Mr. Peter Walsh
Chief Executive
AVMA
Freedman House
Christopher Wren Yard
117 High Street
Croydon
CR0 1QG

Our Ref: JOH-0414-13

Date: 7th October 2013

Dear Mr Walsh,

Re: Invitation to provide a Paper to the Inquiry in relation to Healthcare Complaints in Northern Ireland.

This Inquiry has been investigating the deaths in Northern Ireland of 3 children (Adam Strain, Claire Roberts and Raychel Ferguson), the circumstances following the death of Lucy Crawford and aspects of the care received by Conor Mitchell. The deaths occurred between 1995 and 2003 with 4 of the deaths being caused or contributed to by hyponatraemia. The death of Conor Mitchell followed the issue, by the Chief Medical Officer for Northern Ireland, of clinical guidelines designed to prevent hyponatraemia in children. While hyponatraemia does not appear to have contributed to his death, the Chairman is concerned that guidelines which were applicable to Conor's treatment appear not to have been followed.

The Inquiry's investigation has raised important 'management and governance' issues and required an examination of the ability of the Department of Health, Social Services and Public Safety (DHSSPSNI), and other relevant bodies, to learn lessons from the unexpected deaths of children in hospitals and to act upon them.

The Inquiry's public hearings are drawing to a close, and will end in the week commencing 11th November 2013. During that week evidence will be heard about practices and procedures which are currently in place and which are intended to make the Health Service in Northern Ireland safer for, and more responsive to, patients and their families than might previously have been the case.

It is important for me to understand the extent of any changes which have taken place in recent years. The events which I am looking into occurred primarily between 1995 and 2003 when governance was significantly less well-developed than it is now. I have heard evidence about various issues including: failures to communicate with parents during the treatment of the children and after their deaths, failures to heed or respond to parents' concerns, failures in the complaint system and failures in the investigation of what would now be called serious adverse incidents. I have also heard evidence which may suggest that there was a failure on the part of doctors and managers to face up to and admit errors and failings which had occurred. Transcripts of this evidence given during the public hearings can be found on the Inquiry website, together with witness statements and other key Inquiry documents (http://www.ihrdni.org/). I invite you to consider these documents which will provide you with the necessary details of each case, and introduce you to some of the issues (including those set out above) which are of concern to the Inquiry.

I note from your website that a stated aim of your organisation is to move *"patient safety higher up the agenda in the UK."* I would be interested to hear the steps you have taken to fulfil that task, the difference which you have made, and the extent to which you think that the National Health Service is now more alert and responsive to patients' issues. It has been suggested on a number of occasions that hospital governance has changed a lot (and for the better) over the last decade. In order to explore the contention that the same events could not happen again, or would be far less likely to happen again, I invite you to express your views in a paper which will be made public on the Inquiry's website and which may be referred to at the hearings in the week commencing 11th November 2013. If you accept the offer to provide such a paper it may be considered against the background of papers received from organisations such as the Patient and Client Council for Northern Ireland (PCC), the DHSSPSNI, the Belfast Health and Social Care Trust (Belfast Trust) and the Health and Social Care Board (HSCB). It will be very helpful to me to be able to compare systems and mechanisms described in these papers with your organisations experiences on the ground, and to explore whether other lessons remain to be learned which might lead to additional improvements.

I have made available to you the PCC's first Annual Report on Health and Social Care Complaints 2011/2012 which was published in November 2012. This shows that year-on-year more and more complaints have been supported. I also provide you with a paper published by the HSCB following a workshop held on 14th May 2013. That paper is entitled "Report on the Outcomes from the 'Improving the Complaints Process in the HSC' Workshop" and expresses some concerns as to the adequacy and effectiveness of the complaint system, the public awareness of the existence and role of the PCC and the level of support received by individuals who had used its services. Within the Report these concerns are referred to specifically at page 6, at pages 10–11, and provide recommendations at page 12. Reference to these documents will provide you with a background to some of the issues as pertain to Northern Ireland.

It would be helpful if any response which you make to assist the Inquiry could focus on complaints involving hospital services, particularly where they involve children. It will be appreciated that the Inquiry is principally concerned with matters relating to Northern Ireland, and therefore would be very grateful if you could focus on any experience your organisation has in this jurisdiction. If your organisation has little experience of patient issues in Northern Ireland please indicate whether there has been any significant change in Great Britain in respect of the areas which concern the Inquiry.

It would be valuable if you could cite in your paper, specific examples from your experience, and include any supporting statistics and documentation, touching on the following topics:

1. How you think that the complaint system in relation to hospital services is now working, especially in relation to the extent to which complainants are involved in the investigation of complaints.

2. How you think the complaint system might be improved.

3. How well you think that medical and nursing staff communicate with children and their parents and listen to them when treating children.

4. Whether you think that investigations of serious adverse incidents have improved in recent years and, if so, how they have improved.
5. How you think that the investigation of serious adverse incidents might be improved upon.

6. How open you think doctors, nurses and managers now are in discussing events which have occurred, accepting criticism and admitting failures.

7. Any suggestions you might have as to how the Health Service might be improved and further developed.

After the public hearings have concluded, I will prepare a report which will go to the Minister for Health and which will then be published. In that report I will set out my conclusions about the events surrounding the treatment and deaths of each child and make recommendations about improvements or steps which might now be taken to build on progress which there has been in the decade or so which has passed since the children died. Your contribution to that element of my task would be very welcome. If your organisation accepts this invitation, I would hope to receive its paper by Friday, 25th October 2013. In the meantime you are free to contact me or the Inquiry solicitor, Ms Anne Dillon, at the address and telephone number set out above.
Thank you in advance.

Yours sincerely,

John O'Hara

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