so no complaint no investigation in many cases.

So when a hospital tells a family they have lost a relative that a full investigation will be carried out what does that actually mean.

Well it may mean a number of things but the fullest investigation that a hospital will carry out internally is the internal Chief Executives review which may or may not involve an external report being commissioned but beyond that essentially there's no external accountability involved there the hospital investigates itself and it may find itself to have fallen short or it may not but ultimately if it finds that there has been no error the family members may not necessarily have any other means of redress.

Its quite clear that the Chief Executive in this instance has a vested interest in the outcome of that internal enquiry has he not.

Well that's why we go back to basic Human Rights Law principles. Article 2 says it must be independent because the importance of independency is that in order to identify individual errors or more important systems failures you have to have an external body scrutinizing the incident in question and while Chief Executives in most cases will no doubt be acting in good faith they for understandable institutional reasons may not make those findings of individual error or systems failure and that's a flaw.

What's it say about the culture that is presently within our hospitals about the level of investigation and enquiry after a death.

Well currently we've got a peace meeting provision and the obligation to have proper investigations is an obligation on the State not necessarily on the Trust or the Chief Executive so it's a rather patchy provision and what we would need I think following the introduction of the Human Rights Act is a coherent system of investigating hospital fatalities so that we can find out what the individual errors were and what the systems failures were and that's important from the public point of view to ensure that they're not repeated it will help the families of course to cope with their bereavement but critically there's a public interest in making sure these things don't happen again.

So is the public interest level not being met at the moment.

Well currently we don't have a systematic means of looking at all these fatalities it doesn't exist we have a random process which is dependant on the initiative of family members making complaints its depending on the good faith of junior members of the hospital staff rising issues which are perhaps uncomfortable but there is no automatic requirement for a hospital fatality to be thoroughly and effectively investigated if there was I think we may well have some answers for some people who have lost loved ones but importantly also we may well prevent other adverse outcomes other incidents which may kill or may lead to very serious illness on the part of patients.

So when the Health Authority say that there are a number of measures in place and clinical governs and national patients and various schemes and what is in place are any of those things actually in place that if something happens in a hospital that is automatically triggered at the moment.

Well critically in the event of a hospital fatality that's say it's a surgical fatality the working practice is that's referred to the Coroner within 24 hours but there's no statutory requirement for that to happen and if the hospital doctors persuade the Coroner that there is no need for a further investigation and if the family members don't actually complain then there will necessarily be no any follow up at all so its possible that in a controversial circumstance where there is no initiative taken by the family that there is no investigation.

That's quite incredible do you think the public are aware that is presently the status quo here that there isn't any proper examination even though hospitals may tell us there's investigations and reviews that are taking place.

Well this issue has been scrutinized closely because of things like the Bristol heart enquiry and because of the Shipman enquiry in England and Wales and very important recommendations have been made as a consequence of those investigations which might have raised the public awareness but I think the important question is are the recommendations following Shipman following Bristol will they be implemented here in Northern Ireland.

Because they are not at the moment.

Currently we don't have exactly the same provision as in England and Wales and its difficult to see what the justification is for a difference in this part of the United Kingdom but defects have been identified elsewhere important defects and remedies have been suggested and it would seem plain that those remedies should be implemented in this jurisdiction also.

If we could address the Coroner system particularly now the authorities would see that a full investigation into a death in a hospital will have taken place in the Coroner where does the Coroner system Court system here in Northern Ireland actually fall short.

Well not all cases go to the Coroner if there is a hospital fatality you may have a hospital post-mortem to determine the cause of death you may have a Coroners post-mortem that happens if the hospital authorities contact a Coroner and the cause of death triggers him to hold that post-mortem but he has a discretion to do that and he may decide that a post-mortem shouldn't be held and if the post-mortem isn't held when then clearly that aspect of the case is never investigated alternatively the Coroner has a discretion having held the post-mortem to have an inquest it doesn't follow just because you have post-mortem that you have an inquest so there may be cases where there is some degree of controversy the post-mortem is held but the matter does not progress any further because cause of death has been identified so that discretion which the Coroner has may be problematic so its not automatically the case that a controversial death will lead to a full Coroners inquest.

If we're also relent on the evidence and the testimony of the hospital is there a culture within Northern Ireland particular when you look at this that information sometimes isn't assimilated in the proper matter or for whatever reason.

Well if we get to the situation where the Coroner is examining one of these cases the critical issue is the death certification process because we need to see what's on a death certificate to see what the cause of death was now the death certification process has been closely scrutinized following the Shipman case and recommendations have been made that that has to be overhauled because there's too much pressure on an individual doctor to certify the cause of death and there's too much scope for concealment of the case of death that's clear from Shipman that process is pivotal in triggering the investigation that follows so we need to have our death certification process reviewed in exactly the same way as in England and Wales.

Because if that isn't right I mean everything else can fall down and that's the point you're making.

Everything follows from the death certification process if the cause of death identified is innocuous on the certificate then it won't trigger any investigation and there is no other mechanism for scrutinizing that innocuous cause of death it may be the case that there is some other underlying cause no identified or that there is some neglect or failure or systems problem and it ought to have been identified that may not appear on the certificate and if it doesn't appear well it will never be challenged and never be followed up and the difficulty of course is that the error could be repeated at an individual or at systems level.

One of the difficulties that many people watching this would have difficulty grappling with is that we've known about the Human Rights Act for sometime now since 1998 and yet here we are sitting 6 years later and the Department of Health has not been addressing some of these issues has there been a reluctance upon the authorities not to address this and if so why.

Well I think the Human Rights Law which I'm talking about Article 2 has commonly been thought about as a politicized issue often dealing with shoot to kill cases and controversial deaths at the hands of Security Forces but the crucial point is this the principles developed out of that area of law are applicable to any public authority not the Police or the Military they're applicable to the health care professions to our hospitals and our Trusts they are public authorities and they must hold proper investigations where there has been a death which they have been involved in and perhaps that's something that hasn't been fully understood but certainly that is something that my report to the Human Rights Commission directly addresses.

They have been very slow to pick up on this haven't they.
Yes there's been some emerging case law on these points in England and Wales there's been very little here in Northern Ireland but it can't be argued against I think we now have a new standard against which we must measure the investigation process in these controversial cases. My view is currently we're falling short in a number of critical areas.

Which of the critical areas that you've mentioned surprised you most we you actually looked at how hospital deaths are looked at.

Well the reliance on internal review mechanisms is understandable in one sense because that's what a Trust will do when a criticism is leveled against it but the fact that an investigation can stop at that internal level even in a very controversial case strikes me as out of step with our understanding of what the State should do in the case of a controversial death there has to be some open and objective scrutiny of a controversial fatality whatever sphere of public life we're talking about but particularly in the hospital sector you to have something more than an internal review and I think that's a matter that has been addressed in England and Wales and needs to be addressed in here Northern Ireland.

The concern sometime that's thrown up about a blame game that they were attaching blame to doctors and having attached that is that something that has been dealt with properly in England and Wales and what has been put in place in order to resist that or what how has that been opened up to scrutiny.

Well I think its important to consider hospital fatalities can occur because of natural causes they can occur because of individual error or neglect on the part of a clinician or they can be caused by a systems failure and the most important of those to investigate I think is the systems failure individual errors will always happen and we've got the Civil Law to deal with that the Law of Negligence but system errors may not be picked up in that way but Trusts and those hospitals with inside knowledge can clearly identify them and its in their interests as well as the public interest to ensure that those sorts of systems errors are not repeated because not only will they cause fatalities they'll also cause significant injuries to other persons so there's no rational economic argument as I can see it for not investigating systems failures that's something that's been identified elsewhere in the United Kingdom recommendations have been put in place and I think that they ought to be extended to this jurisdiction.

One of the problems that Trust would say I would say we were speaking to the Chief Executive of Trust in Northern Ireland he would say that the problem is for him that when he is carrying out an internal review or investigation and the family involved have gone through the complaints process maybe got the answers that they want and then suddenly resort to litigation at that stage there's very little he can do in that I'm snared in a litigation we have to hand it over to the lawyers.

Well understandable again in some circumstances families who are frustrated by the whole process will resort to the Courts will resort to a negligence action the problem with that is that doesn't comply with our Article 2 Obligations under the Human Rights Act the difficulty is this you may have a Civil Action in the High Court looking at a fatality but it will not necessarily give you the answers which you need to find out about why the death occurred if it is a very controversial case then there may be an incentive on the Trust to settle the case within having a factual investigation in other words we'll never find out why the death occurred. What will happen is the case may be settled or there will be an argument about he value of compensation but there won't be an investigation about what actually occurred so that process of Civil Litigation doesn't answer the crucial questions why did they death happen and how can we avoid it recurring again.

Another specific point inside that is the complaints procedure how good is the complaints procedure and whenever somebody goes to the hospital and complains about something that's happened to either himself or herself or a member of the family how is that handled by the Trust at this point and is it any way above average never mind reaching the proper threshold.

Well if you have a complaints procedure it may well trigger an internal review or an internal investigation that runs into the same problem its not open its not transparent its not objective and its not independent it may find some important information about why the death occurred it may make important recommendations but the fundamental flaw is the lack of independence it cannot be said that a Trust investigating itself and coming up with a recommendation is an independent body, it may be acting in good faith, they may conduct perfectly laudable review but it falls short on that heading then it doesn't comply with International standards which we now have in our own domestic law.

Finally Tony what labor of responsibility has to lie within the Health Department here and whether it's the Chief Medical Officer or the Health Minister but are there reporting systems in place now in Northern Ireland now that if there is an untoward event a death a near miss that that is properly reported through the structures and that someone can spot it identify it and carry out an investigation.

Well where does the investigation take place if it takes place at all it will take place in the Coroners inquest and the critical issue there is, is there a feedback mechanism from the Coroners inquest to the Department of Health to ensure that a defect is remedied and the answer to that is no. The Coroner has the power to make a referral to the appropriate professional body he may send the case to the GMC for example but it doesn't necessarily go back to the Department of Health the loop isn't necessarily closed so a Coroner can identify a critical failing and a critical weakness but he's limited in what he or she can do the matter may be sent to the professional bodies but they don't have to come back to him even though he's identified something that may cause fatality elsewhere that may move on to another public body but the loop is not necessarily closed.

They'll got a lot of informal structures but we have absolutely nothing formally in place in Northern Ireland today to ensure that that loop is closed and whatever occurs inside a hospital.

Exactly and if we look at the whole point of Article 2 and Human Rights law the point of it is to ensure that States prevent a repeat of a situation that leads to a loss of life that's the overall thrust of the case law from Strasburg and if we implemented the spirit of that then what we would do I imagine is ensure that if there was a health care fatality here in Northern Ireland we would do everything in the power of the public authorities to prevent it being repeated.

The Coroner system and what you need to do is being identified elsewhere and what must happen is that the Coroner who's legally qualified is assisted by a medically qualified expert who will scrutinized the notes and records in the case of a fatality because post-mortems are one thing they tell you what the cause of death was but looking at the notes and records tells you what the circumstances in the background where and that may show you that there's some serious problem.

And that is in place in .....

.....have been recommended for England and Wales yeah and they're coming in under the loose review.

Tony if we look at the Coroner system and the defects in it at this point in time what exactly have others who have looked at their Coroner systems particularly in England and Wales what solutions have they come up to that and how have to embolden the system of Coroners course.

Well Coroners have discharged their functions admirable here in Northern Ireland but they are legally qualified individuals who can apply the law to determine how a death occurred what's missing from the Coroners system is the assistance of a medically qualified expert now a medically qualified expert in the case of a hospital fatality perform a crucial function by examining the clinical notes and records around the time of the death they can assist and add a piece of information additional to the post-mortem the post-mortem will tell you what the cause of the death was but looking at the notes and records will tell you what the circumstances were surrounding that death and if you scrutinize those you may well find that there has been a systems failure individual error or neglect which has caused a death even if there is a benign post-mortem its been recommended in England and Wales that they have a Statutory Medical Assessor who performs that function and that person would be medically qualified and would assist the Coroner and if that recommendation were implemented in Northern Ireland then we may well be able to prevent an recurrence of avoidable medical fatalities.

What we're talking about here first of all how would that just explain to me again exactly that would be triggered how would a medical assessor be brought in who would call in the medical assessor and what in your view should his or her powers be once he gets into hospital.

Well the medical expert should always be involved where there is a hospital fatality where there has been a surgical fatality or an unexpected death which leads to a complaint from a family member those would be trigger factors which would mean that the medical expert would take possession of the clinical notes and records and the nursing notes and scrutinize them to see whether or not there's need for a fuller Coroners investigation or an inquest even if the post-mortem suggests that there shouldn't be so if you have those trigger factors then the medical expert becomes involved and ultimately assists the Coroner in exercising his discretion as to whether or not a full investigation should be held.

One final question in Shipman as a result of Shipman there was a specific recommendation on dehydration appearing on a death certificate what was that and what was the ramifications of that.

The Shipman review indicated that the death certification process is flawed because it permits the concealment for good reasons or for bad reasons of the cause of death in some circumstances and the recommendations have been made to overhaul the certification process there are certain indicators on a death certificate which would suggest a further investigation should follow if for example a death certificate records dehydration and nothing more that would indicate that there may have been neglect particularly if the death occurred in a hospital situation and that an investigation should follow so there are certain triggers even in the current death certificate process which ought to suggest this is a case that requires closer scrutiny.

And the obligation falls on whom to trigger that once they see something like dehydration on a death certificate.

Well the death certificate is completed by the hospital doctors involved but that certificate goes ultimately to the Registrar of Deaths and they again have function to scrutinize the cause of death in those circumstances and the Shipman enquiry by Dame Janet Smith has been critical of this process because a cause of death can be entered on the death certificate and it may never be checked there may be no further scrutiny the Registrar will have no medical qualification and won't look behind it so that's seen as a fundamental flaw in the current process and the Shipman review recommends change and there will be no reason I think for withholding that kind of change here in Northern Ireland.