

RECOMMENDATIONS

9.1 The lessons of these sad cases must be learnt because it cannot be assumed that such tragedy could not happen again. Although much has been achieved, much remains to be done. These recommendations have been guided by the following principles:

- (i) That healthcare services exist to serve the patient.
- (ii) That quality of healthcare is dependent upon both clinical and non-clinical services.
- (iii) That the particular needs of children must be addressed.
- (iv) That leadership and candour must be accorded the utmost priority if the fullest learning is to be gained from error.
- (v) That progress should be subject to regular external review.

9.2 I believe that parents must be involved in the implementation of these recommendations. It is to be recognised that improvement cannot be achieved without expenditure. These recommendations have not been costed.

Recommendations

Candour

1. A statutory duty of candour should now be enacted in Northern Ireland so that:
 - (i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public.
 - (ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or

its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.

- (iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).
 - (iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.
 - (v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.
 - (vi) Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.
 - (vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.
2. Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.
 3. Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.

4. Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.
5. Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.
6. Support and protection should be given to those who properly fulfil their duty of candour.
7. Trusts should monitor compliance and take disciplinary action against breach.
8. Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.

Leadership

9. The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.

Paediatric - clinical

10. Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.
11. There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.
12. Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.

13. Foundation doctors should not be employed in children's wards.
14. The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.
15. A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.
16. The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.
17. Any change in clinical accountability should be recorded in the notes.
18. The names of all on-call consultants should be prominently displayed in children's wards.
19. To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.
20. Children's ward rounds should be led by a consultant and occur every morning and evening.
21. The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.
22. Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.

23. The care plan should be available at the bed and the reasons for any change in treatment should be recorded.
24. All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart.
25. All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician.
26. Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.
27. Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.
28. Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent.
29. Record keeping should be subject to rigorous, routine and regular audit.
30. Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.

Serious Adverse Clinical Incident Reporting

31. Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').
32. Failure to report an SAI should be a disciplinary offence.

Serious Adverse Clinical Incident Investigation

33. Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.
34. The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.
35. Failure to co-operate with investigation should be a disciplinary offence.
36. Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.
37. Trusts should seek to maximise the involvement of families in SAI investigations and in particular:
 - (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.
 - (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.
 - (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.
 - (iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.
 - (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.

- (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.
 - (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.
 - (viii) Family GPs should, with family consent, receive copies of feedback provided.
 - (ix) Families should be formally advised of the lessons learned and the changes effected.
 - (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation.
38. Investigations should be subject to multi-disciplinary peer review.
39. Investigation teams should reconvene after an agreed period to assess both investigation and response.
40. Learning and trends identified in SAI investigations should inform programmes of clinical audit.
41. Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.
42. In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.

In the event of a Death related to a Serious Adverse Clinical Incident.

43. A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.

44. Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.
45. Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.
46. Where possible, treating clinicians should attend for clinico-pathological discussions at the time of post-mortem examination and thereafter upon request.
47. In providing post-mortem reports pathologists should be under a duty to:
 - (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them.
 - (ii) Work in liaison with the clinicians involved.
 - (iii) Provide preliminary and final reports with expedition.
 - (iv) Sign the post-mortem report.
 - (v) Forward a copy of the post-mortem report to the family GP.
48. The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.
49. Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.
50. The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved.

51. Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.
52. Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.
53. In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.
54. Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.

Training and Learning

55. Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.
56. All Trust Board Members should receive induction training in their statutory duties.
57. Specific clinical training should always accompany the implementation of important clinical guidelines.
58. HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and hyponatraemia.
59. There should be training in the completion of the post-mortem examination request form.
60. There should be training in the communication of appropriate information and documentation to the Coroner's office.

61. Clinicians caring for children should be trained in effective communication with both parents and children.
62. Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.
63. The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.
64. Parents should be involved in the preparation and provision of any such training programme.
65. Training in SAI investigation methods and procedures should be provided to those employed to investigate.
66. Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.
67. Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.
68. Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.

Trust Governance

69. Trusts should appoint and train Executive Directors with specific responsibility for:
 - (i) Issues of Candour.

- (ii) Child Healthcare.
 - (iii) Learning from SAI related patient deaths.
70. Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.
 71. All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.
 72. All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.
 73. General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.
 74. Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.
 75. Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies.
 76. Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.
 77. Trusts should appoint a compliance officer to ensure compliance with protocol and direction.
 78. Implementation of clinical guidelines should be documented and routinely audited.

79. Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.
80. Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.
81. Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.
82. Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.
83. Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.
84. All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.

Department

85. The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.
86. The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.
87. The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.
88. The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel.

89. The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.
90. The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include:
 - (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability.
 - (ii) The identification of specific training requirements necessary for effective implementation.
91. The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.
92. The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.
93. The Department should review Trust responses to the findings and recommendations of this Report.

Culture and Litigation

94. The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.
95. Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward

protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.

96. The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.