1 Tuesday, 12 November 2013
2 (10.00 am)
3 (Delay in proceedings)
4 (10.10 am)
5 MR COLM DONAGHY
6 DR ANTHONY STEVENS
7 MS BRENDA CREANEY
8 DR PAUL JACKSON
9 THE CHAIRMAN: Good morning, everyone. Thank you for
10 coming. I'm pleased to welcome the panel from the
11 Belfast Health and Social Care Trust which, as you know,
12 is the body which incorporates what was the former Royal
13 Group of Hospitals Trust, together with the
14 City Hospital, the Mater Hospital, Musgrave, Belvoir --
15 is that enough?
16 What I intend to do is I'll introduce each of the
17 members of the panel and I will pause after I introduce
18 each one so that each of you can add anything you want
19 to what I've said. And then I think, Mr Donaghy, you
20 want to make a statement on behalf of the trust; is that
21 right?
22 COLM DONAGHY: Yes, chairman.
23 THE CHAIRMAN: We'll then go through some of the issues
24 which I want to discuss or debate with you.
25 The gentleman who I have just been talking to

1 directly is Mr Colm Donaghy. He has been the
2 chief executive of the Belfast Health and Social Care
3 Trust since September 2010 and previously filled
4 a number of chief executive posts in the Health Service,
5 going backwards in time: the Northern Health and Social
6 Care Trust from 2009 to 2010; the Southern Health and
7 Social Care Trust from 2006 to 2009; its predecessor or
8 a predecessor, the Southern Health and Social Services
9 Board, from 2002 to 2006; and before that, between 1992
10 and 2002, various positions in the Southern Board area.
11 Is that right?
12 COLM DONAGHY: Yes.
13 THE CHAIRMAN: Do you want to add anything to that?
14 COLM DONAGHY: No, chairman, that's fine.
15 THE CHAIRMAN: Dr Stevens graduated in medicine in 1982, his
16 specialist area is occupational medicine, in which
17 I think, Dr Stevens, you have been a consultant since
18 1992.
19 DR ANTHONY STEVENS: That's correct.
20 THE CHAIRMAN: Dr Stevens then became deputy medical
21 director in the former Royal Trust in 2003; he held that
22 post until 2006. From 2006 to 2007 you were the acting
23 medical director and for the last six-and-a-half years
24 you have been the medical director of the expanded
25 Belfast Health and Social Care Trust.

1 DR ANTHONY STEVENS: That's correct.
2 THE CHAIRMAN: Anything to add?
3 DR ANTHONY STEVENS: That's comprehensive.
4 THE CHAIRMAN: Ms Creaney qualified as a nurse in
5 Northern Ireland in 1988, but from 1990 she worked
6 in the Chelsea and Westminster Children's Hospital --
7 BRENDA CREANEY: Chelsea and Westminster Hospital.
8 THE CHAIRMAN: But I think you were specialising as
9 a paediatric or children's nurse?
10 BRENDA CREANEY: Yes, that's correct.
11 THE CHAIRMAN: In 2000, Ms Creaney came back to
12 Northern Ireland, to the Royal, as a directorate manager
13 in the medical directorate. From 2002 to 2007 you were
14 the directorate manager, but you also were the principal
15 paediatric nurse in the Royal Belfast Hospital for Sick
16 Children --
17 BRENDA CREANEY: Yes, that's correct.
18 THE CHAIRMAN: -- which for this inquiry is a particularly
19 significant post. From 2007 to 2009 you were the
20 co-director of child health and associate director of
21 nursing in the Belfast Trust.
22 BRENDA CREANEY: Yes.
23 THE CHAIRMAN: And for coming on four years now, you have
24 been the executive director of nursing for the Belfast
25 Trust and the director for user experience.

1 BRENDA CREANEY: Yes, that's right.
2 THE CHAIRMAN: Thank you.
3 Dr Jackson has been a consultant paediatrician since
4 1987.
5 DR PAUL JACKSON: That's correct.
6 THE CHAIRMAN: Initially in Craigavon Area Hospital, from
7 1987 to 1989, then in Belvoir Park from 1989 to 1997.
8 I think, doctor, you moved to the Children's Hospital in
9 1997 as a consultant paediatrician --
10 DR PAUL JACKSON: Yes, that's correct.
11 THE CHAIRMAN: -- and you have remained there, but you have
12 been clinical director for paediatrics from 2008 in the
13 Children's Hospital.
14 DR PAUL JACKSON: That's correct.
15 THE CHAIRMAN: And does anybody want to add any more about
16 background or CVs before I move on?
17 Having introduced today's panel from the
18 Belfast Trust and welcomed them, Mr Donaghy, can
19 I invite you to make a statement on behalf of the trust?
20 Opening statement by MR COLM DONAGHY
21 COLM DONAGHY: Thank you, chairman, for inviting my
22 colleagues and me to the inquiry today.
23 Let me begin by categorically stating that the
24 Belfast Trust, on behalf of the former Royal Hospitals
25 Trust, regrets most sincerely the pain and suffering

1 experienced by the families of Adam Strain,
2 Claire Roberts, Lucy Crawford, Raychel Ferguson and
3 Conor Mitchell and apologises for all the shortcomings
4 in care at the Royal Hospitals that have been identified
5 either prior to this inquiry or during the hearings.
6 I am in front of you today, chairman, as a
7 chief executive and as a parent. The unqualified agony
8 and pain felt by the parents of these five children
9 cannot be underestimated. The abject sorrow and grief
10 felt by the families I know has not lessened with the
11 passing the time. In fact, I fully accept it is as raw
12 today as it was then, exacerbated by the actions of the
13 three trusts involved. For the part the Belfast Trust
14 has played in prolonging this agony, I'm deeply sorry.
15 Chairman, I'm aware through this inquiry that how
16 litigation has been handled by the Belfast Trust has
17 added to the hurt and grief felt by the families. Whole
18 I will outline later in this statement how litigation is
19 dealt with now, I wish to apologise unreservedly to the
20 families for the unacceptable delay in the Belfast Trust
21 accepting liability.
22 It is clear that important aspects of the care and
23 treatment afforded to the children at the Royal Belfast
24 Hospital for Sick Children, in particular fluid
25 management, was poor. When the parents entrusted their

1 most precious children into our care, when their
2 children were at their most vulnerable, and their
3 parents rightly expected their children to have had the
4 best and safest care possible, they also rightly
5 expected their children to be made a priority. This
6 didn't happen and for that we are deeply and sincerely
7 sorry.
8 Communication with the families was not sufficiently
9 transparent, our medical and nursing staff missed the
10 opportunity to reflect on what may have gone wrong and
11 consequently there was a lack of communication with the
12 wider acute hospitals network in Northern Ireland and
13 the Department of Health.
14 The evidence presented shows that training in fluid
15 management in children was inconsistent, record keeping
16 was incomplete and our governance was not sufficiently
17 developed or robust. I also accept that reflective
18 clinical practice and candour, which is how we work
19 today, was clearly missing. I will discuss further
20 these issues in the context of how we work today later
21 in the statement.
22 Chairman, I want to assure you that in all my years
23 as chief executive, the inquiry into
24 hyponatraemia-related deaths in children in
25 Northern Ireland has had the most significant impact on

1 my trust in terms of learning from it. There is no
2 member of staff who has remained untouched by the
3 inquiry's impact. I also want to assure you that the
4 trust now has the necessary framework and mechanisms in
5 place to implement the recommendations of this inquiry
6 when required.
7 While I understand that you will wish to have a more
8 detailed discussion this morning on a number of issues,
9 I thought it would be useful if I touched on some of the
10 main issues which have been highlighted during the
11 inquiry.
12 The first of those is clinical governance. From the
13 outset of the Belfast Trust in 2007, an integrated
14 approach to governance was taken, ensuring that clinical
15 and wider organisational risks were managed within
16 a single integrated assurance framework. The assurance
17 framework has been continuously developed in intervening
18 years taking account of new thinking at a regional and
19 national level. It's an ongoing journey.
20 The most recent iteration of the assurance framework
21 took account of lessons from the Francis report into the
22 events at Mid-Staffordshire Hospital. Belfast Trust has
23 worked hard to developed robust clinical governance
24 arrangements within our assurance framework. The key
25 elements of clinical governance in Belfast include

1 clinical audit, incident reporting, education and
2 training, appraisal and the development of
3 evidence-based practise to ensure safe and effective
4 care. We also introduced clear and robust arrangements
5 for the management of concerns about doctors and
6 dentists.
7 In relation to openness and candour, chairman,
8 underpinning our risk management and clinical governance
9 arrangements is a determination to engender and
10 encourage a culture of openness and fairness where staff
11 feel able to report events, whether these are near
12 misses or actual adverse incidents. This is an ongoing
13 process which builds on the lessons on the past and
14 present. We have engaged actively with staff
15 representatives and professional bodies to develop our
16 risk management and clinical governance arrangements.
17 This is exemplified by the development of both our trust
18 health and safety annual report and the quality and
19 safety improvement plan.
20 We also have engaged with the users of our service
21 in the delivery of our risk management and clinical
22 governance arrangements. For example, the involvement
23 of laypeople in clinical audit design and the use of
24 patient feedback in the revalidation of doctors. We
25 also will review the deaths that occur in our trust.

1 High-level data is reported at our trust board.
2 However, we have not been content with this and have
3 developed a system in Belfast whereby every death in
4 hospital can be recorded and reviewed by clinical teams.
5 We are in the process of implementing a bottom-up
6 approach where all our doctors are linked to a specialty
7 morbidity and mortality meeting. We have developed an
8 IT system which makes the recording of deaths
9 straightforward. In the Children's Hospital, all deaths
10 are now reviewed irrespective of whether there have been
11 any concerns about the quality of care.
12 These meetings are recorded and a culture of
13 openness and candour is being actively encouraged.
14 I believe this is a real and practical example of the
15 sea change that has occurred in the way the
16 Health Service in Northern Ireland works. It
17 particularly demonstrates the active engagement of our
18 doctors and other clinical professionals in providing
19 information upon which the trust can learn and act. It
20 encourages the culture of openness, candour and
21 reflection that is being promoted nationally through
22 reports such as that of Robert Francis QC. We have an
23 open approach to dealing with the coroner and are
24 committed to providing him with all relevant
25 information.

1 Chairman, having followed the oral hearings of this
2 inquiry and listened to your discussion yesterday with
3 representatives from Action Against Medical Accidents
4 and the Patient and Client Council, I believe this is an
5 area where we need to improve. To that end, I would
6 wish to offer to meet with the families to firstly
7 highlight any further learning that they can assist the
8 trust to identify and, secondly, to provide reassurance
9 about the lessons we have learned and action taken to
10 prevent other families experiencing the same trauma.
11 I would like to turn to litigation, chairman. The
12 Belfast Trust has always had an open approach to
13 coroner's inquests and seeking to support the coroner in
14 establishing the facts of any case. We have always
15 shared expert reports and information. We have learned
16 from the events of this inquiry and are updating our
17 arrangements to ensure a proper separation of coronial
18 and medicolegal functions. We already seek to ensure
19 that the process of litigation does not prevent us from
20 supporting patients and families and helping them to
21 resolve issues and concerns. We often have an ongoing
22 relationship with patients and recognise the need to
23 maintain a therapeutic relationship with them, ensuring
24 their confidence in the service they receive while any
25 legal process is ongoing. This can only be achieved

1 through dialogue, openness and honesty.
2 In relation to serious adverse incidents, we have
3 a robust process for reporting, investigating and
4 learning from serious adverse incidents. The trust
5 reports approximately 100 per year. These are all
6 reviewed at an SAI review board. We have recently
7 strengthened our corporate arrangements by establishing
8 a learning from experience steering group chaired, on my
9 behalf, by the deputy chief executive. This group will
10 have oversight of adverse events, SAIs, mortality data
11 and external reviews of our service. The group builds
12 on our existing arrangements and will report to the
13 executive team and trust board.
14 In conclusion, chairman, I realise that you will
15 want to explore these issues further with the panel.
16 I wish to finish by, once again, offering the trust's
17 heartfelt apologies and condolences to the families.
18 THE CHAIRMAN: Thank you very much, Mr Donaghy.
19 Before I go into the issues that we've alerted you
20 to, on the offer that you have made to meet the families
21 so that they can highlight anything more that the trust
22 might learn and for the trust to give some reassurance,
23 if more reassurance is required, can I take it that, if
24 the families are willing to do this, you're happy at
25 least to meet them today, but anything following from

1 that can take place outside the confines of this inquiry
2 and back in the Royal or wherever?
3 COLM DONAGHY: Yes, absolutely.
4 Questions from THE CHAIRMAN
5 THE CHAIRMAN: Can I say that, as a general introduction,
6 the papers that we've been provided with for this week
7 from Patient and Client Council, from your trust, from
8 the Health & Social Care Board, from the RQIA and from
9 the department, all make is very clear that the
10 procedures which are in place now are, I think,
11 incomparably better than the procedures which were in
12 place from the mid-1990s to the early 2000s. And
13 of course, that's very welcome and it's hugely
14 important.
15 But I think for both me and for the families, the
16 more important question is how the procedures are
17 operated by the people who are given that
18 responsibility. Because whether you have procedures or
19 not, and no matter what those procedures are, the people
20 who are operating them and the people who are
21 responsible for activating the procedures must do so in
22 a certain way, otherwise the value of the procedure is
23 negated or minimised.
24 So the areas that I want to explore with you today,
25 as I think you'll have picked up from yesterday, is how

1 things actually work in practice, because that's the
2 reassurance I can gather and that's the reassurance that
3 the families can gather that the lessons have truly been
4 learned.
5 If we deal first with the area of complaints.
6 You'll have heard from yesterday's discussion that my
7 concern was that while the trust policy on complaints
8 was in keeping with the departmental policy, it appeared
9 on its face to limit the involvement of the family or
10 the complainant to their initial letter or notification
11 of complaint, and the investigation would then go ahead
12 without them and they find they're then told at the end
13 what the outcome of the complaint is.
14 I understand when I raised this with you in
15 a follow-up paper a few weeks ago, the response
16 I received was to indicate that in fact there's more to
17 it than that. Whatever the letter of the policy is,
18 more actually happens than that. Who might help on
19 that? Who is most --
20 COLM DONAGHY: Well, I could begin, chairman, and then I'll
21 ask Dr Stevens, because it's an area of his
22 responsibility, to be more detailed.
23 I think your observation is right, chairman. The
24 guidance, if we stuck to the letter of the guidance,
25 would mean that there would be, in all of our

1 complaints, very little engagement with families. In
2 practice, how complaints are dealt with in the
3 organisation, initially we have a local resolution stage
4 where we engage directly with complainants in relation
5 to the complaint in order to resolve it before it gets
6 to a formal stage.
7 THE CHAIRMAN: Okay. I'm sorry to break this up, but let's
8 pause there. When you say that "we engage directly",
9 let's suppose it's my complaint. Who talks to me at the
10 local resolution stage?
11 COLM DONAGHY: At the local resolution stage, chairman, you
12 would probably raise your issue, it hasn't become
13 a formal complaint at this stage, and you have an issue
14 about care or the care that you received, you would
15 raise it directly with the staff, for example, providing
16 that care, or in some cases with the manager, who may be
17 there at that point, and at that point there is a local
18 resolution in terms of having a conversation with people
19 about the level of care they received and if people
20 remain discontent with the local resolution process,
21 then they are advised that they can complain formally in
22 writing to the trust.
23 THE CHAIRMAN: Okay. I was given -- Mr Lavery promised me
24 this yesterday and I received it this morning -- I think
25 a photocopy of a leaflet, which I understand is

1 available, entitled "You have made a complaint, what
2 happens next?" and that refers to the Patient and Client
3 Council.
4 COLM DONAGHY: Yes.
5 THE CHAIRMAN: But in order to know how I make a complaint
6 and who I make a complaint to, how do I know how to do
7 that?
8 COLM DONAGHY: You could receive advice directly from staff
9 if you wish to complain. There are, in the context of
10 the environment, leaflets and posters, which would
11 explain to people the process for complaining. If in
12 the context of making a written complaint you write to
13 us, then with the acknowledgment you receive, you will
14 receive that leaflet, which you have just referred to,
15 chairman --
16 THE CHAIRMAN: Okay.
17 COLM DONAGHY: -- which then will indicate --
18 THE CHAIRMAN: Just for the record, that says that in terms
19 of support during the complaints process:
20 "Our complaints department staff can provide you
21 with more information."
22 And there's an address, phone number, fax number and
23 e-mail address. And it then says:
24 "Alternatively, the Patient and Client Council can
25 provide free and confidential advice."

1 And that is followed by a free phone number for the
2 Patient and Client Council and their website.
3 COLM DONAGHY: Yes, and that leaflet is also freely
4 available within our facility, so that can be given to
5 a complainant even before they send in a written --
6 THE CHAIRMAN: Okay. So that's the local resolution stage.
7 Then I put in a complaint if I feel, rightly or wrongly,
8 that I should. At that point, according to your
9 supplementary paper, there's a range of issues, and
10 you've given illustrations that range from car parking
11 issues, which you'll know I'm not concerned with, even
12 if they trouble you from time to time, but I'm looking
13 at more serious issues. And you've referred to the
14 input from two sources: one is of lay reviewers, and the
15 second one is of independent experts.
16 Let's look at lay reviewers first. What sort of
17 people are lay reviewers: are they trust staff,
18 external?
19 COLM DONAGHY: I'll ask Dr Stevens, but lay reviewers are
20 a panel of people, who have been identified by the
21 Health & Social Care Board, who we can call on to assist
22 in particular complaints in terms of their complexity
23 and difficulty. But I will ask Dr Stevens to elucidate
24 more on that.
25 DR ANTHONY STEVENS: Thank you. The lay review panel

1 includes a wide range of people from different
2 backgrounds. We have, for example, used a retired
3 schoolteacher to assist us with one of our panels.
4 THE CHAIRMAN: This is the panel which has been identified
5 by the Health & Social Care Board; are these lay
6 reviewers given training by the board?
7 DR ANTHONY STEVENS: They are given training and support in
8 developing their role.
9 THE CHAIRMAN: Okay. I'm sure that there's a whole range of
10 complaints, far wider perhaps that I can imagine, but in
11 what (than) sort of scenario are lay reviewers engaged
12 to assist?
13 DR ANTHONY STEVENS: We have used lay reviewers now in two
14 complaints, both of them tending to be more complex
15 complaints. As you will know from the papers we
16 submitted, we grade all our complaints, and obviously
17 we'll have an eye to resolving either locally or as
18 quickly as possible as many of those as we can. You'll
19 be aware of the target or standard that's set to try and
20 resolve and respond to complaints within 20 days.
21 So the use of lay reviewers or any advocacy service
22 or the use of independent experts usually reflects
23 a more complex or serious case where we believe there
24 are more significant risks to deal with, and inevitably
25 they're going to take a great deal longer. We're

1 talking about a smaller proportion, a significant --
2 a minority, really, of the total number of complaints we
3 deal with.
4 THE CHAIRMAN: Is this a recent development, doctor, the
5 introduction of lay reviewers? When you say you have
6 used them twice, that suggests to me they're rarely used
7 or this has only just started.
8 DR ANTHONY STEVENS: We started in the last year to use them
9 and I envisage this being something we'll do more often
10 as time goes on and we get more experience. Our
11 experience to date has been very positive. We've found
12 them hugely helpful.
13 THE CHAIRMAN: In terms of the complexity of the complaints,
14 would I be wrong to think that these would not be
15 medically complex issues because you might then go to
16 independent experts rather than lay reviewers?
17 DR ANTHONY STEVENS: They would tend to deal with all the --
18 very rarely is an individual's complaint about just
19 a very narrow point of medical practice. So they will
20 help with all the other issues: they will bring the
21 perspective of a layperson, maybe the complainant's
22 perspective, to it; they will help to resolve some of
23 the issues; they'll try and establish -- help establish
24 the facts and ensure that we're communicating those in
25 a very straightforward way.

1 THE CHAIRMAN: Okay. There are people who less articulate
2 and less able to formulate exactly what their problem or
3 complaint is than other people, so they would get
4 particular assistance from a lay reviewer, would they?
5 DR ANTHONY STEVENS: The lay reviewer is clearly part of the
6 review process and, yes, they will help and support the
7 individual complainant, particularly those who are less
8 able to express themselves. But then we will also have
9 access to advocacy services, indeed the Patient and
10 Client Council being one example of that. So people who
11 need assistance to articulate their concern or to put
12 a more forceful argument have a number of resources to
13 go to.
14 THE CHAIRMAN: It sounds as if the formal complaints policy
15 from the department, which is also your formal policy,
16 has actually fallen behind the practice; would that be
17 right?
18 DR ANTHONY STEVENS: I think that's fair to say. Mr Donaghy
19 made reference to the informal stage. That is becoming
20 an increasingly important part of what we do. We see
21 the issue with complaints as achieving resolution,
22 satisfying an individual that we've provided an
23 explanation to them, that we've resolved their concerns
24 or their difficulties. So the process for us is a very
25 iterative one, a continuous process of working with

1 a complainant to try and reach that point. And so, for
2 example, our complaints managers -- and we have a very,
3 very experienced team of managers who are a central
4 resource -- they may be the first point of contact for
5 a complainant and it may come in as an e-mail or
6 a letter, or it may be a phone call into our complaints
7 department.
8 And from the very word go, our complaints staff are
9 working to build a relationship with that complainant to
10 understand their issues, to ensure that they can
11 articulate their concerns. So right from the get-go,
12 really, we're trying to build a communication with the
13 individual or the family, and to provide explanations.
14 At each stage we determine what next we need to do.
15 So if we can answer a complainant's problem quickly and
16 simply, then we'll do that. It may be a simple issue
17 about "When is my operation going to be done?" or "I'm
18 confused about what exactly is meant to happen next".
19 So maybe a complaints officer can go and find that out
20 and give a person a detailed explanation. If it's
21 a matter of something having gone wrong or the patient
22 or their relatives believing there's been a mistake or
23 error or harm has been done, obviously the complaints
24 department is starting to identify that, and then
25 starting to formulate our plan around the need for an

1 investigation.
2 THE CHAIRMAN: Okay. That's lay reviewers. In what
3 circumstances might you then bring in independent
4 experts? What sort of experts are we talking about?
5 DR ANTHONY STEVENS: We are usually talking about clinical
6 experts -- so it may be a doctor, a nurse, a midwife, a
7 physiotherapist -- usually in a relevant specialty.
8 This is where the issues that are arising are starting
9 to go down a more clinical line, particularly if there's
10 uncertainty about the quality of care. So where we
11 require an expert opinion on whether we've done the
12 right thing or the wrong thing and we want independence
13 in that. So it's our way of sometimes triangulating the
14 information we already have because we now already have
15 the opinion of our own clinicians, we may have
16 differences of opinion, and the expert opinion is our
17 early attempt and effort to actually understand all the
18 issues and also to provide reassurance that we are
19 attempting to get to the bottom of things.
20 So sometimes even though we may feel that we
21 understand all the issues, to give confidence to
22 a family or a complainant that we really have explored
23 all the issues, we will seek that level of independence.
24 THE CHAIRMAN: When you say "independent", does that mean
25 outside the Belfast Trust or outside Northern Ireland or

1 where?
2 DR ANTHONY STEVENS: It can be both. It would be outside
3 the Belfast Trust and it would depend on the complexity.
4 Belfast carries a significant number of the regional
5 specialties, so if I need an independent expert on
6 neurosurgery or plastics or cardiac surgery, I will have
7 to go outside Northern Ireland.
8 THE CHAIRMAN: Okay. You indicated a few moments ago that
9 the lay-reviewer system has been used perhaps twice in
10 the last year or so since it was introduced. How often
11 has the independent expert system been used?
12 DR ANTHONY STEVENS: I can't give you an exact number, but
13 very much more often than that.
14 THE CHAIRMAN: Does the complainant see the independent
15 expert's report or letter, whatever form it comes in?
16 DR ANTHONY STEVENS: The complainant would normally receive
17 our response, which would reference that and if they
18 wished to see the independent expert report, I can't
19 envisage any situation where we wouldn't share it.
20 THE CHAIRMAN: So the typical approach would be that the
21 gist of what the independent expert has written will be
22 incorporated in the final trust response to the
23 complainant?
24 DR ANTHONY STEVENS: We always try and meet with the family
25 or the individual and, again, we will share our sources

1 and information. So I can't say that we would always
2 share a report upfront, but we will make no secret of
3 the fact that we have an independent expert report and
4 we'll certainly share it on request.
5 THE CHAIRMAN: One of the points that was made yesterday by
6 Mr Walsh from Action Against Medical Accidents was that
7 although there's sometimes resistance to it, the fact
8 is that having a better complaints process diffuses and
9 sorts out a lot of issues, which might otherwise
10 sometimes go into litigation and unnecessarily go into
11 litigation.
12 DR ANTHONY STEVENS: There are a whole lot of reasons for
13 having a good complaints process. Litigation is
14 probably the least of my concerns. The first is, as
15 Mr Donaghy says, we have an ongoing relationship with
16 patients, sometimes because we have to manage the
17 consequences of our own errors. So if a patient gets an
18 infection, MRSA, for example, we'll still be caring for
19 that individual. If we make a medical error, we'll
20 still be caring for that individual.
21 So we absolutely have to be open with people, be
22 clear what's happened, satisfy them that we've explored
23 all the issues that may have arisen and provide them
24 with the confidence to allow them to go on with their
25 care.

1 We also have an absolute responsibility to ensure
2 that if things have gone wrong that they don't go wrong
3 again. So just as with -- we see complaints as an
4 incredibly important part of our intelligence system.
5 So just as we would have 23,000 adverse incident reports
6 a year in the Belfast Trust, we have 1,700 complaints.
7 We see all of those as a source of intelligence, which
8 we're continuously wishing to analyse.
9 So being absolutely clear that we've dealt with
10 a complainant properly and understood the issues is
11 essentially and is a core part of our clinical
12 governance arrangement.
13 THE CHAIRMAN: There was a point which you'll have heard
14 raised yesterday, which seems to be tricky. It's about
15 what happens to a complaint if there's an apprehension
16 or the reality of litigation. Does that bring the
17 complaints process to a stop in that it puts the
18 investigation of the complaint on hold?
19 DR ANTHONY STEVENS: It's a really important question. Our
20 policy, and clearly departmental policy, is that once we
21 receive a statement of claim that the complaints process
22 would cease. And I would have to tell you in some cases
23 that has and does happen, and I think probably still
24 does, but I would wish to say that we now have a number
25 of examples where we very clearly decided to continue.

1 Often because we're so far into the complaints process
2 that it would seem perverse not to complete it. Also
3 very often, irrespective of the litigation that's likely
4 to come, getting the answers is going to significantly
5 improve the litigation process if we've established the
6 facts.
7 And also, because, as I've said ... And I can think
8 of some very notable examples -- and really
9 confidentiality would only prevent me from sharing it
10 here -- where our continuing requirement of care for the
11 individual requires us to complete the complaints
12 process. I certainly would be happy to give examples if
13 that was required, where in particular we've had to
14 understand exactly what's gone wrong if we're going to
15 be able to provide the individual with answers and
16 further care. And also, I mean, I can think of one
17 example where, in handling the complaints process, we've
18 been fairly honest with people and told them that they
19 should go and see a solicitor and take advice. So you
20 know, I think the reality for us now is that our
21 complaints process, our incident recording process, our
22 litigation process, the process of interaction with the
23 coroner, they're all becoming overlapping, and one of
24 the reasons we have an integrated governance approach in
25 Belfast is that we really need to be able to look at all

1 of those things simultaneously if we're going to
2 effectively manage the risks in our organisation.
3 THE CHAIRMAN: Then perhaps, just to finish off this point,
4 why is it then that in any cases the complaints system
5 comes to a halt if there's litigation?
6 DR ANTHONY STEVENS: I think that has been the practice and
7 is the practice that we are now in reality changing, and
8 I think it would be my view that, going forward,
9 irrespective of any recommendations out of this inquiry
10 or indeed any reflection that the department has, that
11 we would see a progressive change in this area.
12 Subject, obviously, to taking legal advice in some
13 cases.
14 THE CHAIRMAN: Mr Walsh was suggesting yesterday that there
15 has been an instinctive assumption, really, that
16 a complaint should be put on hold, but his experience in
17 England is that that's happening less and less with
18 positive outcomes. Whether the complaint is upheld or
19 not, it still brings an earlier end and a more
20 satisfactory end. And the range of outcomes to
21 a complaint is rather better than the range of outcomes
22 to litigation. Litigation, unless you settle, you win
23 or lose, and that doesn't necessarily even make the
24 winner walk away feeling much better.
25 DR ANTHONY STEVENS: I think the critical thing for us is

1 we can usually resolve a complaint within weeks or
2 months, sometimes days. We're very unlikely to resolve
3 litigation in any short time frame, and if we have to
4 manage risk and in particular if we have to make sure we
5 don't make the same mistakes again, then we have to
6 pursue and complete the complaints process. We can't
7 wait to learn the lessons from the outcome of
8 a litigation.
9 I think that genuinely has become one of the big
10 changes in Belfast in terms of the way we manage our
11 risk. And again, a complaint may actually now become
12 a serious adverse incident. So irrespective of whether
13 there's litigation or irrespective of whether we're
14 dealing with a complaint, we may have to trigger a SAI
15 investigation. So it's very hard now, in my view, to
16 make any distinction between the processes. They
17 clearly do have different elements to them, but if we're
18 to effectively manage our relationship with patients and
19 minimise risk, we have to see these processes
20 overlapping now.
21 THE CHAIRMAN: Is the fundamental and most important point
22 about continuing to care for patients and minimise risk?
23 DR ANTHONY STEVENS: Absolutely.
24 THE CHAIRMAN: So everything else, complaints, SAIs,
25 litigation, inquests, that should always be secondary to

1 the continuing care of patients?
2 DR ANTHONY STEVENS: The patient's still there --
3 THE CHAIRMAN: Yes.
4 DR ANTHONY STEVENS: -- unless it's obviously a death, but
5 then you're still dealing with a family who may actually
6 be your patients as well.
7 THE CHAIRMAN: Yes. Just maybe to complete this, you've
8 told me in the documents about a number of committees
9 and how you have a whole assurance framework in place
10 now. If there is some learning to come out of
11 a complaint, could you just summarise how that learning
12 is then spread within the hospital? Maybe you'll be
13 able to think of a suitably anonymised example of
14 something which has been learned from a complaint or
15 something which has struck you "We can do this better"
16 and that then leads into improved practice.
17 DR ANTHONY STEVENS: I could give you an example that's been
18 well trailed in the media, which would be from our
19 emergency departments where we've had difficult
20 outcomes. Those started life as -- one at least started
21 life as going to the media, but then I felt that was
22 a complaint by a different route. We managed that
23 complaint, we carried out an investigation, it was
24 an SAI investigation. That was then an action plan
25 developed and implemented. And interestingly,

1 subsequently, I think litigation is to come. So the
2 litigation was following long behind the learning of our
3 lessons.
4 We can think of other examples ...
5 COLM DONAGHY: Chairman, just to say that in terms of
6 learning across the organisation, that particular
7 example that Dr Stevens gave is one that was shared
8 across all directorates, all directors across the
9 organisation. The feedback was to our entire executive
10 team and in fact to our trust board in terms of the
11 learning from that particular SAI in that incident.
12 It's the responsibility then for individual directors to
13 ensure that they follow the action plan and that's
14 monitored on a regular basis, particularly those areas
15 that have an impact directly, but also the lessons from
16 it in terms of some of the issues and principles that
17 would emerge from it.
18 DR ANTHONY STEVENS: Mr Chairman, I can give another example
19 from just last week where we had a complaint directly to
20 my office -- and complaints sometimes come into
21 directors' offices -- from an individual. It related to
22 a late-night transfer of an elderly patient at the
23 hospital. It has been well trailed in the media. We've
24 already instituted a review of that and we're dealing
25 with it very, very definitely as a complaint.

1 We haven't even waited for the outcome of that review,
2 we've already changed our policy and practice, and, as
3 Mr Donaghy has said, that knowledge and information has
4 been passed through our directorates. So sometimes
5 we're responding very quickly.
6 THE CHAIRMAN: And in this scenario, there's no -- you're
7 not sitting on your hands waiting for somebody to write
8 in "I want to make a formal complaint about something",
9 it's anything which comes to your attention which is
10 categorised as something which needs to be sorted out?
11 DR ANTHONY STEVENS: Mm.
12 THE CHAIRMAN: So in fact the complaint heading has become
13 a slight misnomer, hasn't it?
14 DR ANTHONY STEVENS: Anyone who raises a material concern of
15 any sort, but sometimes you have to hang things on a peg
16 and the complaints procedure gives us a peg and gives us
17 standards by which we've got to adhere.
18 THE CHAIRMAN: Okay. Well, that's really what I want to ask
19 about complaints. Unless there's anything else that any
20 of the four of you want to add, I will move on to
21 serious adverse incidents.
22 I think what I need to do is I need -- because this
23 hasn't been explained publicly yet. It's referred to in
24 your paper, but I want to call up two documents, if
25 I can, side by side. If I can call up 331-008-008.

1 I think this is the 2010 Health & Social Care Board
2 procedure for reporting and following up serious adverse
3 incidents.
4 The reason I want to bring it up side by side with
5 something is that there's now a new policy in place
6 from October this year. We can bring up beside that
7 then 331-010-013. Mr Donaghy, your panel will be
8 familiar with this. But to explain to everyone in
9 particular and, in particular, to explain it to the
10 families.
11 On the left-hand side we have -- I think it might
12 have been the 2010. And at 4.2, the criteria for
13 a serious adverse incident are in bullet points:
14 "Serious injury to, or unexpected/unexplained death
15 of a service user."
16 And in this context, "a service user" includes
17 a patient; right?
18 COLM DONAGHY: Yes.
19 THE CHAIRMAN: The next bullet point is:
20 "Unexpected serious risk to a patient."
21 And then it continues. And the contrast which
22 I want to highlight is with the new October 2013 policy
23 on the right-hand side of the screen. 4.2.1 repeats the
24 left-hand side:
25 "Serious injury to, or the unexpected/unexplained

1 death of a service user."
2 And then 4.2.2 is new, isn't it?
3 COLM DONAGHY: It is, chairman.
4 THE CHAIRMAN: This is:
5 "Any death of a child in receipt of health and
6 social care services (up to 18th birthday). This
7 includes hospital and community services."
8 And so on. So the effect of this change in policy
9 is that any death of a child in hospital now triggers
10 a serious adverse incident review. Is my understanding
11 correct?
12 COLM DONAGHY: That's right, chairman.
13 THE CHAIRMAN: So if a child died in the circumstances of
14 Adam or Claire, Lucy, Raychel or Conor, then that is now
15 automatically a serious adverse incident review?
16 COLM DONAGHY: That's right.
17 THE CHAIRMAN: Okay. So it no longer depends on somebody
18 thinking "We've done something wrong here", it now
19 automatically becomes an SAI?
20 And just to follow up on this, if you could drop the
21 left-hand side of the screen, please, drop the 008
22 document and replace it, if you would, with another
23 extract from the 2013 policy, which is 331-010-017.
24 In terms of timescales, the current policy is that,
25 at 6.1:

1 "Any adverse incident which meets the criteria
2 indicated in section 4.2 should be reported within
3 72 hours of the incident being discovered using the
4 notification form."
5 And then 6.2 has investigation reports and this
6 depends on the level at which the incident is
7 identified; is that right?
8 COLM DONAGHY: That's right.
9 THE CHAIRMAN: So not only must the death be reported, must
10 any death be reported, but the report must come within
11 72 hours and there's then a timetable within which the
12 investigations should be completed.
13 COLM DONAGHY: Yes. That's right.
14 THE CHAIRMAN: So just to spell this out, this actually
15 applies to a child who dies of cancer?
16 COLM DONAGHY: Yes, chairman, and since the introduction of
17 the guidelines, there have been one or two instances
18 that have arisen where we believe applying the serious
19 adverse incident process could potentially cause further
20 hurt or trauma to families. You have mentioned cancer.
21 Another hypothetical situation could be where
22 antenatally it has been identified that when a child
23 that goes to full term is born that it will have a very
24 life-limiting illness within hours or days and that
25 child could pass away. Our obstetricians would indicate

1 they don't believe it appropriate that they would then
2 say to the family "We're going to institute a serious
3 adverse incident" because again it would just add to
4 their grief in that.
5 Given that this is a new policy, we're in discussion
6 with the Health & Social Care Board for example around
7 those sorts of areas and there may be another way --
8 I mean, we introduced our mortality and morbidity
9 process -- which we referred to in our papers to you,
10 chairman -- prior to this new process and these new
11 guidelines being introduced. And therefore, every death
12 is reviewed and we make provision for every death to be
13 reviewed. Therefore, escalating it to a serious adverse
14 incident in some cases may not be the appropriate way to
15 deal with it.
16 THE CHAIRMAN: I understand. I'm going to come on to the
17 mortality and morbidity audit in a few minutes.
18 There's an issue in terms of the inquiry about those
19 audits because, although we were told that audit was in
20 a somewhat embryonic form in the mid-1990s onwards, I'm
21 not sure that I've received any evidence that any of the
22 children's deaths in this inquiry were subject to audit.
23 Okay? So we will have to deal with audit in a few
24 minutes so that you can explain if and how things have
25 changed.

1 But in terms of this, I understood that the positive
2 side of the extension of the criteria as of October this
3 year was that every death, in effect, has to become
4 an SAI.
5 What then happens, as I understand it, is that some
6 are immediately downgraded and the review comes to
7 a very quick end if it is a case of nature inevitably
8 taking its course.
9 COLM DONAGHY: Yes.
10 THE CHAIRMAN: And what you're describing, I think
11 Mr Donaghy, if I understand it correctly, is you're
12 trying to work out with the Health & Social Care Board
13 how that line of cases might be most sensitively
14 handled.
15 COLM DONAGHY: Yes. A significant review or a significant
16 event audit would be something which we would suggest is
17 probably more appropriate in terms of the terminology.
18 I accept that the different levels that have been
19 identified in the new guidance -- and by the way,
20 chairman, we welcome the new guidance. We were a part
21 of helping devise the new guidance, so it's something we
22 believe is positive as well. It's just in the
23 application of it then that I think we need to be
24 sensitive to certain circumstances and situations.
25 THE CHAIRMAN: Right. I think the reassurance for the

1 families involved in this inquiry is that each one of
2 the deaths which I've been looking at, if it's missed
3 under 4.2.1, is automatically going to be picked up
4 under 4.2.2?
5 COLM DONAGHY: Yes.
6 THE CHAIRMAN: So to the extent that the families believe on
7 some of the evidence that they've heard that there was
8 a cover-up, this actually precludes a cover-up?
9 COLM DONAGHY: It does.
10 THE CHAIRMAN: The other element of it, which I think is
11 important to explain, is that sometimes, under this new
12 procedure, a review can be brought to a fairly summary
13 end or downgraded because it turns out that the event
14 doesn't merit a review?
15 COLM DONAGHY: Yes.
16 THE CHAIRMAN: But that cannot be done by the trust off its
17 own bat; isn't that right?
18 COLM DONAGHY: It can't; it has to be agreed, yes.
19 THE CHAIRMAN: It has to be agreed with the Health & Social
20 Care Board?
21 COLM DONAGHY: That's right.
22 THE CHAIRMAN: Depending on what type of case it is, there
23 is a person who's appointed as the designated reviewer?
24 COLM DONAGHY: That's right.
25 THE CHAIRMAN: And that officer then, would it be fair to

1 say, oversees the SAI investigation?
2 COLM DONAGHY: And would monitor it in the context of the
3 board, and any change to the investigation or to the
4 level that was initially given to the investigation
5 would have to be discussed and agreed with the officer.
6 THE CHAIRMAN: Okay. And when the review is complete, the
7 findings of the review have to be signed off by the
8 designated review officer, is that right --
9 COLM DONAGHY: Yes.
10 THE CHAIRMAN: -- who will be external to the trust?
11 COLM DONAGHY: That's right, yes.
12 THE CHAIRMAN: So if there is a concern, as bluntly there
13 is, that there wasn't sufficient investigation or there
14 was a degree of cover-up, then under this new procedure
15 that becomes hugely more difficult to achieve --
16 COLM DONAGHY: Yes, absolutely.
17 THE CHAIRMAN: -- even if somebody's inclined to go down
18 that route?
19 COLM DONAGHY: It does, chairman, yes.
20 THE CHAIRMAN: I have seen from the Health & Social Care
21 Board a document which they now provide -- I think it's
22 a six-monthly review of serious adverse incident reviews
23 in which they bring together in a report examples of
24 particularly significant cases from which lessons might
25 be learned generally. They also announce what they're

1 going to do next. For instance, earlier this year they
2 said they were going to review all serious adverse
3 incidents involving people over 65 to see if there were
4 trends or themes which could be identified from those.
5 So when the board is here on Thursday, I can explore
6 that with them. But let me step back instead to trust
7 level for the moment. Particularly because you're the
8 Belfast Trust and particularly because you have some
9 regional specialties here, is there scope within this
10 SAI procedure for the trust itself identifying issues of
11 significance and or trends or particularly important
12 examples of things going wrong or things which might be
13 improved on without waiting for the HSCB to do its
14 six-monthly report?
15 COLM DONAGHY: There is, chairman, and we have within our
16 organisation our SAI review board, which actually brings
17 together all of the SAIs within the organisation -- and
18 other incidents as well -- and looks to see if there's
19 any trend or any issues that we need to learn from them.
20 And again, depending, as Dr Stevens has highlighted, on
21 the complexity and severity of some SAIs, the outcome of
22 an investigation process is shared again within the
23 organisation and externally in relation to any learning
24 that can immediately be put in place from those SAIs and
25 those complex issues. So whether we have a process

1 in the organisation, which is an SAI review board and
2 spreading the learning, we don't always wait for that to
3 be the mechanism because it meets on a quarterly basis
4 and it means that learning wouldn't happen in between.
5 So we're very conscious that that needs to happen on
6 a regular and ongoing basis.
7 And again, in relation to SAIs that our organisation
8 believe may have a significance across Northern Ireland
9 or for other trusts, that is something that we would
10 flag up early on in terms of our SAI process.
11 THE CHAIRMAN: I couldn't find it last night, but I'm sure
12 I have come across in recent papers a reference to an
13 early notification system.
14 COLM DONAGHY: Early alert.
15 THE CHAIRMAN: Who raises the early alert and who does it go
16 to?
17 COLM DONAGHY: Dr Stevens can give you the detail on that,
18 chairman.
19 DR ANTHONY STEVENS: The early alert system is a parallel
20 system for flagging, with the department and the board,
21 any early concerns. It's very often a precursor to
22 an SAI, but for example if we felt a story was likely to
23 attract early media interest, we would wish to put an
24 early alert in, or if we felt we were likely to be
25 dealing with a very significant adverse event, or for

1 example we were going to do a call back of patients, then
2 we would put in an early alert just to advise the system
3 of what was happening. It is nothing other than that.
4 As I said, it's often a precursor to a serious adverse
5 incident report being made and then a formal process
6 carrying on.
7 THE CHAIRMAN: Right. But we heard evidence last week about
8 whether there was a system for the department being
9 notified of deaths, the deaths of the children in this
10 inquiry, and I'm afraid it turns out that there wasn't
11 a system worth the name. But the early alert system is
12 now that system, is it?
13 COLM DONAGHY: It is, chairman. But on a very practical
14 basis, where I'm made aware of early alerts or where I'm
15 made aware of potentially serious issues, I have
16 a direct connection now with the department. I would
17 directly phone the Permanent Secretary and alert him to
18 issues that might have a serious consequence or nature
19 in the organisation, particularly if those issues would
20 be potentially in the public domain, for example. So
21 there is a direct contact between myself and the
22 Permanent Secretary in those cases.
23 THE CHAIRMAN: Do you have an equivalent direct line to
24 Dr McBride as the Chief Medical Officer?
25 DR ANTHONY STEVENS: I would. Often it is the early alert

1 system, and again I think we've reached a stage where
2 the systems are a little more formal than they would
3 have been even five years ago, and normally if you are
4 alerting the department -- so if I'm alerting down the
5 professional line, medically, then an early alert will
6 follow, and that becomes the backstop, if you like, for
7 ensuring that the department can follow up with us at
8 a later stage.
9 THE CHAIRMAN: The system clearly looks better and is better
10 on paper than it was before. Are you learning more from
11 it? Because it's one thing to have procedures in place;
12 it's another that the trust is actually benefiting from
13 those procedures.
14 DR ANTHONY STEVENS: I think the key for us is, at the very
15 beginning of the trust, we established a standards and
16 guidelines committee that develops and revises and
17 reviews all our policies. It takes information from
18 national standards, so from NICE or, from when NPSA
19 existed, from NPSA. It also takes information from our
20 own experiences. So we're continually refreshing our
21 policies and procedures, developing local protocols
22 based on experience.
23 So, for example, we had a serious adverse incident
24 in radiology, which required us to review our systems
25 and processes, and we completely revised those

1 processes, put in place new standards, new training. If
2 you take -- I think a really good example would be chest
3 drains. NPSA issued concerns and alerts about the
4 insertion of chest drains some considerable time ago.
5 We were also aware that we'd had one or two adverse
6 events with chest drains. We completely revamped our
7 protocols, effectively put in a desist system, so only
8 people who had been fully and appropriately trained and
9 could demonstrate competence were allowed to insert
10 a chest drain. We ensured there were a sufficient
11 number of trained people available to always be able to
12 do that and we now monitor our performance. We reported
13 it to our board of directors as a so-called never event,
14 along with NG tubes and other things.
15 So I think that's a really good example where we
16 identified a high-risk procedure, where we were
17 probably -- didn't have a robust set of processes in
18 place to protect patients. We completely revamped our
19 system, put in as secure a system as we could. And as
20 far as I can see, from talking to people in England,
21 we're as robust as anywhere and we haven't had, touch
22 wood, a serious adverse incident in that regard really
23 since we put it in place.
24 THE CHAIRMAN: Did that come from a serious adverse incident
25 review under another name or under an earlier name?

1 DR ANTHONY STEVENS: It certainly came from our own
2 experience, plus the NPSA alert coming in as well.
3 COLM DONAGHY: Another example -- and Dr Stevens touched on
4 it earlier -- was in relation to our emergency
5 departments again where we did have a serious adverse
6 incident situation, and we used independent experts to
7 review that for us. Those independent experts were
8 outside our trust, but were from within the
9 Northern Ireland system. As a result of the learning
10 from that serious adverse incident, for example we had
11 a ward in our hospital, 2F, which was not a great
12 environment for caring for patients. We physically
13 moved the ward to a new environment and we improved our
14 medical admissions process as a result of the learning
15 from that particular SAI and as a result of the learning
16 from that independent expert opinion we received.
17 THE CHAIRMAN: Right. In the serious adverse incident
18 process, what support is there for the patient or, if
19 it's a death case, the family of the patient?
20 DR ANTHONY STEVENS: If it's a death, along with
21 a complaint --
22 THE CHAIRMAN: I'm thinking in terms of the families in this
23 inquiry.
24 DR ANTHONY STEVENS: We particularly introduced new
25 procedures and involved our bereavement coordinator as

1 part of the team that deals with significant events
2 where a death has been involved. And we will offer
3 support, we will also offer the support of our clinical
4 psychology department -- and I have done that on
5 a number of occasions -- and we'll also try and identify
6 if there are any ongoing care needs for a family in
7 terms of support.
8 THE CHAIRMAN: You've answered me on one level. On another
9 level, in the way that there are ways of helping
10 a family during the complaints process through Patient
11 and Client Council or through the other systems that you
12 described to me earlier, in a serious adverse incident
13 review involving the death of a child there might need
14 to be -- I presume that the family is involved in the
15 investigation.
16 DR ANTHONY STEVENS: Mm-hm.
17 THE CHAIRMAN: And in the experience of this inquiry, the
18 families can have some very important information to
19 contribute to an investigation. Who is available to
20 assist them in doing that? Because that's not really
21 for clinical psychology or the bereavement counsellor.
22 Is there somebody available to deal with that?
23 DR ANTHONY STEVENS: Obviously, once we decide that an
24 incident is a serious adverse incident, we'll be setting
25 up our procedures to do the appropriate investigation.

1 The family will be notified of that. We will offer
2 a meeting with the family that may involve the people
3 from the investigating team, it may be members of my
4 team, who are the central corporate governance team.
5 We will also look to the clinical folks to support the
6 family, provide information to the family.
7 We will use the resources that are best suited. If
8 the ward, for example, or the nursing staff there have
9 maintained a good relationship with the family, we would
10 use that as a way in to support the family.
11 If we feel -- we will offer them more formal support,
12 you know, for example the advocacy or the Patient and
13 Client Council. So we try and identify the best route
14 to support an individual.
15 THE CHAIRMAN: Patient and Client Council told me they have
16 nothing to do with serious adverse incidents. Because
17 I asked them about complaints and about serious adverse
18 incidents, and they say, "We are involved in complaints,
19 but not at all with serious adverse incidents".
20 DR ANTHONY STEVENS: Very often they're one and the same.
21 Well, not very often, but not infrequently. They will
22 be inasmuch as it may have started with a complaint or
23 the complaint may come in on the back of our first
24 initial contact with the family.
25 THE CHAIRMAN: So you're not so much worried about the

1 definition? Okay. It didn't work very well at all in
2 Altnagelvin in 2001, but they had a patient advocate
3 system. I'm not sure if they still have, but did you
4 ever have a patient advocate system in the Royal?
5 BRENDA CREANEY: No, we didn't.
6 THE CHAIRMAN: Okay. What I'm thinking about, as you may
7 know, depending on how much you've been able to follow
8 the inquiry -- this system is clearly better. Let me
9 take one example. Mr and Mrs Roberts who are here.
10 When Claire died, her death was attributed a cause,
11 which was at least incomplete, if not entirely
12 inaccurate. There was no inquest and they effectively
13 identified what happened eight years later when they saw
14 a documentary.
15 On this scenario, if that happened again, at the
16 very least the death would be picked up under 4.2.2, if
17 not 4.2.1?
18 COLM DONAGHY: Yes.
19 THE CHAIRMAN: So there would be a serious adverse incident
20 review into Claire's death? It would start quickly
21 because the timescale makes a quick start, notification
22 and progress mandatory. If, in the course of an
23 investigation into a death like Claire's, which wasn't
24 entirely straightforward, they needed some or they
25 suggested "Look, you need an expert's opinion" or "We

1 need some help in working our way through the
2 information that we're receiving, the views which we're
3 giving you or the facts that we're reporting to you as
4 part of this investigation", then the ways of doing that
5 are -- I think you've described a variety: maybe nurses
6 if there's a continuing good relationship with the
7 nurses who were treating their child on the ward; it may
8 be an advocacy group such as the PCC.
9 The investigating team itself is within the trust,
10 isn't it? It's a trust team?
11 DR ANTHONY STEVENS: It may be variously set up. So for
12 example, Mr Donaghy made reference to the emergency
13 department. There was an independently chaired SAI
14 review, albeit with professional support from within the
15 trust, or it may have a trust chair with independent
16 people coming in. But all our SAIs are supported by our
17 corporate governance function, and those individuals can
18 and will provide advice and updates to the family.
19 THE CHAIRMAN: Those people you're describing, Dr Stevens,
20 are people who would not have been -- they're employed
21 by the trust, but they're not people who would have been
22 involved in any way in the care of the dead child?
23 DR ANTHONY STEVENS: This is a team under the charge of
24 Mrs June Champion, who's our risk and governance
25 coordinator and head of office, and they would be

1 entirely independent of the clinical teams and have
2 built up very substantial expertise in managing adverse
3 incidents, including serious adverse incidents.
4 THE CHAIRMAN: I can ask this on Thursday when the Health &
5 Social Care Board is here, but do you know if the family
6 has access to the designated review officer?
7 DR ANTHONY STEVENS: Gosh, that's a good question. I'd need
8 to --
9 THE CHAIRMAN: I can ask on Thursday. I think that's an
10 additional or alternative route for a family input.
11 DR ANTHONY STEVENS: I'm not aware that that has been the
12 case, but I can check that later. In fact, I'm getting
13 a shake of the head from the back of the court --
14 THE CHAIRMAN: Okay.
15 DR ANTHONY STEVENS: -- that it's not the case.
16 THE CHAIRMAN: I'm just throwing out ideas here about what
17 might be done and whether that's necessary depends.
18 Mr Donaghy?
19 COLM DONAGHY: Chairman, I just want, if it's helpful, to
20 give a context to advocacy generally within the trust.
21 Because we do actually provide advocacy in quite
22 a number of different circumstances and it's primarily
23 where we believe the individual or group are unable to
24 articulate to some extent their own needs. So in
25 learning disability, in mental health, people with

1 dementia, some of our elderly population, we would
2 provide definitive advocacy in those circumstances, and
3 I think what you're highlighting is maybe the need to
4 think about that more strongly in the context of the
5 serious adverse incidents, particularly where there's
6 a death of a child.
7 THE CHAIRMAN: It will depend. Some people are quite
8 intelligent, articulate, coherent, other people will
9 just have a bit more trouble absorbing information that
10 you're giving them or communicating information to you.
11 COLM DONAGHY: Yes.
12 THE CHAIRMAN: Okay. I don't need to go into this, but on
13 your social care side you'll have children in care and
14 so on, who need support.
15 COLM DONAGHY: That's right.
16 THE CHAIRMAN: Right. I think I've raised everything I want
17 to raise about serious adverse incidents, unless there's
18 anything else we need to tidy up at your end before we
19 move on.
20 Ms Creaney, there's one specific issue which came up
21 during Claire's case through the evidence of
22 Nurse McRandal. Can you help me on that? Just for
23 everybody else's information, part of the hyponatraemia
24 guidelines -- in fact central to the hyponatraemia
25 guidelines -- is monitoring hydration levels so that you

1 measure fluid output and intake.
2 BRENDA CREANEY: Yes.
3 THE CHAIRMAN: I'm just looking for my note. Give me
4 a second. It was said to us in very stark and confident
5 terms on 29 October last year by Staff Nurse McRandal
6 that -- she said that, in 1996, when Claire was being
7 treated, it was not normal to measure urine output. And
8 she then said:
9 "It is still not normal to measure urine output on
10 the Allen Ward, but it is on other wards."
11 You'll understand why that's a matter of concern.
12 Can you help with that?
13 BRENDA CREANEY: Yes. That is a matter of concern,
14 chairman, and on reviewing our policy, you will be aware
15 that in the monitoring section, it talks about in
16 section 8.4.2 that:
17 "All fluid output must be assessed and, if
18 clinically indicated, measured and recorded on the fluid
19 balance chart."
20 Subsequent to the evidence given last year, it
21 became apparent to us that our policy wasn't explicit
22 enough in that regard. So to that end, we have reviewed
23 the policy and made it much more explicit now so it says
24 that children who are having IV fluids must have any
25 nappies weighed and children on other forms of fluid

1 intake must have nappies weighed when clinically
2 indicated. So I feel that gives much more direction for
3 the nursing staff in that regard.
4 THE CHAIRMAN: Yes. Okay, that's helpful, thank you very
5 much.
6 Let me move on. We've touched on this a bit
7 already, but I want to look at the issues -- some of
8 them run into each other -- of litigation, inquests and
9 claims for privilege.
10 For those who haven't been here before, the context
11 of the concern about claim for privilege is this, that
12 a trust, like any other individual or organisation
13 involved in court proceedings, is entitled to get expert
14 evidence for the purpose of those proceedings, which
15 it is not obliged to disclose to the other side or to
16 the court. That's a long-established legal principle.
17 It has been highlighted in this inquiry as a result of
18 Raychel's inquest because, as we now know -- and
19 I should emphasise at this point that this was not
20 a Royal or a Belfast Trust inquest; it involved
21 primarily Altnagelvin -- but the issue is, I think,
22 common in that the Altnagelvin Trust obtained an
23 expert's report having seen the coroner's expert's
24 report. The trust's independent expert report
25 effectively agreed with the coroner's expert report, but

1 was not then shared with the coroner. Or, to put it
2 another way, as the family might describe it, the
3 coroner had an expert's report withheld from him because
4 it was not helpful to the trust.
5 In our written exchanges which have preceded today,
6 the Belfast Trust has effectively spelt out that it will
7 continue to assert privilege if it believes it should do
8 so, if that's not an unfair way of summarising it.
9 COLM DONAGHY: Yes, and given the legal complexities,
10 chairman, which you'll be much more familiar with than
11 me, in the context of an inquest we have never withheld
12 an expert or other report, whether it was in agreement
13 with the coroner or contrary to what we might have felt
14 was the case. So it has never been the case that
15 Belfast has withheld reports from the coroner. And in
16 fact -- and Dr Stevens can outline this for you -- we
17 have in place liaison arrangements with the coroner's
18 service, which actually means we work very, very closely
19 with the coroner in the context of inquests.
20 THE CHAIRMAN: Part of my concern, Mr Donaghy, was -- and
21 again this might have been overtaken by time -- that the
22 coroner was surprised to learn when he gave evidence at
23 this inquiry that an expert report had been withheld
24 from him in Raychel's case. And he specifically said
25 that he worked on the basis that he shares his expert's

1 reports with the parties who are involved in an inquest
2 and he traditionally worked on the basis that they did
3 so with him. I'm putting words in his mouth, but
4 I think it was quite clear to everybody here that he was
5 surprised and disappointed to learn that that wasn't the
6 case.
7 COLM DONAGHY: In Belfast we do. We've always shared those
8 reports.
9 THE CHAIRMAN: Can I ask you: is that on the basis that
10 while a trust is entitled to claim privilege, the
11 fundamental reason for a trust existing is to provide
12 care for patients?
13 COLM DONAGHY: Absolutely.
14 THE CHAIRMAN: So if you have an expert's report which says,
15 to your disappointment, that something has gone wrong in
16 the trust, it's not in the interests of patients that
17 you withhold that?
18 COLM DONAGHY: Absolutely not, and we would share that,
19 chairman.
20 THE CHAIRMAN: Do you want to add anything, Dr Stevens, or
21 have you covered that?
22 DR ANTHONY STEVENS: I think you've covered that. We
23 haven't chosen in the past to withhold expert reports,
24 and we clearly won't be in the future. We again work on
25 the principle, particularly with the coroner, that what

1 we're trying to do is establish facts. If we are at
2 fault, the earliest we know that and the earliest we can
3 develop an action plan to deal with the consequences,
4 the better. Leaving any sentimentality out of this, in
5 pure business terms, the sooner we can get to the bottom
6 of the thing and can deal with it, the better from our
7 point of view, but also clearly from the point of view
8 of our patients.
9 THE CHAIRMAN: Perhaps the single biggest issue about
10 inquest is to prevent things happening again. You can
11 prevent things happening again if you have an expert's
12 report which you withhold -- I'm glad to hear that. Let
13 me not be naive: you're not saying that you may not do
14 the same in litigation. If you think it's appropriate,
15 you may obtain an expert's report in the litigation
16 setting and withhold it.
17 DR ANTHONY STEVENS: Clearly, we would be taking legal
18 advice in that situation, and I think it is a different
19 situation.
20 THE CHAIRMAN: Yes. Staying with inquests for the moment,
21 there was an example which I'm concerned about from
22 Claire's inquest, and I think you'll have heard me
23 yesterday about this, but just for those who weren't
24 here: when Claire's case eventually came to an inquest,
25 I think almost 10 years after she died, Dr Webb, who had

1 been helping in her care, drafted a statement for the
2 coroner in which he expressed some regret and said that
3 he wished he'd referred her to paediatric intensive care
4 before he finished his duties on a particular day. And
5 it was then suggested to him that he should leave that
6 regret out of his statement to the coroner.
7 I'm concerned about that primarily because I think
8 that's information that the coroner should have. I know
9 the coroner's trying to establish the facts, but the
10 coroner's also trying to work out the way forward in
11 future and the more openness there is -- I mean, Dr Webb
12 wasn't admitting fault. This is where it seems to me to
13 have gone wrong. He wasn't admitting fault or saying,
14 "I was negligent in not referring Claire to PICU", but
15 in a sense he was thinking aloud and saying: well, if I
16 had referred Claire to PICU, things might have turned
17 out better. Would an equivalent of Dr Webb still be
18 discouraged from including that in a witness statement
19 to the coroner?
20 DR ANTHONY STEVENS: We do have an ongoing relationship with
21 the coroner. As Mr Donaghy has said, we meet twice
22 a year with the coroner and the coroner's medical
23 adviser. We have taken the opportunity to reflect on
24 some of the evidence that's been given in this inquiry.
25 We would be very clear that the primary purpose of

1 a statement is to set out the facts as an individual
2 understands them and knows them. We also would be clear
3 that now that if they wished to reflect on their own
4 part in that, that that is also entirely reasonable.
5 We wouldn't necessarily be encouraging an individual to
6 give opinion or an opinion on the practice of other
7 people, but I think we would accept that an individual's
8 statement can reasonably include a reflection on their
9 own part to play and anything that they felt they could
10 have done better.
11 We have spoken to the coroner on these matters and
12 I believe we do have his continuing support for us
13 assisting our clinical staff in preparing statements,
14 roughly along the lines that I've described.
15 THE CHAIRMAN: There was a point at which the coroner had
16 raised the possibility that the statements should no
17 longer be forwarded to him through the hospital, as had
18 been the practice. In fact, he had suggested, but
19 effectively he let it drop, that it should be the police
20 who take the statements. I presume that is not
21 happening?
22 DR ANTHONY STEVENS: No. My understanding is that through
23 our ongoing liaison with the coroner that the
24 arrangements we now have in place meet his requirements.
25 THE CHAIRMAN: Right. Let me just tease out with you one

1 point that you made there, doctor, about how you
2 wouldn't encourage doctors to comment on the practice of
3 others. There's at least one of the deaths which I'm
4 concerned with where the primary blame lay with a doctor
5 and that was recognised almost immediately by two other
6 senior staff who were involved. That view, which has
7 a lot of weight behind it, was not shared with the
8 coroner.
9 I can see from a legal perspective how that might be
10 appropriate, but I can also see from the families'
11 perspective that if Dr A and Dr B think that their child
12 died because Dr X happened to make a terrible mistake on
13 a very bad day that Dr A and Dr B should be willing to
14 say that at an inquest.
15 DR ANTHONY STEVENS: I think what is clearly said at inquest
16 and what might be put into a preparatory statement may
17 presumably be slightly different in detail. My
18 understanding in the advice that certainly I've received
19 in terms of advising my department on how to deal with
20 this is that we should encourage our clinicians to
21 provide statements that are factual, that our role is to
22 ensure that they are comprehensive, there are no obvious
23 omissions, that we would also assist them in terms of
24 the quality of the report -- in terms of just even the
25 use of English -- and ensure that they're apposite. But

1 we would not necessarily encourage an expression of
2 opinion beyond the individual's own practice. Clearly,
3 if they believe that somebody has made a very definite
4 mistake and they believe there's a clear matter of fact
5 in that, then I could see that that would clearly be
6 reasonable to include that. I suppose there's just
7 a subjective element in this that we probably are
8 wanting to possibly discourage.
9 THE CHAIRMAN: Okay. There's one other issue, which I think
10 applies to Claire's case, which is the fact that her
11 death wasn't referred to the coroner. And given the
12 notes which are on the death certification process, it's
13 rather difficult to understand how that wasn't the case.
14 But it raised an issue, which didn't go away, because it
15 appeared through the evidence of a number of people that
16 they weren't actually very clear about the circumstances
17 in which a death should be reported to the coroner.
18 A small number of them said that they hadn't ever
19 actually been trained in this. That surprised me, and
20 as I suspect it might surprise each of you, that
21 a doctor -- and we're talking about doctors, but I think
22 the same might apply to nurses, that they should know
23 the circumstances in which a death should be reported to
24 the coroner. How is that training given to them? Is it
25 training which is given to them only at undergraduate

1 level or is there any training along those lines at
2 trust level?
3 DR ANTHONY STEVENS: Well, the training for doctors occurs
4 at probably three levels. There's the undergraduate
5 level, there is postgraduate training that the
6 Northern Ireland Medical and Dental Training Agency
7 would be responsible for, and then there's the training
8 that the trust is responsible for. Training in this
9 area is undertaken -- or teaching, if not training --
10 at the undergraduate level. I am aware that at the
11 foundation year 2 level, which is the second year out,
12 the Northern Ireland Medical and Dental Training Agency
13 runs a day for those doctors on a range of legal issues.
14 We obviously provide advice and support to our doctors.
15 I think one really important thing here that might
16 help provide you with some assurance and the families
17 with some assurance is that our morbidity/mortality
18 process, when we're reviewing deaths, even if we hadn't
19 reported a case to the coroner -- and of course, we may
20 become aware retrospectively that there are concerns
21 about a case that might make it necessary or appropriate
22 to refer to the coroner. And we've had conversations
23 with the coroner's medical adviser about the possibility
24 of a late referral to the coroner, and they've accepted
25 that.

1 Now, that's obviously not a terribly satisfactory
2 situation.
3 THE CHAIRMAN: It could come from, for instance, an autopsy
4 report, could it?
5 DR ANTHONY STEVENS: It could come from an autopsy report,
6 but the autopsy report, if it was being reviewed at our
7 morbidity/mortality meeting -- I suppose what I'm saying
8 to you is we're putting a belt and braces on this, and
9 we've done that in this process, but also because I was
10 a little anxious about the possibility of late referral
11 to the coroner. We approached his offices in this
12 regard and confirmed that, while not ideal, he would
13 still welcome us raising these.
14 So I think the checks and balances that we're
15 putting in place ensure a good liaison with the coroner
16 and that we get advice from the coroner are there.
17 THE CHAIRMAN: You mentioned the coroner's medical officer.
18 Has the appointment of a medical officer to the coroner
19 helped things?
20 DR ANTHONY STEVENS: Hugely. It allows us to have
21 a dialogue, to test uncertainty and to take an opinion
22 on individual cases. But also, the particular medical
23 adviser, Gillian Clarke, we've invited her into the
24 trust to meet with different groups of staff and to have
25 a liaison, both at the coronial role, but also her role

1 and how she can support our medical staff.
2 THE CHAIRMAN: What's her specialty?
3 DR ANTHONY STEVENS: I think she was a general practitioner
4 by background.
5 THE CHAIRMAN: I was going to say, does she then have the
6 facility to turn for specialist advice, if needs be, or
7 if she needs to do that, does that indicate in itself
8 that it's a case potentially for the coroner?
9 DR ANTHONY STEVENS: I'm not sure I'm in a position to
10 answer the detail on that.
11 THE CHAIRMAN: Okay, thank you.
12 Staying on the area of training of doctors and
13 nurses, one of the issues which has emerged -- and not
14 just through this inquiry but on a much broader range,
15 including the Francis report -- is the way in which
16 doctors and nurses can be trained or are now being
17 trained in how they might discuss cases and how they
18 might engage more openly and frankly with families.
19 Let me ask Ms Creaney and Dr Jackson about this at
20 the children's end and then we'll lead into it
21 generally. Can either of you help me about how training
22 in this area has changed or developed in recent years?
23 Has it, for a start?
24 BRENDA CREANEY: Well, chairman, there is training
25 in relation to communication, both at undergraduate

1 level for nurses -- and that's all nurses including
2 children's nurses -- and certainly part and parcel of
3 the care of children is what we call family-centred
4 care, where the parents and the wider family are viewed
5 as very much part and parcel of the care of their child.
6 And certainly all children's nurses would be trained to
7 involve families at every opportunity.
8 Another issue for us --
9 THE CHAIRMAN: Just let me interrupt you. I welcome that,
10 Ms Creaney. That is not the experience of this inquiry,
11 I have to say. These are at least 10 years ago now, but
12 there were significant failings in the extent to which
13 the families were listened to or anybody engaged with
14 the families in any meaningful way. So for at least two
15 of the deaths I'm concerned with, the parents went home
16 thinking that their child was ill and not that ill, and
17 were called back a few hours later, in both cases, to be
18 told, to all intents and purposes, that their daughter
19 was dead.
20 That's an absolute lack of communication with the
21 families. I understand, that even by the standards of
22 the mid to late-1990s/early 2000s, that wasn't good
23 enough. From what you have just been telling me, have
24 things moved on or improved since then in terms of
25 recognising that the families know the children best and

1 therefore their advice on whether their quiet child is
2 always a quiet child or is abnormally quiet is
3 fundamental?
4 BRENDA CREANEY: That's absolutely the case and I would
5 suggest that should have been the case in the mid-90s.
6 However -- certainly it's something in nursing that
7 we're working very, very closely on at the moment. And
8 we call it "person-centred care" and that reads over
9 into the care of children as family-centred care as
10 I have said. It's a very important element of care.
11 Another point that I think is very, very important:
12 this isn't just about undergraduate teaching, this is
13 about a maintenance of that level of care through
14 someone's entire career. And certainly it is a piece of
15 work that the Children's Hospital are looking at at the
16 moment and have been for many years on how we can
17 improve communication with families and with children so
18 that parent do feel an integral part of their child's
19 care and in decision-making in relation to their care.
20 We've recently started doing some work
21 internationally in this regard as well. However,
22 certainly the senior staff in the Children's Hospital,
23 the ward sisters and the staff nurses, are absolutely
24 key in maintaining that culture of good communication.
25 THE CHAIRMAN: Okay. Dr Jackson, can you add to that from

1 the perspective of the paediatricians?
2 DR PAUL JACKSON: Well, yes, certainly, especially trainees
3 coming through their training have their training
4 coordinated by NIMDTA, as Dr Stevens mentioned, the
5 Northern Ireland Council for Medical and Dental
6 Education. And part and parcel of that are modules --
7 and the thrust often will be the holistic approach
8 within paediatrics as a specialty and that has come more
9 and more to the fore.
10 Within the hospital, I think our approach has
11 changed as well. Now particularly for the complex
12 children, planning of their care is often on
13 a multi-team, multidisciplinary approach, and often the
14 parent will be involved in that. So a child with
15 complex needs, for example, who is cared for by a number
16 of specialists, led by a lead paediatrician or a lead
17 surgeon, will often have that coordinated through
18 meetings, multidisciplinary meetings, to which the
19 parents are invited.
20 THE CHAIRMAN: Right. And then in this area, that maybe
21 sort of leads us into the Francis report about the
22 proposed statutory duty of candour. I think, perhaps as
23 described by Mr Walsh from the AVMA, the problem at the
24 moment is that there are examples of very good practice
25 all over the place, and in every hospital and every area

1 there are examples of very good practice, but inevitably
2 in any organisation there are some examples of practice
3 which isn't as good and he was saying that -- but the
4 duty of candour, what's proposed is a duty to be imposed
5 on all medical practitioners to inform parents in open
6 and frank terms about deaths or serious harm where that
7 has occurred as a result of something which has gone on,
8 for instance, in a hospital. Do you want to express any
9 view on that or do you have any view on it?
10 COLM DONAGHY: Yes, chairman. I think, as yesterday's
11 discussion that you had with Mr Walsh indicated, the
12 debate in England is in regard to when the duty of
13 candour would apply and in what circumstances and
14 I think I would agree with the conclusion of your
15 discussion yesterday about near misses, for example,
16 in the context of duty of candour.
17 THE CHAIRMAN: That that should be discretionary?
18 COLM DONAGHY: Yes. And the other thing maybe just to
19 say -- and again Dr Stevens can outline in a wee bit
20 more detail some of what we already do and encourage
21 in relation to doctors being open and nurses being open.
22 It's actually a part of their professional
23 responsibilities to be open and to have candour in terms
24 of how they deal with patients.
25 Whether or not introducing a statutory duty will

1 improve that, I think, is something which would need to
2 be evidenced if that were to happen. For my part and
3 for the part of the Belfast Trust, it's something that
4 we really want to be ingrained and endemic in terms of
5 how we deliver care and take forward that care.
6 THE CHAIRMAN: And if the Francis recommendations are
7 adopted, the proposal just doesn't go to medical
8 practitioners; it goes to people like yourself,
9 Mr Donaghy, as directors.
10 COLM DONAGHY: It does. Francis does deal both with people
11 who deliver care and also directors of an organisation,
12 individual directors, but directors in an organisational
13 sense as well in terms of a duty of candour.
14 THE CHAIRMAN: Dr Stevens, you don't have to contribute on
15 this if you don't want to [inaudible] or just wait to
16 see what happens.
17 DR ANTHONY STEVENS: To emphasise what Mr Donaghy said, our
18 being open policy is already -- and our adverse incident
19 policy made it very clear that we expect people to
20 report incidents, not just at the severe end, as was
21 discussed yesterday, but also moderate or even some
22 minor incidents. The issue for us is, I think,
23 continuing to drive a culture of openness and honesty,
24 and to do that you need to create a sense of safety for
25 staff. They need to be held to account appropriately,

1 but they also need a sense of safety and building a --
2 that sense of openness, that real culture of openness
3 that I hope that we've been able to express today to
4 some degree does require people to have some trust and
5 I do worry a little bit that if the legal process
6 intrudes on that, it may make that a little more
7 difficult.
8 THE CHAIRMAN: I floated this with Mr Walsh yesterday, that
9 I'm not sure that lawyers and insurers necessarily make
10 this whole process any easier.
11 Just one issue, before I leave the general area of
12 litigation. A specific concern here was about the use
13 of a confidentiality clause in a settlement of a case.
14 Am I right in understanding that, as I picked it up from
15 one of the papers, maybe a departmental paper, that
16 confidentiality clauses do not go into legal settlements
17 now unless at the request of the plaintiff or family?
18 COLM DONAGHY: That's right, chairman. They have been
19 removed, yes.
20 THE CHAIRMAN: Is that departmental-led or is that ...
21 COLM DONAGHY: I think it was department-led. Yes, I think
22 it's department policy now. I'm trying to think of the
23 time.
24 DR ANTHONY STEVENS: I do believe it was. I can't give you
25 a date, but we've certainly followed that.

1 THE CHAIRMAN: Right, okay. I'll take a break in a few
2 minutes to see what else has to be covered, but just
3 before I get there. In the statement that you made this
4 morning, Mr Donaghy, when you were dealing with openness
5 and candour, you have a paragraph that said:
6 "We also review the deaths that occur in our trust."
7 It's on page 4 of the draft of the statement that
8 was sent through to me.
9 COLM DONAGHY: Yes.
10 THE CHAIRMAN: That paragraph developed what happens at the
11 specialty morbidity and mortality meetings. You then
12 said that:
13 "In the Children's Hospital all deaths are now
14 reviewed irrespective of whether there have been any
15 concerns about the quality of care. These meetings are
16 now recorded."
17 And I wanted to ask you about that -- or Dr Jackson
18 or Dr Stevens might help with that -- because the
19 evidence that we've heard here over the last 18 months
20 indicated that, certainly in the 1990s, the discussions
21 at morbidity/mortality meetings were not recorded in any
22 way and that seems to have been partly led by insurers,
23 who were saying to their members "You can't contribute
24 on an open debate because it might then turn out to be
25 a discoverable document in the context of litigation".

1 Do I gather from this that those days are gone?
2 COLM DONAGHY: Those days are, and the minutes are actually
3 minuted, chairman, in terms of the discussion that took
4 place.
5 THE CHAIRMAN: Sorry, I take it that's what you mean by
6 recorded. You don't mean tape recorded?
7 COLM DONAGHY: No, a written minute is taken of the
8 proceedings and maybe both Dr Stevens and Dr Jackson
9 could give you a bit more detail.
10 DR ANTHONY STEVENS: I think you highlight an important
11 issue and one that's been an area of development. If
12 you go back in time to, say, the year 2000/2001, when
13 trusts like the Royal Hospitals Trust were developing
14 incident reporting, there was a strong view from
15 a number of clinicians that even incident reporting
16 should be anonymous and that had to be dealt with at
17 that time. The culture's changed now that, as I say, of
18 our 23,000 annual incident reports, 19,000-odd of those
19 refer to patients, and those are all done openly, all
20 clinicians participate in that system, so there has been
21 a change in mood.
22 With regard to morbidity and mortality, when we were
23 setting up our new policy, which I believe is reasonably
24 ground breaking, there was some discussion about whether
25 or not meetings should be minuted on the basis that it

1 might stifle debate and criticism. But that argument's
2 been dealt with, we've moved on, and all clinicians now
3 have accepted the absolute need not only for us to be
4 seen to be holding our M&M meetings, but to actually
5 have evidence of what was discussed, and for us, if
6 we're going to manage risk, to have a record of what's
7 been discussed.
8 So I think the whole issue about minuting of
9 meetings and anonymity has been an issue over the last
10 two decades, and which reflects the issue you're dealing
11 with and, I think, reflects the massive change in
12 attitude.
13 THE CHAIRMAN: How did you get round the insurers?
14 DR ANTHONY STEVENS: Obviously, we self-insure as a trust,
15 and we haven't particularly taken regard to the defence
16 organisations in this. We're looking at international
17 best practice, national best practice, looking at
18 clearly what's in the "Being open" policy and are just
19 setting our own pace on this now.
20 THE CHAIRMAN: Has this development had any effect on the
21 debate, the intensity of debate or what I was told,
22 which was that there would be quite stark criticism from
23 time to time by colleagues of each other?
24 DR ANTHONY STEVENS: I don't believe it has had an impact.
25 I believe now -- I mean, the very fact that the

1 Belfast Trust reports close on 100 serious adverse
2 incidents is largely down to the fact that clinicians,
3 be they doctors or nurses or other professionals, are
4 recognising when things go wrong and reporting them and
5 also using incident reporting system. So I think it
6 took a little bit of confidence. And again I would go
7 back to my earlier comment about our culture of openness
8 and fairness, and certainly the key leadership group in
9 medicine for this is our consultants because they set
10 the tone for the juniors. And we've worked really hard.
11 We work hard with them from induction, we have an
12 induction programme for all our consultants, and again
13 at that at least two of the speakers, myself included,
14 do a piece on openness.
15 So for me it's absolutely about that sense of
16 a culture, of an open and honest or open and fair
17 culture that drives this, and once clinicians feel they
18 will be treated fairly, then I think you break those
19 barriers down.
20 THE CHAIRMAN: In this changing scene, how willing are
21 junior doctors to raise an issue or a concern about
22 a consultant?
23 DR ANTHONY STEVENS: I believe they are. They have a number
24 of routes to do it, and they can do it directly through
25 their educational or clinical supervisor. That happens

1 a little, not terribly often, but does occasionally
2 happen. They can do it through the deanery, the
3 Northern Ireland Medical and Dental Training Agency, who
4 meet with their trainees on a very regular basis and who
5 do regular visits to all our sites and effectively
6 interview trainees, and they can raise concerns. And
7 they can also do it --
8 THE CHAIRMAN: I'm obviously not asking you for names, but
9 do you know that this has been done in recent years?
10 Dr Jackson's nodding there.
11 DR ANTHONY STEVENS: What they normally raise concerns about
12 are primarily concerns that they may have about
13 undermining or bullying behaviour from consultants, but
14 they will also raise concerns. They normally are
15 raising concerns about unsafe systems rather than
16 individuals. The only recent experience I've had of
17 a concern about a consultant was actually from another
18 route, which is the national trainee survey. The GMC
19 carries out a trainee survey every year, all trainees
20 are welcome to participate in it, and a significant
21 section on that is on safety. And I'm aware of one
22 example where a trainee raised a concern about
23 a consultant. Interestingly in that case, after very
24 detailed investigation, we didn't feel that the concern
25 could be upheld. But there are a number of routes for

1 trainees.
2 THE CHAIRMAN: But the point is it was investigated?
3 DR ANTHONY STEVENS: It was very thoroughly investigated.
4 THE CHAIRMAN: Okay. Let me stop for a few minutes.
5 If I haven't finished, I am coming close to finishing.
6 We'll take a few minutes' break and you can reflect if
7 there's anything more you want to add and I will pick up
8 anything that's coming from the floor.
9 (11.58 am)
10 (A short break)
11 (12.35 pm)
12 THE CHAIRMAN: Thank you for waiting, it just took a little
13 bit longer than expected. I have one point I have been
14 asked to clarify and then, I think, Mr Hunter, you have
15 another point.
16 Let me tidy up one point, Ms Creaney, with you.
17 It's when I was asking about the implementation of the
18 guidelines about monitoring the passing of urine. You
19 answered in terms of children with nappies. Do I take
20 it that the guidelines were clarified for older children
21 such as the age that Claire would have been, children
22 without nappies?
23 BRENDA CREANEY: Oh yes, it does. It actually talks about
24 measurement of the urine, but it specifically mentions
25 the weighing of nappies. But obviously where a child is

1 able to have its urine measured more conventionally,
2 then that is indicated as well in all children who have
3 intravenous fluids.
4 THE CHAIRMAN: So any previous lack of clarity or ambiguity
5 in the guidelines and in the practice has now been
6 removed as a result of the redrawing of them?
7 BRENDA CREANEY: Yes. Would it be helpful if I read the
8 earlier part of the guidance?
9 THE CHAIRMAN: Yes, if you have it handy.
10 BRENDA CREANEY: I have. Section 8.4.2, the fourth bullet
11 point. It says:
12 "All fluid output of any kind must be assessed if
13 considered necessary. It should be measured and
14 recorded on the fluid prescription and balance chart."
15 Then it goes on to say the sentence I mentioned
16 earlier. I could provide the inquiry with the updated
17 guidance.
18 THE CHAIRMAN: That would help, thank you very much.
19 I think there was just one other point. Mr Hunter,
20 you had a query arising out of the adverse incident
21 reports about the consequences or follow-up to those
22 reports.
23 Questions from MR HUNTER
24 MR HUNTER: Yes, I have two matters, sir, I would like to
25 raise.

1 The first is the one you've just referred to. If
2 one looks at the documentation provided by the
3 Belfast Trust, in it you will see that in a five-year
4 period from 2007 to 2012, there were five referrals to
5 the GMC. And in a similar period, there were 56
6 referrals of nurses to their professional bodies.
7 Given the statistics that Dr Stevens has given you
8 today that per year in the Belfast Trust there are
9 23,000 adverse incident reports and there are 1,700
10 complaints, one wonders how robust the system is if all
11 of that leads to just one referral per year of a doctor
12 to the GMC.
13 THE CHAIRMAN: Okay. A second aspect to it is the number of
14 referrals of nurses to the NMC. This isn't to say that
15 there was any adverse findings, but there was a referral
16 to the professional bodies, the professional regulator.
17 MR HUNTER: Yes, there is. If you take an average of the
18 figures over the five years, there seems to be ten
19 referrals of nurses per year against one referral for
20 doctors.
21 THE CHAIRMAN: And these are arising --
22 MR HUNTER: Arising out of the Belfast Trust position paper.
23 THE CHAIRMAN: Which segment of it, just so that we can
24 bring it up?
25 MR HUNTER: 332-003-035.

1 THE CHAIRMAN: Okay. Can I ask you: do you have this to
2 hand or do you know what document we're referring to?
3 This is your initial response to the issues I'd raised
4 with you. Internally, page 18.
5 So Mr Hunter, that's the number of incidents which
6 have been reported, right?
7 MR HUNTER: Yes.
8 THE CHAIRMAN: Then the figures in terms of referrals to the
9 GMC and NMC?
10 MR HUNTER: If you look at 322-003-035, it says there that,
11 in the period 2007 to July 2013, there were six
12 concluded fitness-to-practise hearings for doctors
13 relating to Belfast Trust between 2007 and 2012.
14 THE CHAIRMAN: It's not coming up on that reference. In the
15 internal numbering that you've just been referring to,
16 is that page -- Mr Hunter, can you help me?
17 MR UBEROI: I think it's page 35 of the internal numbering.
18 (Pause)
19 THE CHAIRMAN: The internal numbering is page 35?
20 MR UBEROI: I believe so, sir.
21 THE CHAIRMAN: Sorry, this comes at a couple of different
22 points in your paper. I'm not sure it's coming out with
23 the right reference on screen, but if you have page 35
24 of the original paper, there's a heading "Referring
25 medical staff to GDC/GMC"; do you have that?

1 COLM DONAGHY: We have that, chairman.
2 THE CHAIRMAN: That says:
3 "The trust has made the following referrals to the
4 GDC/GMC from 2007 to July 2013. There are six concluded
5 fitness-to-practise hearings for doctors relating to the
6 Belfast Health and Social Care Trust for that period."
7 If you hold that page and then you look on at
8 page 38, towards the bottom of page 38 you will see
9 a paragraph which starts:
10 "Since 1 April 2007 there have been 56 nurses and
11 midwives reported to the NMC. Of these referrals, 35
12 have been made by the trust, 10 by the NMC, nine by
13 members of the public and two by the registrant
14 themselves."
15 So I think the question that's been raised is
16 twofold. The comparison between the overall numbers of
17 nurses or midwives reported on the one hand and doctors
18 reported on the other. In terms of referrals by the
19 trust, it looks as if it's six as against 35 --
20 MR UBEROI: Sir, I'm sorry to intervene, but just in terms
21 of the way the question was put, there is obviously a
22 distinction between concluded fitness-to-practise
23 hearings, which is the phrase which has been used on
24 page 35, and referrals. They're very different matters.
25 There may be many more referrals than concluded

1 fitness-to-practise hearings.
2 THE CHAIRMAN: Shall we get our terminology right? At
3 page 35 when you say there are six concluded
4 fitness-to-practise hearings, does that mean that there
5 were six references by the trust to the GMC or more?
6 DR ANTHONY STEVENS: Chairman, can I -- I think the wording
7 in there is a little unfortunate. A "concluded
8 fitness-to-practise hearing" means somebody's been taken
9 to the final stage of a GMC procedure and there will be
10 undertakings or findings against them, and we will have
11 a significantly greater number of doctors who have been
12 as far as an interim orders panel or indeed have been --
13 issues have been raised.
14 Before I go on to maybe explain the detail of that,
15 I'd also point out that the denominator is different
16 here. We would directly employ maybe just over 800
17 doctors and a similar number of trainees, whereas we
18 employ over 7,000 nurses, so we're not comparing like
19 with like:
20 THE CHAIRMAN: Okay.
21 DR ANTHONY STEVENS: I'd also point out that we would, at
22 any point in time, be managing a number of doctors
23 through the "maintaining professional standards"
24 process, and at any point in time that might amount to
25 20 or even more doctors, often with relatively minor

1 issues. So doctors can be referred to the GMC, not just
2 by the employer, but by a complainant, by the police for
3 a traffic offence, or any number of reasons. So that
4 figure of six concluded hearings hugely underestimates
5 the total number of doctors with whom we'd be in
6 correspondence with the GMC, and if the inquiry wishes
7 to have details as to the total number of doctors
8 we would be in correspondence with, I'm happy to provide
9 it separately.
10 THE CHAIRMAN: I think the confusion arises because in terms
11 of referrals of nurses as opposed to referrals of
12 doctors, the information has been presented in
13 a different format. So it leaves the way open for
14 misunderstanding or the need for clarification. So
15 if we take it in that way, Mr Hunter. If the trust
16 could provide us with the information about doctors,
17 broken down as closely as you can to the way in which
18 you've broken down the information about nurses.
19 COLM DONAGHY: Okay.
20 DR ANTHONY STEVENS: Okay.
21 THE CHAIRMAN: Thank you very much. That was your point,
22 Mr Hunter, so we'll get that clarified and we'll receive
23 that information.
24 MR HUNTER: Thank you, sir. There's another point that
25 I would wish to make to you, just again for

1 clarification.
2 THE CHAIRMAN: I should say to the panel that Mr Hunter
3 represents the family of Adam Strain, who, in the
4 sequence of the inquiry, was the first child to die in
5 1995.
6 MR HUNTER: Mr Donaghy has said to you that the
7 Belfast Trust has always shared any expert reports with
8 the coroner. But then I think he has qualified that --
9 or I think it might have been Dr Stevens who said that,
10 of course, it's a different matter if litigation is
11 going on. So can I ask if a coroner's case is also the
12 subject of litigation, then I'm assuming that the report
13 isn't shared with the coroner in those circumstances, or
14 am I wrong in that?
15 Because it would seem to me, sir, that if a case has
16 gone to litigation and to the coroner, it probably has
17 more issues with it than a case that's gone to the
18 coroner and it might be more of a straightforward case.
19 THE CHAIRMAN: It may or may not be straightforward, but if
20 the trust has engaged an expert to provide a report
21 which has a dual function of covering a coroner's
22 hearing and a potential medical negligence case, in that
23 scenario is the report provided to the coroner?
24 COLM DONAGHY: It is.
25 DR ANTHONY STEVENS: As far as we know.

1 THE CHAIRMAN: Can I clarify this with you? When you said,
2 "This is the position of the Belfast Trust", do I take
3 it from that that the Belfast Trust was formed in, what,
4 2007?
5 COLM DONAGHY: Yes.
6 THE CHAIRMAN: Is that a conscious change of policy on the
7 part of the trust from an earlier time or was that the
8 Royal's position as well?
9 DR ANTHONY STEVENS: As far as I'm aware -- and this is my
10 understanding, based on the brief I've received to give
11 evidence here -- that was also the practice in the
12 previous Royal Hospitals. I can't talk for all six of
13 our legacy trusts, but I would probably have to defer to
14 the Directorate of Legal Services on that. But for
15 those organisations with which I have been directly
16 associated, that's my understanding of the practice.
17 THE CHAIRMAN: I'm asking that for completeness, but you'll
18 understand it's a side issue for me today because my
19 concern is what is happening now and what reassurance
20 there is for the public now. The unambiguous position
21 is that now, and for some time before, if the trust
22 obtains a report for the purposes of a coroner's
23 inquest, that report will be shared with the coroner and
24 therefore with the other parties.
25 COLM DONAGHY: Yes.

1 THE CHAIRMAN: Thank you very much.
2 Questions from MR QUINN
3 MR QUINN: Mr Chairman, I have a number of issues that the
4 families would like me to raise. It will maybe take
5 10 minutes.
6 THE CHAIRMAN: I'm sorry, I haven't been alerted to any of
7 them, Mr Quinn.
8 MR QUINN: Yes, I know. I was consulting with Mr Roberts
9 during the break. I'll just briefly set them out.
10 Number 1 was in relation to the note taking or
11 review of the medical notes and the SAI. The second one
12 is linked together with two or three issues, that is
13 what happened after Claire's SAI in March 2006. The
14 third issue, which I can expand upon, is how do these
15 members of the trust who are here today to apologise --
16 and the very forthright apology that they've given --
17 how do they see the trust going forward in relation to
18 any doctors or nurses who are under investigation as
19 a result of this inquiry?
20 THE CHAIRMAN: Well, let's take those one by one. But I'm
21 going to control this very strictly because this isn't
22 the point of today's session.
23 MR QUINN: I understand that. I've explained that to the
24 families.
25 THE CHAIRMAN: Let's deal with them one by one and I'll see

1 how far I'll let you go. I had hoped the families also
2 understood that.
3 Let's deal with the first point about note taking.
4 What is the point?
5 MR QUINN: We've heard how the SAI and the complaints
6 procedure now works and we're relieved to hear that the
7 whole system has been revised and that there are now
8 safeguards and fallback positions. What we want to know
9 is now that a review officer is appointed in relation to
10 the SAI and given that that reviewing officer comes in
11 as an independent reviewing officer and reviews the case
12 and the complaint, who is the first person to see the
13 patient's medical records? Where are they stored and is
14 it the reviewing officer who first sees them? If not,
15 why not? That's the first issue I have.
16 THE CHAIRMAN: So if an SAI --
17 MR QUINN: If an SAI or a complaint is raised within the
18 complaints procedure -- well, two issues arise. If it's
19 an SAI, you have a reviewing officer who comes in. If
20 it's a complaints procedure, I'm not quite sure where
21 that goes to or how the reviewing officer comes on board
22 there, but what I know to know is, in either system, who
23 is it that first sees the patient's medical notes?
24 THE CHAIRMAN: Do they go straight to the reviewing officer?
25 DR ANTHONY STEVENS: Can I answer that? I might, with your

1 forgiveness, ask a question of a question. If we're
2 talking about reviewing officer, do you mean the
3 designated responsible officer or DRO --
4 MR QUINN: Sorry, yes.
5 DR ANTHONY STEVENS: -- at board level? I suspect you're
6 misunderstanding the role of that individual. They
7 would not be the first person to see the notes. They
8 have a much more hands-off, distant relationship, and
9 it is their job to sign off the final report and be
10 satisfied as to the robustness of the process rather
11 than to be quite so intimately involved in the process,
12 and certainly not to take receipt of the notes.
13 THE CHAIRMAN: Yes, the serious adverse incident is
14 investigated within the trust, but not by a person who
15 was involved in the care of the patient and the
16 designated responsible officer has an overseeing role
17 from the Health & Social Care Board to which the serious
18 adverse incident has been reported and the function of
19 the DRO is to ensure that a proper investigation is
20 carried out. The final point of the investigation
21 is that the DRO, in effect, signs off on the
22 investigation report; is that right?
23 DR ANTHONY STEVENS: On behalf of the board.
24 THE CHAIRMAN: In effect confirming that there has been
25 a proper investigation and the conclusions in the report

1 are reasonable conclusions.
2 DR ANTHONY STEVENS: That's it.
3 THE CHAIRMAN: And either if the investigation is not
4 adequate or if the conclusions are not reasonable, then
5 the designated responsible officer will not sign off on
6 the report?
7 DR ANTHONY STEVENS: That's correct.
8 THE CHAIRMAN: So that person has an overseeing role, but
9 then within the trust, if there's a serious adverse
10 incident, do the medical notes go straight to the person
11 who's charged with the investigation within the trust?
12 DR ANTHONY STEVENS: Whatever process we're in, be it
13 a serious complaint or an SAI or litigation, by and
14 large we will secure the notes within the corporate
15 governance function and make them available, make copies
16 as required. Custody of the notes is important to us as
17 much as anything because if they move around the system
18 too much there's a danger of them being lost. So we're
19 always keen to ensure the integrity of them and the
20 security of them.
21 THE CHAIRMAN: Okay.
22 MR QUINN: So does that mean we can take it, sir, that the
23 first person who gets to review the notes is not someone
24 directly involved with that patient's care?
25 THE CHAIRMAN: Well, the fact that the -- I'm not sure that

1 necessarily follows, does it? I should say, the context
2 for this is that Mr and Mrs Roberts have a concern,
3 which we have investigated to the extent of getting
4 a forensic analysis of Claire's notes about whether
5 Claire's notes were altered or tampered with after the
6 event. That's the context. To be fair to this panel,
7 they may not necessarily know that, but that's the
8 context in which you're being asked these questions.
9 I think you're being asked them in order to probe
10 whether, if there is a serious adverse incident today,
11 will those notes be effectively secured and custody of
12 them taken by the governance unit so that the
13 investigating officer within the trust will then start
14 the investigation?
15 DR ANTHONY STEVENS: If we're dealing with an SAI, yes, at
16 that point we will wish to secure the notes and to
17 ensure that access to them is such that they couldn't be
18 altered. Though having said that, we would view that as
19 an exceptional possibility, I think, but we don't leave
20 it to trust.
21 THE CHAIRMAN: Thank you.
22 MR QUINN: Thank you.
23 The second issue I have is in relation to Claire's
24 SAI, which was commenced on 1 March 2006. It can be
25 found on the site on 302-164-003. If that could be

1 brought up, please.
2 What I want to ask here is that we know that after
3 the inquest in May 2006 that Mr Walby has told this
4 inquiry that there was no adverse criticism of the care
5 of this patient, that being Claire Roberts, so the panel
6 know where we're going with this, and this is Claire's
7 SAI. On a general point, when one looks at paragraph 5
8 in relation to the regional action recommended, what on
9 earth has been done? Because we have answers that are
10 not known at this stage and not at this time. So how
11 has Claire's SAI been closed out, to use that particular
12 term?
13 THE CHAIRMAN: Well, first of all, do you know factually
14 what has happened on foot of this in terms of Claire?
15 DR ANTHONY STEVENS: I would prefer to have had notice and
16 to pull out the final outcome on this. The question
17 sounds like a broader question about everything that
18 we've done, and if the inquiry wishes a reiteration of
19 that, I'm happy to give it.
20 COLM DONAGHY: Chairman, I might be mistaken, but was this
21 dealt with by Dr McBride in his evidence to this inquiry
22 in the context of this inquiry?
23 THE CHAIRMAN: There was evidence to this inquiry and,
24 Mr Quinn, I think it's inevitable that this panel --
25 first of all, this panel is not in a position, it

1 appears to me, to answer this question as to what
2 happened on foot of this document in March 2006 and is
3 certainly not in a position to answer it without the
4 issue being raised with them. That's not the purpose of
5 the panel being here today.
6 MR QUINN: I understand that, sir. But what does happen,
7 can they answer in general terms? How is an SAI closed
8 off so that if we need further investigation on this by
9 way of documents, that we can look for them?
10 THE CHAIRMAN: Well, can I explain to you what I understand
11 happens and then you can tell me how far wrong I am?
12 There will now be a report, which will be completed by
13 the trust, the family will have input into it, the
14 designated responsible officer at the board will sign
15 off on that report once it is completed to his or her
16 satisfaction, and that report will include any
17 appropriate recommendations as to what happens next.
18 For instance, if we take this paragraph 5, "Is any
19 regional action recommended?" I assume that that's the
20 exception rather than the rule that any regional action
21 is recommended; would that be right?
22 COLM DONAGHY: Yes.
23 DR ANTHONY STEVENS: Yes, because that would trigger
24 a learning letter and you can have -- the figures would
25 be available on the number of learning letters that the

1 board or the department has issued.
2 THE CHAIRMAN: Right. But from what you've already said
3 today and what's in the documentation, you have
4 a scenario where the Health & Social Care Board prepares
5 a six-monthly summary of the adverse incident reports it
6 receives, highlights any which are of particular
7 significance and draws together threads from different
8 reports from different trusts. So if the Belfast Trust
9 has done a report on an area and there's also a report
10 from the Southern Trust or the Western Trust, HSCB is
11 in the ideal position to draw those together in its
12 six-monthly reports. So that's what happens at regional
13 level, but within the trust you can also improve or
14 adapt your practices if there's any learning from what
15 has happened within the Royal. It might be a Royal or
16 a City, for that matter, or a Mater issue, but it might
17 be a situation pertinent to that particular unit or
18 hospital; is that right?
19 DR ANTHONY STEVENS: Yes.
20 MR QUINN: So when will we expect to have some finalised
21 report? When is the DRO going to sign this off?
22 THE CHAIRMAN: I don't think the DRO system existed in 2006.
23 DR ANTHONY STEVENS: It pre-dates the Belfast Trust and that
24 specific guidance and what we do now. I'm more than
25 happy to review our documentary evidence on this.

1 MR QUINN: The last point is a more general point. When one
2 looks at that, which is why I raised this in relation to
3 what happens now and what happened then, when we look at
4 what has passed since March 2006, and we hear of the
5 system that's now in place, how have the trust addressed
6 the issues of openness and candour with the families?
7 Apart from the apology that we've heard from Mr Donaghy,
8 are the trust going to engage in any further
9 investigations of the issues that have been raised in
10 this inquiry over the last 18 months?
11 DR ANTHONY STEVENS: I think there's a -- I would answer
12 this question in two ways. The first is that we are
13 awaiting the outcome of the inquiry and will act upon
14 that. But the other thing is that we haven't sat on our
15 hands throughout the -- a significant number of staff
16 have given evidence to this inquiry and an equally large
17 number of staff have been following the transcripts, and
18 we have acted as appropriate. Ms Creaney has given
19 evidence with regard to nappies, which was something we
20 picked up very, very quickly. So we have an ongoing
21 process of response.
22 We've been very clearly implementing NPSA22 and the
23 departmental circular of 2007, and that's an ongoing
24 process for us. We've tried to describe the ongoing
25 development of an open and honest or open and fair

1 culture in the Belfast Trust, which I hope we've been
2 able to give some impression of.
3 One of the big steps we've taken, which I think is
4 of particular relevance to this inquiry -- and I hope is
5 a reassurance to the families -- is the introduction of
6 our M&M processes, morbidity and mortality processes,
7 which is comprehensive and not just for children, but
8 for all deaths that occur in the Belfast Trust and
9 something that our Chief Medical Officer has now asked
10 be rolled out across the Province.
11 So the actions of the Belfast Trust have had both
12 a local and a regional impact. I might also add that it
13 was the issues arising out of NPSA22 and RQIA that led
14 us to work on a paediatric fluid balance chart for the
15 Belfast Trust. The desire to also produce
16 a complementary adult fluid balance chart, which are now
17 being implemented in Belfast and are being rolled out
18 across the Province and with all the appropriate support
19 in terms of training of junior doctors and nurses.
20 So I would have liked to have thought that we could
21 give evidence and some reassurance that we have been
22 very active in learning lessons from the experience of
23 all the families in this and also, as I've said, have
24 not waited for the outcome of the inquiry, although
25 equally obviously we will have to be sensitive to that

1 in any further action that will be required of us.
2 THE CHAIRMAN: Thank you.
3 MR QUINN: Finally, on a point of information. We've heard
4 that the mortality meetings are now minuted; is that
5 correct?
6 DR ANTHONY STEVENS: Correct.
7 MR QUINN: Why are they minuted and what happens in relation
8 to any incidents or near misses that are minuted? Do
9 they automatically go into an SAI system? What I'm
10 looking for is an answer to what's the purpose of
11 minuting these meetings now and what's the purposes of
12 the meetings --
13 DR ANTHONY STEVENS: I think that's a really important
14 question --
15 MR QUINN: -- in comparison to what they weren't minuted and
16 now they are minuted and what the families' perception
17 of that is?
18 DR ANTHONY STEVENS: I think you ask a really important
19 question. Can I go back to the concept of openness and
20 fairness and learning? We're trying to create a system
21 whereby we learn, not necessarily blame, where we
22 encourage people to flag up problems that occur, not all
23 of which are serious, some of which may be near misses,
24 some of which may cause minor harm or injury, but all of
25 which have a value in terms of learning. We want to be

1 able to identify trends in practice, we want doctors to
2 be able to reflect together on how they would improve
3 their service.
4 That is the international thinking on best practice.
5 The ability to create an atmosphere of excellence, not
6 always looking over your shoulder. And that, in a way,
7 is where the debate about minuting came from. Doctors
8 actually at a point in time believed that they could
9 have that open reflection and learning without minutes
10 and would be encouraged by that. But the position of
11 the trust has very, very clearly been that without a set
12 of minutes, you cannot demonstrate that you've done the
13 reflection, that you've taken appropriate action, we've
14 no starting point or finishing point.
15 So the challenge for us -- and it is an ongoing
16 challenge -- is to support our staff to learn by their
17 own volition, to use reflection, which is at the very
18 heart, for example, of the GMC's revalidation guidelines
19 that doctors actually learn from their experience,
20 reflect on their practice, share that reflection and at
21 the same time while we're doing that, if you like,
22 softer side of things, we also have a hard-edged side to
23 it, where we identify -- say for example there is a case
24 that maybe should have been referred to the coroner,
25 we will do that, and I have already indicated to you

1 that we have had the conversation with the coroner that
2 he might possibly expect a later referral and the
3 minutes of a meeting are the basis upon which you would
4 take that action forward.
5 But those meetings will also potentially trigger
6 an SAI investigation. We may go back to a family and
7 I've certainly -- I've already said it at this
8 inquiry -- talked to a family about the fact that they
9 might wish to seek remedy in law. So a whole range of
10 opportunities, hard-edged opportunities, come, but the
11 important thing for us is that we continue to create
12 this culture of excellence, this striving for the
13 highest quality. And my reassurance to you would be
14 that if you look at the performance of the Belfast Trust
15 overall, the Belfast Trust as the regional centre for
16 a lot of specialties, as a teaching hospital, the major
17 teaching hospital in Northern Ireland, our performance
18 against the best hospitals in the UK in terms of
19 mortality is among the best and we have that data,
20 we can demonstrate it against national audit. After
21 national audit, be it in hip fracture, aortic aneurysms,
22 cardiac arrest, that the Belfast Trust performs against
23 its peers, not just against the average hospital in the
24 UK, but the likes of University College Hospital London
25 or Imperial College. Those are the people we set our

1 standards against.
2 So I would like to think that you would accept that
3 we are continuing to build something and all these small
4 pieces like morbidity/mortality meetings, clinical
5 audit, all the aspects of clinical governance, our
6 safety and quality improvement plan, all feed into that.
7 But is isn't all about the hard-edged "Is it a
8 complaint? Is it litigation? Should it be with the
9 coroner?" A lot of this is actually people working
10 together to improve the way they deliver service, making
11 sure they know the latest evidence from international
12 evidence in the journals, making sure they reflect on
13 individual cases and, if they go back to the journals,
14 they could find a different way of doing something,
15 bringing information back from international conferences
16 that they can then feed into their practice. This is
17 a very complex system of checks of balances, of
18 improvement, of quality assurance, of intellectual
19 vigour that we believe we put in place. But we won't
20 get it right all the time and there are real areas,
21 particularly around engagement with families, where we
22 recognise we've still got a great deal to do.
23 MR QUINN: Can the families and the public in general take
24 some comfort from the fact that there is another layer
25 in place now that can now, as it were, catch those

1 things that may have slipped through the system
2 otherwise and that is that the mortality morbidity
3 meetings, they do raise issues that may have slipped
4 through the net?
5 DR ANTHONY STEVENS: I think the key is nothing is taken for
6 granted any more. The senior management of the
7 organisation are looking over the shoulder of the
8 managers, and the service managers, the clinical
9 directors, are supervising the work of their staff,
10 senior nurses are supervising and looking at the work of
11 more junior nursing staff. And what we don't do, the
12 Health & Social Care Board -- and indeed the
13 department -- is doing these checks and balances right
14 through the system now that wouldn't have been there
15 in the mid-1990s, even at the turn of the century. So,
16 yes.
17 THE CHAIRMAN: Just to take that example about the
18 additional check that Mr Quinn is talking about: what
19 the Health & Social Care Board does in terms of serious
20 adverse incidents is incomparable compared to what the
21 Eastern Health Board used to do because the Eastern
22 Health Board didn't have a remit. There's a bit of
23 a debate about what their general obligation was. They
24 were a commissioning body, so they should have been
25 anxious to ensure they were commissioning a service of

1 quality. But on the serious adverse incident report
2 system now, the Health & Social Care Board has to
3 approve the finalisation of an investigation. Without
4 that, the investigation does not close.
5 DR ANTHONY STEVENS: It cannot be closed without their
6 satisfaction. It's an iterative process. We may go
7 through several stages to close off remaining concerns.
8 THE CHAIRMAN: Okay, thank you very much.
9 Ms Creaney, gentlemen, we've reached the end of our
10 questioning. You don't have to say anything more, and
11 thank you for coming this morning, but if you want to,
12 you're free to make closing remarks before you go if you
13 want. You're not obliged.
14 COLM DONAGHY: I understand that, chairman, I just want to
15 make one remark. I want to reiterate my offer to the
16 families to meet. It's a genuine offer. I understand
17 that the families may want to reflect on that and I'll
18 make that an open offer for when the families might want
19 to. Even at some stage in the future, if they don't
20 feel like talking today, that's an open invitation to
21 talk to the trust and trust staff.
22 THE CHAIRMAN: Thank you very much indeed.
23 (The witnesses withdrew)
24 Let me finish with this: we are going to have to sit
25 tomorrow to hear Dr Carson, who's not available beyond

1 tomorrow. This had to be re-arranged in circumstances
2 that you're familiar with, so we'll start tomorrow with
3 Dr Carson at 10 o'clock.
4 I don't know if you've had a chance to see, but I've
5 circulated some correspondence that we've had over the
6 last 24 hours with the department about the need to call
7 Professor Scally. My own view is that the oral evidence
8 from Professor Scally is no longer required because at
9 least some of the ground between him and the department
10 was narrowed as a result of last week's evidence.
11 I wrote as much to the department yesterday, a reply
12 has come in this morning from the Permanent Secretary,
13 which you will see, and unless anybody persuades me that
14 Professor Scally is still required to give evidence
15 tomorrow, I don't intend to ask him. Have you had
16 a chance to see this, Mr Quinn?
17 MR QUINN: I have only just read it moments ago.
18 THE CHAIRMAN: Do you want five minutes?
19 MR QUINN: I would like five minutes.
20 THE CHAIRMAN: We'll break. We're going to be here anyway
21 for Dr Carson.
22 MR LAVERY: I was going to make one point, Mr Chairman,
23 arising out of yesterday's session. You'd indicated
24 yesterday that you were pleased to hear that
25 complainants to Belfast Trust were being made aware of

1 the Patient and Client Council, but you wanted some
2 reassurance that that was also the case outside of
3 Belfast.
4 Could I just say, on behalf of the Western Trust and
5 the Southern Trust, that that is also the position, that
6 when complainants write to the Western Trust and the
7 Southern Trust in an acknowledgment letter they're told
8 of the existence of the Patient and Client Council.
9 That's something they're being made aware of. I think
10 certainly some of the correspondence and a leaflet from
11 the Western Trust has been made available to the inquiry
12 this morning as I understand it.
13 THE CHAIRMAN: I think that's right. Thank you very much
14 indeed. That helps.
15 We'll break for five or ten minutes to give you
16 a few minutes to look at this correspondence about
17 Professor Scally, and I will sit again in a few minutes
18 to deal with that. But other than that, we will resume
19 tomorrow in any event with Dr Carson. So we've just to
20 sort out the professor.
21 (1.14 pm)
22 (A short break)
23 (1.25 pm)
24 MR QUINN: Mr Chairman, in relation to the issue of whether
25 or not Professor Scally should be called, we're happy to

1 take the evidence as it stands and the letters can go on
2 to the website and be paginated if need be.
3 THE CHAIRMAN: There's a bit of detail in Dr McCormack's
4 response today, but my position is clearly from
5 yesterday's letter.
6 Does anybody require Professor Scally? No? And on
7 the basis of this exchange, Mr Sharpe, we'll cancel him.
8 MR SHARPE: Yes, sir, you have the letters and the letters
9 are available and in the circumstances ...
10 THE CHAIRMAN: Thank you very much.
11 Tomorrow will be another morning session with
12 Dr Carson to explain what the RQIA has done, what it is
13 doing, and what it has done specifically in terms of
14 hyponatraemia and what it is doing generally. This
15 looks like it's going to be a week of morning sessions,
16 but there we are, we're getting there. Three left.
17 Thank you. 10 o'clock.
18 (1.27 pm)
19 (The hearing adjourned until 10.00 am the following day)
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1 I N D E X

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3 MR COLM DONAGHY 1

4 DR ANTHONY STEVENS 1

5 MS BRENDA CREANEY 1

6 DR PAUL JACKSON 1

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