Mrs Rosemary Todd
Head of Litigation
Departmental Solicitors Office
2nd Floor
Centre House
Chichester Street
BELFAST
BT1 4JE

Your Ref: NSCB04/1
NSCW50/1
NSCS071/1

Our Ref: AD-0614-13

Date: 5th August 2013

Dear Mrs Todd,

Re "Department and Additional Governance Matters" Segment

The public hearings in this Inquiry are moving towards the final segment dealing with the role of the DHSSPS and additional governance matters.

Some of the evidence presented to date has raised concerns about certain events and how they were handled between the mid 1990s and the early 2000s when governance was significantly less developed than it is now. It has been suggested on a number of occasions that hospital governance has changed a lot (and for the better) during the last decade. Some evidence to that effect has already been provided by witnesses such as Dr McBride in explaining how the Royal Trust handled Claire's case when it was raised by Mr. and Mrs. Roberts in 2004 after the UTV documentary. The Chairman has been urged to judge the actions of the relevant institutions and individuals by the standards of the time rather than by current standards. While this will be taken into consideration, the Inquiry also needs to examine how and to what extent things have changed.

This area is of fundamental importance to the Inquiry. In order to explore the contention that the same events could not happen again or would be far less likely to happen again the Chairman is inviting the Department of Health, Social Services and Public Safety (DHSSPS), the Belfast Health and Social Care Trust (Belfast Trust) and the Health and Social Care Board (HSCB) to provide papers dealing with the issues set out in the attached schedules.

These issues are among those which have caused significant concern to him as the evidence has unfolded. Those papers will be shared with the interested parties and put on the Inquiry's website. The Chairman will then invite individuals from each of these bodies to give evidence in the closing days of the oral hearings in Banbridge Courthouse, expanding on the information provided and answering questions which probe that information and explore whether there are other lessons to be learned from past events which might lead to additional improvements.

Secretary: Bernie Conlon
Arthur House, 41 Arthur Street, Belfast, BT1 4GB
Email: inquiry@ihrdni.org **Website:** www.ihrdni.org **Tel:** 028 9044 6340 **Fax:** 028 9044 6341

The format of the questioning will be developed at a later stage when the Inquiry has gathered all relevant information from the Department and Trust, along with information from other sources. It may involve a team of individuals giving evidence together rather than one after another. In the case of the DHSSPS, two obvious witnesses are the Permanent Secretary and the Chief Medical Officer. It may be that others would also be relevant. In the case of the Belfast Trust the obvious people would include the Chief Executive, the Director of Medicine, the Director of Nursing and the Director of Specialist Hospitals. In the case of the HSCB the Chief Executive and one or more of the Executive Directors may be appropriate. The Chairman is open to suggestions from the respective bodies on this point.

The point of the exercise outlined above is to allow some reassurance to be provided by the DHSSPS the Belfast Trust and the HSCB that we should retain our confidence in the National Health Service notwithstanding past failings.

I appreciate that in responding to the issues raised in the schedules it may be helpful to give examples of actual events. If that is so it is acceptable, where necessary, to anonymise the people and patients who were involved in the events. Since this Inquiry involves the deaths of children it would be particularly helpful to give illustrations involving children where it is possible and relevant to do so.

Please obtain papers dealing with the issues from your client the DHSSPS.

The Chairman requests that the papers sought are provided within 4 weeks of the date of this letter.

Thank you for your assistance.

Yours sincerely,

P+P Anne Dillon
Solicitor to the Inquiry

Issues for the Department

1.

a. Are all trusts responsible to the Department for providing healthcare of an acceptable standard?

b. How does the Department ensure that this responsibility is met?

c. To whom in the Department do trusts report issues about the quality of healthcare provided by them?

d. Specifically how does the Department ensure that the health care provided in the RBHSC is of the required standard?

2.

a. What arrangements are now in place to ensure that the Department becomes aware of serious adverse incidents such as the unexpected deaths of children?

b. How do those arrangements work in practice?

3.

a. It is understood that since May 2010 the responsibility for management of the system reporting of serious adverse incidents transferred from the Department to the Board.

    i. Is this correct?

    ii. What were the reasons for the change?

    iii. What arrangements are now in place for the reporting of a serious adverse incident such as the death of a child, the learning of lessons (if any) from the incident, and the dissemination of that learning?

    iv. How do these arrangements work in practice?

    v. Is the Department satisfied with the effectiveness of the arrangements?

4.

a. What arrangements are now in place to collate all adverse clinical incidents including 'near misses'?

b. How are findings collated and disseminated to Trusts?

5.

a. Where the investigation of a serious adverse incident finds that poor quality healthcare contributed to the incident what options are available to address that finding?

6.

a. What if any liaison is there between the Coronial Service and the Department to ensure that the Department is made aware of upcoming inquests which are relevant to its role?

7.

a. What are the respective roles of the Department, the HSCB, the Trusts, the Public Health Authority, the Chief Medical Officer and the RQIA?

b. How do these various bodies and individuals interrelate with each other?

8.

a. How do new guidelines and practices and recommendations which are developed in Northern Ireland become embedded in practice?

b. How is adherence to them enforced/confirmed?

9.

a. How are guidelines practices and recommendations which are developed elsewhere in the United Kingdom considered and, where appropriate, adapted for use in Northern Ireland?

10.

a. Have any lessons been learned from other Northern Ireland inquiries such as C Diff which are relevant to this inquiry?

11.

a. Have any lessons been learned from inquiries outside Northern Ireland such as the Kennedy and Francis Inquiries which are relevant to this inquiry?

12.

a. Have any lessons been learned from the earlier stages of this inquiry and put into practice?

13.

a. What is the attitude of the Department to the duty of candour which is being debated in England and Wales at present?

b. How far does the Department envisage any such duty extending? Specifically:

   i. what is the position of the Department on whether trusts should disclose to families and to coroners the existence and contents of expert reports which are obtained by trusts for inquests and/or internal investigations?

   ii. what is the position of the Department on whether it is appropriate to suggest to doctors and nurses who prepare statements for inquests that it is not for them to include an acceptance that they may or should have acted differently in treating a patient?

14.

a. What is the Department's perspective on the extent to which reports are made to the GMC, the NMC and professional bodies about alleged failings of doctors and nurses?

b. Does the Department share the view expressed in evidence by Dr Carson and others that there is still a fear factor which discourages reports?

c. If that is the case, what can and should the Department do about it?

15.

a. What is the Department's perspective on the effectiveness of Trusts in investigating complaints concerning substandard care against nurses and doctors and taking action where complaints are upheld?

16.

a. In hospitals such as Altnagelvin does the Department have a view on who should take the lead role in caring for children as between paediatricians on the one hand and general surgeons who have experience in looking after children but who don't specialise in caring for them on the other?

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Issues for Belfast Trust with particular reference to the RBHSC

1.

a. What systems have been devised to ensure that the Trust meets its obligation for the quality of care provided to its patients?

b. How do those systems work in practice?

2.

a. What systems are in place to investigate complaints against staff concerning quality of care?

b. Where complaints are upheld what guidance is available to support action taken?

c. How is this monitored?

3.

a. How do the Director of Specialist Hospitals, the Director of Nursing, the Director of Medicine, the Chief Executive and the Trust Board know what is going on in the RBHSC in terms of serious incidents including deaths of children?

4.

a. To whom do the relevant senior post holders in the Trust report issues of concern about the care of children outside the Trust?

5.

a. Why and in what way have reports of children's deaths to the Coronial Service changed since Claire's death in 1996 and Lucy's death in 2001?

6.

a. Does the Trust continue to believe that it is appropriate to obtain an expert's report for the purposes of an inquest and then withhold it from the Coronial Service if it is adverse to the Trust? If so, why?

7.

a. Does the Trust continue to believe that it is appropriate to suggest to doctors and nurses who prepare statements for an inquest that it is not for them to include an acceptance that they may or should have acted differently in treating a patient? If so, why?

8.

a. In what circumstances does the Trust now report doctors to the GMC or nurses to the NMC?

b. How are these circumstances different to what would have been done 10 or 15 years ago?

c. How many doctors or nurses have been reported by the Trust (or its predecessor the Royal Trust) to the GMC or NMC in each year for the last 10 years?

d. Have any consultants been among those reported?

e. Does the Trust share the view expressed in evidence by Dr Carson that there is still a fear factor which discourages reports? If that is the case, what can and should the Trust do about it?

9.

a. How does the Trust ensure that new guidelines and practices issued by the Department become embedded in practice?

b. How are new staff trained in them?

10.

a. How does the Trust involve families such as the families of dead children in investigations about the treatment received by those children?

b. And how does it report the outcome of such investigations to them?

11.

a. What measures are now in place to ensure that if a child receives care of a questionable or inadequate standard at another hospital before being transferred to the RBHSC that issue will be raised with the transferring hospital?

12.

a. Are nurses now involved in investigations of incidents involving the treatment of children in the RBHSC? (There is no evidence that they were involved in Adam's or Claire's cases).

13.

a. In what circumstances is Solution 18 still used in the RBHSC?

14.

a. How does the Trust become aware of issues arising from the treatment of children in other hospitals in Northern Ireland and elsewhere in the UK, which are relevant to practice in the RBHSC?

b. Is there a system for it to become aware?

15.

a. How have practices continued to develop to allow for lessons to be learned from audit and mortality meetings?

Issues for Health and Social Care Board

1.

a. Explain your understanding of the respective responsibilities of the Board and the Department for ensuring that trusts provide healthcare of an acceptable standard.

b. How does the Board discharge any such responsibility? Specifically how does the Board ensure that the healthcare provided in the RBHSC is of the standard required?

2.

a. What arrangements are now in place for the reporting and investigation of a serious adverse incident such as the unexpected death of a child, the learning of lessons (if any) from the incident and dissemination of that learning?

b. How do these arrangements work in practice?

c. How robust are these arrangements?

d. In what circumstances will the Department be notified of such an incident?

3.

a. Where the investigation of a serious adverse incident finds that poor quality healthcare played a part in the incident what options are now available to address that finding?

4.

a. How do new guidelines, practices and recommendations which are developed in Northern Ireland become embedded in practice?

b. How is adherence to them enforced/confirmed?

5.

a. How are guidelines, practices and guidelines developed elsewhere considered and if appropriate adapted for use in Northern Ireland?