E-mail Message

From:	Dillon, Anne [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=IHRDADILLON]
To:	Rodgers, Catherine [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=[redacted]
Cc:	Conlon, Bernie (IHRD) [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=[redacted], Anderson, James [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=Ihrd-andersonj]
Sent:	10/06/2013 at 12:10
Received:	10/06/2013 at 12:10
Subject:	Document Request
Attachments:	Pages from WS-062-1.pdf

Dear Catherine

Attached above is a witness statement made by Mr Clive Gowdy in 2005. At page 4 he refers to a “survey provided each of the organisations with an assessment of their position against the average performance on each of the factors.”
I would be grateful if you would provide the Inquiry with a copy of this survey within 10 days.
Many thanks
Anne

Anne Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
41 Arthur Street
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Witness Statement Ref. No. 062/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Clive Gowdy

Title: Mr

Present position and department/employer:

Permanent Secretary, Department of Health, Social Services and Public Safety

Length of time in post: 8 Years 3 Months

Previous position and department/employer in 1995:

Director of Personnel for the Northern Ireland Civil Service ("NICS")

Central Personnel Group, Department of Finance and Personnel

Previous position and department/employer in 2000:

Permanent Secretary

Department of Health, Social Services and Public Safety

Previous position and department/employer in 2001:

Permanent Secretary

Department of Health, Social Services and Public Safety

Membership of Professionals Bodies:

Companion of the Institute of Healthcare Managers

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

a) Adam Strain – I first became aware of his death in October 2004 around the time of the UTV Insight programme.
b) Lucy Crawford – I became aware of her death in February 2004. I was alerted to the circumstances by the Deputy Chief Medical Officer, Dr Ian Carson, at a meeting of the Departmental Board (004-019-236) and I subsequently read the reports of the Inquest.
c) Raychel Ferguson – I do not have a clear recollection of when I first became aware of her death. I believe that it was shortly after I learned of the circumstances of Lucy's death.

(ii) With whom did you discuss their deaths, when and for what purpose?

I discussed the circumstances of the deaths with colleagues in the Department – particularly the Chief Medical Officer ("CMO") and her colleagues, Dr Carson and Dr McCarthy - in the aftermath of the Lucy Crawford Inquest and in the light of the media comments over subsequent months. My purpose was to find out more about the circumstances of the deaths, to learn more about hyponatraemia and to review the action which had been or which needed to be taken on foot of these deaths.

(iii) What steps did you take to ensure that the DHSSPS discovered the cause of death of each child?

At the time when I learned of the deaths, the cause of death had been determined by the Coroner on foot of the Inquests already held.

Particular areas of interest (Cont'd)

(iv) What steps were taken by your staff to ensure that the appropriate directorates and persons were consulted and involved in the process of ascertaining what happened and ensuring that so far as possible lessons would be learned?

From my discussions with the CMO and her staff, I was satisfied that she and her staff were aware of the circumstances of the deaths and that they had considered the action that should be taken. I was aware that they had concluded that guidance on hyponatraemia was needed and that they had consulted widely with relevant medical professionals in taking the necessary action to develop guidelines on hyponatraemia. I was also aware that the guidance they had drawn up had been issued to all relevant parties across the HPSS.

(v) What was the system in place in Northern Ireland at the time of Adam Strain's death in 1995 for reporting untoward deaths to the DHSSPS and disseminating information on the outcomes of Coroners' Inquests within the Health Service?

I was not in the Department in 1995 and cannot give a first hand account of the system in place at that time. However, I am aware that there was no formal reporting requirement to the Department for untoward deaths. This was consistent with the basis on which Health and Social Services Trusts had been established in the 1990s. As set out in the circular METL 2/93 (copy attached) issued to the HPSS in October 1993 by the then Management Executive (a part of the then Department of Health and Social Services), the Trusts were intended to operate with maximum operational freedom and autonomy.

There were, however, some national reporting systems for deaths in the UK. These included the Confidential Enquiry into Maternal Deaths, the Confidential Enquiry into Stillbirths and Deaths in Infancy and the Confidential Enquiry into Perioperative Deaths. There was also a Yellow Card System, which was operated by the UK Committee on Safety of Medicines. This system required all incidents relating to adverse effects of medicines to be reported to the Committee. I understand that the death of Raychel Ferguson was reported under this system in 2001.

There were only two formal requirements in relation to the reporting of adverse incidents affecting patients to the Department in Northern Ireland at this time. One was in respect of adverse incidents and reactions and defective products relating to medical and non-medical equipment and supplies, food, buildings and plant, which had to be reported to the then Northern Ireland Defect and Investigation Centre in the HPSS Management Executive (Circular PEL (93) 36 – copy attached). The other was in relation to the notification of untoward events in psychiatric and special care hospitals, which required notification to the Department of all untoward events (unauthorised absences, accidents and sudden, unexpected or unnatural deaths) involving patients in pyschiatric or special care hospitals (Circular HSS4 (CS) 1/73 – copy attached).

I understand that the outcomes of Coroners' Inquests were not routinely notified to the Department or circulated to the HPSS.

(vi) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (v) above and in ensuring that lessons learned would be fed into teaching/training and the care of patients?

I was not in the Department in 1995 and cannot provide first hand information on this matter. However, I am aware that the Department had no role in determining the content of the training provided to medical and nursing staff. The universities are responsible for the content of their courses and the Royal Colleges are responsible for the training of junior doctors. It is also the case that the General Medical Council is responsible under the Medical Act 1983 for monitoring the content and quality of the medical education provided by Medical Schools across the UK.

Particular areas of interest (Cont'd)

(vii) What procedures existed in 1995 to ensure the fulfilling of roles relating to the reporting, analysing, disseminating of information from a Coroner's Inquest or untoward death and to ensure that lessons would be learned?

I was not in the Department in 1995 and cannot provide first hand information on this matter. I am aware that the role of the Department was to act as a facilitator for the effective operation of the HPSS. This included developing and disseminating any guidance or directions which needed to be issued to the HPSS to address any problems or concerns of which the Department was aware. I understand, however, that there were no formal mechanisms for reporting, analysing or disseminating information from a Coroner's Inquest or untoward death.

(viii) With reference to the queries at (v) to (vii) above, what was the situation in 2000 and 2001 respectively?

In both 2000 and 2001, apart from the arrangements at paragraph (v) above, there was no formal system for reporting untoward deaths to the Department or disseminating information on the outcome of Coroners' Inquests.

In December 1998 the Department commissioned Healthcare Risk Resources International consultants to undertake a survey of risk management in all HPSS organisations. The terms of reference for the survey were to determine the level of application of risk management methods and the implementation of best risk management practices within these organisations. Incident reporting was one of the items included in the survey. When the consultants reported in 1999, they concluded that there was a good level of awareness of the need to develop rigorous systems for risk management and a good level of compliance with the requirements for risk management. However, there was a general perception that there might have been a significant level of under-reporting of adverse incidents. The survey provided each of the organisations with an assessment of their position against the average performance on each of the factors covered in the survey. The Department also initiated work on the development of a regional risk management strategy.

In relation to the wider reporting systems referred to in (v) above, the Northern Ireland Defect and Investigation Centre became the Northern Ireland Adverse Incident Centre in November 2000 and in 1997 Northern Ireland data began to be included in the UK Confidential Enquiry into Suicide and Homicide.

During this period, considerable work was undertaken in both the NHS and HPSS on the issues of patient safety and the standards of performance. Throughout the UK, there was a growing recognition of the significance of these issues. In England, the CMO published the document "An Organisation with a Memory" in May 2000, followed by the Department of Health document "Building a Safer NHS for Patients" in April 2001. Two major Inquiry reports were published in England which had a significant impact on how adverse incidents were viewed. These were the Royal Liverpool Children's Inquiry Report in January 2001 and the Bristol Royal Infirmary Inquiry Report in July 2001.

In Northern Ireland, the Department published "Confidence in the Future – for Patients and for Doctors" in October 2000, a consultation document dealing with the prevention, recognition and management of poor performance by doctors. In April 2001, the Department published the consultation document "Best Practice, Best Care", which was a major policy paper setting out proposals for improving the quality and standards within the HPSS and giving recognition to the need for more effective arrangements for monitoring adverse incidents.

(ix) With reference to the queries at (v) to (vii) above, what is the situation now?

As indicated above, the Department has taken a concerted policy approach to the development of soundly based governance and risk management arrangements to improve and protect patient safety and the Departmental Board has exercised leadership on these matters through its deliberations on a continuing basis. (Extracts of minutes of meetings of 29 June 2001, 28 September 2001, 27 March 2002, 31 May 2002, 27 September 2002, 31 January 2003, 9 May 2003, 27 June 2003, 29 August 2003, 28 November 2003, 27 February 2004, 22 October 2004, 12 November 2004, 14 January 2005, 28 January 2005 and 29 April 2005 attached.)

In March 2002, the Departmental Board decided to adopt a common model of risk management for the Department and all of its associated bodies, including the HPSS. The Australia/New Zealand model of risk management, which was already in use in the NHS in England, was adopted and promulgated to the HPSS through the circulars on Corporate Governance and the Statement of Internal Control (HSS(PPM) 3/2002 and AS/NZS 4360: 1999 – Risk Management (HSS (PPM) 6/2002) – copies attached).

In February 2003, the Department issued guidelines to the HPSS on the implementation of clinical and social care governance (Circular HSS(PPM) 10/2002 – copy attached). These stressed the importance of organisations taking corporate responsibility for performance and for providing the highest possible standard of clinical and social care. The circular also placed an emphasis on adverse incident management.

In April 2003, the statutory duty of quality on HPSS organisations came into effect and core risk management standards were introduced as part of the establishment of controls assurance standards across the HPSS. These arrangements also emphasised the need for an adverse incident reporting system to be in operation and the Risk Management Controls Assurance Standard includes a specific criterion on adverse incidents which requires "an agreed process for reporting, managing, analysing and learning from adverse incidents" to be in place.

The Department subsequently commissioned a report from the consultants, Deloitte, on adverse incident and near miss reporting across the HPSS and their report in March 2004 (copy attached) concluded that there was a lack of uniformity in incident reporting and management. The Department then issued a circular on the reporting and follow-up on serious adverse incidents in July 2004 (HSS (PPM) 6/04 – copy attached). This circular defined an adverse incident and placed the responsibility on senior managers to report those incidents of a sufficiently serious nature to warrant regional action, to be of public concern or to require independent review to the Department within 72 hours of the incident being discovered. The circular also provided that the Department would provide analysis on such incidents to the HPSS as a whole where relevant.

The Department appointed a Clinical and Social Care Governance Support Team in 2004. The work of the team is designed to support and encourage the full and effective implementation of the statutory duty of quality across the HPSS. The team have organised two Incident Investigation Workshops for the HPSS in 2005. These have focused on the current experience in dealing with adverse incidents and will help in the ongoing development work on the quality and patient safety agenda.

Under the aegis of "Best Practice, Best Care" a new HPSS Regulation and Improvement Authority has been established and has formally come in existence in April 2005. It will have an important role in relation to the inspection and investigation of the performance in HPSS organisations.

The Department has also connected into the work going on in England on these issues. A service level

agreement is currently being negotiated with the National Patient Safety Agency which will enable Northern Ireland to share the benefits of the work being done by the Agency. The Agency was established in July 2001 to learn from patient safety incidents occurring in the NHS. The Agency has been developing a National Reporting and Learning System (NRLS) which was rolled out at the end of 2004. It is a major healthcare incident data collection and will allow large scale analysis of incidents and their effects on patient safety.

Particular areas of interest (Cont'd)

(x) Explain in detail the relevant Policies, Guidelines, Protocols and Codes of Practice issued by the DHSSPS from 1995 to 2001 relating to the handling of complaints within the Health Service in Northern Ireland, including those by medical or nursing staff.

The Northern Ireland Health and Personal Social Services Charter for Patients and Clients issued in March 1992 (copy attached) set out the Government's commitment to the provision of quality services and indicated the rights and guarantees which were being introduced in relation to those services. The Charter also advised of the arrangements in place in Boards and Trusts to deal with complaints.

These arrangements were in force in 1995 and required all HPSS organisations to have clear procedures for dealing with complaints. In particular they were required to publicise the name, address and telephone number for a senior officer responsible for handling complaints and to make the necessary information available to all patients and clients. The complaint would be conducted in full by the complaints officer, who would provide the complainant with a written report explaining what went wrong and describing the action being taken. If the complainant was still dissatisfied, there was scope for the matter to be raised sequentially with the Chairman or General Manager of the Board and with the Chief Executive of the Management Executive in the Department. There was also scope for the complaint to be raised at any stage with the Commissioner for Complaints.

There were also special arrangements for dealing with complaints about, inter alia, the clinical judgement of hospital medical and nursing staff.

In March 1995, the Department published "Acting on Complaints", which set out the HPSS response to the work undertaken by Professor Alan Wilson, who published "Being Heard", a report on NHS complaints procedures (but which also embraced the HPSS in NI), in 1994. (Copy attached.)

In March 1996, Professor Wilson published "Guidance on Implementation of the HPSS Complaints Procedure". This document provided advice on how the policy objectives of "Acting on Complaints" were to be achieved.

In April 1996, a number of Directions were introduced under the Health and Personal Social Services Complaints Procedures Directions (Northern Ireland) 1996. Guidance was also issued in March 1996 in the publication "Complaints : Listening .... Acting ..... Improving" (copy attached). Together these introduced a mandatory framework for the HPSS Complaints Procedure and, as described in the published document, set out detailed arrangements to be implemented by all HSS Boards and Trusts.

These arrangements were further refined in the document "Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services" which was published in April 2000 (copy attached).

In 2002, as part of the wider quality agenda, the Department initiated a review of the HPSS Complaints Procedure. A Regional Complaints Review Group was set up to consider the issues emerging from the UK national evaluation of complaints and to draft a framework of proposals to improve the HPSS complaints procedure. As the Group undertook its work, it had to take account of some major emerging issues, including the Shipman Inquiry, the proposals for reorganisation within the Review of Public Administration and the establishment of the HPSS Regulation and Improvement Authority. A draft HPSS Complaints Procedure Consultation Paper has been prepared and it is hoped to publish it for consultation in September 2005.

These complaints procedures were designed primarily for complaints from patients and clients. In February 1996, Circular HSS(GEN1) 1/96 (copy attached) was issued with a document "Guidance for Staff on Relations with the Public and the Media". It was designed to encourage a climate of openness and dialogue within the HPSS so that staff could freely express their concerns to their managers as a means of contributing to the improvement of services.

In October 1999, the Public Interest Disclosure (Northern Ireland) Order 1998 became law. Circular HSS(GEN1) 1/2000 (copy attached) was issued to the HPSS to draw attention to the provisions of this legislation. These so-

called "whistleblowing" arrangements provided for staff to be able to raise concerns about health and social care matters in a responsible way without fear of victimisation and required all HPSS organisations to have local policies and procedures in place to give effect to these arrangements.

In relation to concerns about the performance of doctors, the role of the General Medical Council provides for complaints about a doctor's competence or fitness to practise to be referred to the Fitness to Practice Committee. It is also the case that the HPSS arrangements for dealing with complaints set out in the 1995 document "Acting on Complaints" provide principles which, while primarily focused on complaints by patients and clients, are equally applicable to complaints and concerns from healthcare professionals.

In 1994, the then CMO in England chaired a group to review the guidance and procedures relating to complaints and concerns about doctors whose performance appears to fall below acceptable standard. The final report of this group "Maintaining Medical Excellence" was issued to the HPSS by the Northern Ireland CMO in August 1995, with a covering letter underlining the professional responsibility of individual clinicians in the monitoring of standards. In November 1995, the GMC were given new powers to deal with doctors' performance. The Medical (Professional Performance) Act enabled the GMC to introduce new professional performance procedures and extended the GMC's existing powers to impose interim suspension or interim conditions pending a full hearing of a competence or conduct case. These new procedures came into effect in 1997.

Following the response from the profession to "Maintaining Medical Excellence", the CMO in England asked representatives of the medical profession and NHS employers to suggest how the report's recommendations might be taken forward. The group's conclusions were circulated to the HPSS by the Northern Ireland CMO under cover of a letter, HSS(MD) 3/97 in January 1997 (copy attached) asking that the agreed arrangements be put into effect in Northern Ireland.

In October 1998, the Government announced that it would be reviewing the suspensions procedures for hospital and community medical and dental staff. The CMO in England issued a consultation paper in November 1999, "Supporting Doctors, Protecting Patients" setting out a wide range of new proposals to assist with the prevention, early recognition and improved management of poor clinical performance of doctors. To address similar issues in Northern Ireland, the Department issued the consultation document "Confidence in the Future – for Patients and for Doctors" in October 2000.

(xi) What amendments have been made to those Policies, Guidelines, Protocols or Codes of Practice since 2001?

With the increasing emphasis on the importance of effective governance across the HPSS, this has been an area of continual development in recent years. Actions designed to address the prevention, detection and management of underperformance by doctors were published in May 2002. In addition, new arrangements to support clinical and social care governance came into effect on 1 April 2003, following publication of the policy document "Best Practice, Best Care". A service level agreement has been struck with the National Clinical Assessment Service in England, extending its services of advice, support and assessment of clinical competence to Northern Ireland.

As referred to above, the Department initiated a review of the HPSS Complaints Procedure in 2002 designed to draft a framework of proposals to improve the current complaints procedures and to oversee the content of any new guidelines issued. That review has had to take account of a number of emerging developments and it is intended to publish a consultation document in September 2005.

(xii) What system is in place to ensure that Health Boards and Trusts have a satisfactory complaints system, which provides a fair and accessible route for the concerns of patients and their families about treatment to be addressed?

All HSS Boards and Trusts are required to implement the policy framework for handling complaints set out in the various letters and papers issued by the Department (as described above). These documents stipulate the obligations which these organisations must meet for effective handling of complaints and provide for a fair and accessible system.

Particular areas of interest (Cont'd)

(xiii) What are the procedures in the DHSSPS, Hospital Trusts and Health Boards to handle concerns raised by any person or persons within the hospitals, Boards and Trusts about the running of the health service?

The Department and the HSS Boards and Trusts fully implement the requirements of the Public Interest Disclosure (Northern Ireland) Order 1998. All have "whistleblowing" policies in place and ensure that their staff are aware of these policies and of their personal responsibilities for raising any concerns in a reasonable and responsible way.

(xiv) In your role as a member of the Departmental Board, explain what information you received or solicited about the procedures, investigations and events that followed the deaths of Adam, Lucy and Raychel.

The Departmental Board had a report from the Deputy Chief Medical Officer at its meeting on 27 February 2004 (004-019-236) on the Inquest into the death of Lucy Crawford. There was also a report on the media coverage of the death at the meeting on 28 May 2004 (004-020-238). As indicated above, I discussed the issues related to the deaths of Lucy Crawford and Raychel Ferguson with the CMO and her staff - these discussions took place outside the format of the Departmental Board.

Particular areas of interest (Cont'd)

(xv) Again in your role as a member of the Departmental Board, explain what steps you took to discover why the children died and to ensure that any lessons would be learned.

As above. In addition, following the information portrayed in the UTV Insight programme "When Hospitals Kill", I raised the matter at the Departmental Board meeting of 22 October 2004 (copy of extract of minutes of meeting attached) and there was a discussion of the need for an independent investigation of all of the issues and allegations raised by the programme. This was subsequently discussed and agreed with the Minister and the present Inquiry was established.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

It is important to understand the accountability arrangements across the HPSS.

The Department is responsible for carrying out the wishes of Ministers. Its primary functions are in relation to the formulation and implementation of policy and legislation and the allocation of resources. Apart from providing IT and estates services to the HPSS, the Department has no direct operational responsibilities in relation to the HPSS. The Department sets the framework, priorities and targets within which the HPSS must operate and maintains a high level overview of the performance of the HPSS. As appropriate, the Department issues guidance and direction to the HPSS and ensures that there are effective governance systems in place in the HPSS organisations.

The Boards act as the planners and commissioners of health and social services for the population of their areas. The Department allocates funds to the Boards to meet the cost of providing these services and the Boards in turn use this money to fund Trusts for the services they have agreed to provide. The Boards work in close collaboration with the Trusts on these issues.

The Trusts are the providers of services and are the employers of the professional and administrative staff who work in the hospitals and social care facilities. They are directly responsible for the operation of these services and for the quality of the service delivery. There is a statutory duty of quality on all Trusts. Governance within Trusts is the responsibility of the Board of the Trust. Each Board is made up of a Chair and Non-Executive Directors, who are appointed by the Minister through the public appointments process, and the Executive Directors who sit on the Board on an ex officio basis.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: D. b. Lynch **Dated:** 6 July 2005