1 Monday, 11 November 2013
2 (10.30 am)
3 (Delay in proceedings)
4 (10.50 am)
5 MR PETER WALSH
6 MS MAEVE HULLY
7 Questions from THE CHAIRMAN
8 THE CHAIRMAN: Good morning, everyone. As you all know,
9 we're moving on to the final stage of the inquiry's work
10 this week by looking at the way in which the Health
11 Service is organised now in various areas and
12 specifically today we're going to focus on the area of
13 complaints and the area of looking at serious adverse
14 incidents.
15 We'll do that with the assistance of two people, who
16 I'm grateful for them attending today. If I may first
17 introduce to you the chief executive of Action Against
18 Medical Accidents, AVMA, Peter Walsh. Thank you,
19 Mr Walsh, for coming.
20 AVMA is a charity for patient safety and justice.
21 It provides advice and support to individuals who have
22 been affected by a medical accident. It works with the
23 National Health Service, with health professionals, with
24 government departments and with lawyers in ways that
25 we'll look at over this morning's session. Mr Walsh

1 himself is a Patient Safety Champion with the World
2 Health Organisation and I'll ask him to expand on that
3 in a few moments.
4 Apart from hearing his advice generally, I want to
5 explore with Mr Walsh his organisation's views on the
6 current debate on the recommendations which have been
7 made by Robert Francis QC in his report on the
8 Mid-Staffordshire Trust, and in particular I want to
9 explore the differences to the extent they exist between
10 him and some others on the extent of a statutory duty of
11 candour. You may have seen from the press that there is
12 a debate about the extent to which the statutory duty of
13 candour recommended by Mr Francis will be legislated
14 for. That duty would be a legally enforceable duty on
15 healthcare providers and directors of trusts to be open
16 and honest with patients and families. And that goes to
17 something which the families in this inquiry have major
18 concerns about.
19 We'll also hear this morning from Ms Maeve Hully.
20 Thank you for coming, Ms Hully. Ms Hully is the
21 chief executive of the Patient and Client Council, which
22 was established in Northern Ireland in 2009. It is the
23 successor to the four area Health and Social Services
24 Councils. We have heard about the work of one of them,
25 that is the Western Health and Social Services Council,

1 which featured in the uncovering of what happened to
2 Lucy Crawford and which was also involved, though
3 perhaps on the fringes, of what happened after Raychel's
4 death.
5 The website of the Patient and Client Council
6 describes its functions as:
7 "Ensuring that patients and others have a powerful,
8 independent voice."
9 In light of some of the evidence that we have heard
10 over the last 18 months, the importance of such a voice
11 is difficult to exaggerate. I'm interested to learn
12 from Ms Hully how much progress the council has been
13 able to make and where it believes it might be able to
14 go further in helping patients and families.
15 In this context, and just to give an example of what
16 it is that we are talking about, I remind everyone about
17 Raychel's case in 2001. I'm referring only to Raychel's
18 case at this point because it is the only one which
19 we have examined in which the trust had a critical
20 incident protocol and a patient advocate system.
21 Unfortunately, the protocol only worked in part and the
22 patient advocate appears to have failed, more or less
23 completely, because the family didn't know the role of
24 the patient advocate and the patient advocate, to be
25 fair to her, wasn't actually deployed by the trust to

1 act as a patient advocate should.
2 I will discuss now with Mr Walsh and Ms Hully the
3 extent to which things have changed since 1995, 2001,
4 2002, and how much further change might be advanced.
5 Mr Walsh, can I turn to you first? I think it's
6 fair to put a caveat on the evidence that you do give,
7 which is that your knowledge of the Northern Ireland
8 situation and the work of AVMA in Northern Ireland is
9 quite limited; is that right?
10 PETER WALSH: That's fair to say, Mr Chairman, yes. We are
11 a UK-wide charity, but we receive a relatively small
12 number of cases coming to us from Northern Ireland. So
13 I don't claim any expert knowledge of the way the
14 system's actually working in Northern Ireland, but
15 I would contend that there are such similarities with
16 the rest of the UK that there's useful learning to gain
17 from that.
18 THE CHAIRMAN: We are supposed to have one Health Service,
19 not four, so that might fit. In terms of looking at --
20 let's deal first with the area of complaints because
21 I think you and Ms Hully together can help me with
22 complaints. I have left open in front of you a document
23 which we obtained from the Belfast Trust, which is
24 the -- it's 2010 -- "Policy and procedure for the
25 management of complaints and compliments". It's one

1 particular part of it to which I wish to refer,
2 332-014-016.
3 This is the part of the policy, which sets out how
4 a complaint is to be investigated and resolved. The
5 reason I want to highlight it is this. You'll see from
6 the first paragraph what the purpose of the
7 investigation is. And then we go down to the third
8 paragraph:
9 "It may be more appropriate, depending on the
10 complexity of the complaint, that a meeting would be
11 offered to the family to discuss the outcome of the
12 investigation. This decision would be agreed by the
13 complaints manager and service group manager."
14 And in the fifth paragraph it is stated:
15 "Once the investigation is complete, the
16 investigator should prepare a draft response. The
17 response should include and explain how the
18 investigation was carried out and how the conclusions
19 were reached. This draft response must be shared with
20 the relevant staff to ensure factual accuracy and
21 agreement. It should then be ratified by the
22 co-director/nominated person before being forwarded to
23 the complaints department for formatting and forwarding
24 to the director for final signature."
25 The concern which I want to look at this week

1 is that this policy, at least on paper, provides for
2 very little input on the part of a patient or family
3 into the complaint beyond making the complaint in the
4 first place. And what I'd like to ask you, Mr Walsh, is
5 whether that is similar to complaints procedures and
6 practices which you are familiar with from Britain.
7 PETER WALSH: There's an abundance of good practice guidance
8 around, Mr Chairman, which suggests that families, or
9 the complainant, should be involved as early as
10 practicably possible, not only informing them of what an
11 internal investigation has found out, but actually
12 giving them the opportunity of framing the terms of
13 reference and checking matters of factual accuracy as
14 early as possible.
15 However, there's nothing requiring that. I know
16 that one of the things you said you wanted to come on
17 and talk about is a duty of candour, open disclosure of
18 what's happened very early on. Of course, the other
19 factor is that unless you know that something untoward
20 may have happened, you don't know that you have reason
21 to complain and therefore even spark the kind of
22 investigation which is being described here.
23 In practice, our experience is that very often an
24 approach similar to this is followed and an
25 investigation gathers its own momentum, it's an internal

1 investigation, and the first chance the family get to
2 actually analyse and comment on what's coming from the
3 investigation is at the end of the process. So a whole
4 opportunity --
5 THE CHAIRMAN: Sorry, the end of the process being the point
6 at which the response to the complaint has been formed?
7 PETER WALSH: Correct.
8 THE CHAIRMAN: I should say, in fairness to the trust, two
9 things: first of all, as this procedure indicates, its
10 review date was April 2013, so it is currently under
11 review. The trust has also said in a supplementary
12 paper, which we'll look at tomorrow with the trust
13 witnesses, that there are in fact examples of occasions
14 on which complainants are more involved in the
15 investigation of complaint than that procedure would
16 suggest. My concern is whether that procedure needs to
17 be updated to specifically provide for their involvement
18 on the face of the policy rather than depending on
19 something of an ad hoc approach.
20 PETER WALSH: That's exactly one of our concerns,
21 Mr Chairman, that whilst there's plenty of examples of
22 good practice, I have to say here in Northern Ireland
23 and from the rest of the UK, where people are involved
24 from the very outset, it's discretionary and it's
25 ad hoc. We are asking for -- and I believe Robert

1 Francis QC, who I know recommended there should be --
2 standards for complaint investigations. And that would
3 include early involvement of the family and we're
4 hopeful that that will actually be accepted by the
5 Secretary of State for the Health Service in England.
6 That would be a good step forward to ensure more
7 consistency and not have a situation where every health
8 board or, as it applies to England, trust devises its
9 own approach.
10 So healthcare providers should be able to be
11 assessed against good practice set down in national
12 standards about which they could be held to account if
13 they're not performing well on dealing with complaints.
14 THE CHAIRMAN: Let me step back a bit. I rather gathered
15 from what you said a moment ago that the knowledge that
16 there's something to complain about isn't always
17 present. Do you see the complaints mechanism as
18 secondary to an internal investigation?
19 PETER WALSH: My point there is that there should be full
20 and open disclosure that something may have gone wrong,
21 something adverse may have occurred in the provision of
22 healthcare. Now, that provides the opportunity for
23 different types of investigations. It might be
24 initiated by the healthcare provider, fully involving
25 the family or the patient, and not require a complaint

1 under the formal complaints procedure.
2 In our experience most people don't want to complain
3 if they can avoid it, and if they had a thorough
4 investigation, a thorough explanation and saw that
5 something was happening as a result, it may obviate the
6 need for a formal complaints investigation.
7 THE CHAIRMAN: Right. So in our experience in this inquiry,
8 Adam's family didn't actually make a complaint, Claire's
9 family didn't actually make a complaint and I think
10 Raychel's family actually didn't make a complaint, but
11 each of them knew or sensed that something had gone
12 wrong. They knew something had gone wrong because their
13 child had died, but they also knew there was something
14 more to their child dying. So how big a deal is it for
15 a family to actually initiate a complaint? Maybe,
16 Ms Hully, you can help on that.
17 MAEVE HULLY: One of the duties of our organisation is to
18 help people who wish to make a complaint. So we would
19 have had a fair amount of experience of people right
20 through the whole complaints process, right from "how do
21 I go about it?", right through to the process to the
22 resolution, whatever that is, and quite often after the
23 resolution because families will come to us and say they
24 weren't happy with where the complaint ended up and
25 could we get involved with them, so a lot of experience

1 right across the whole complaints process.
2 I think that people sometimes will complain because
3 they think that something has gone on and quite often
4 it's an opportunity to try and find out more because
5 currently there's no other way to get into the system to
6 try and understand what has happened. And in our
7 experience, people don't complain lightly, so it's an
8 emotional journey for people to complain, particularly
9 if the person who's complaining is still in the system
10 because there's quite a lot of concern about how, if
11 I complain about a service and I'm still in the system,
12 will that affect my service going forward.
13 THE CHAIRMAN: Okay. When you say sometimes families feel
14 as if there's no other way into the system but to
15 complain, what do you suggest might be another way into
16 the system to avoid the onus being on the family to make
17 a complaint?
18 MAEVE HULLY: In our experience, people quite often through
19 the complaints, they want people -- they don't want the
20 same thing to happen to somebody else and they want the
21 people involved to learn from the complaint. And we
22 think it's quite -- it would be really positive to be
23 able to -- for people to voice their concerns or indeed
24 their good experiences of health and social care
25 services in a way that is other than just complaining.

1 So one of the things that we have been working with the
2 service is around providing a forum by which people
3 could leave information about an experience they've had
4 and the service provider would then have to respond to
5 that.
6 So for example, people could -- in a ward ... people
7 quite often complain that wards are very busy at night
8 and very noisy and if you're in for a long period of
9 time that can really affect the time it takes you to
10 convalesce. Currently if you wanted to make the ward
11 aware of that, quite often you would have to go down
12 a complaints route to do that when in actual fact if you
13 had an opportunity to leave that information and the
14 ward to respond to say, "We have received that
15 information and are going to do something about it",
16 that stops that going to the stage where it's actually
17 a complaint.
18 THE CHAIRMAN: So what you're looking for is a way of
19 expressing a concern without it being necessarily
20 treated as part of a formal mechanism of complaining?
21 MAEVE HULLY: Yes, that's right, because some of the
22 feedback we have from the people that we work with
23 is that the complaints process is very bureaucratic,
24 it's very slow, and as is described here, quite often,
25 other than the initial complaint and the letter at the

1 end, they have very little involvement in the process.
2 THE CHAIRMAN: Let me step back a bit before I ask you about
3 your experience of being involved in complaints. If my
4 child's in the Royal and I've got a concern or
5 a complaint that I want to raise, how do I know about
6 the existence of the Patient and Client Council? Are
7 there leaflets or posters in the Royal to tell me about
8 that?
9 MAEVE HULLY: We're a relatively new organisation and we
10 recognise that awareness of the service that we offer is
11 really a very important part of making people aware of
12 what we do and how we can support them. What we would
13 like to see is our information to be part of all the
14 letters that health and social care receive from
15 complainants, so when you complain you get a letter of
16 response, a "We've received your complaint and we're
17 dealing with it". What we would like to see is another
18 line that says, "Patient and Client Council is available
19 to help and support you through this process if you
20 would like that", and our details on that.
21 THE CHAIRMAN: And you don't have that at the moment?
22 MAEVE HULLY: Currently that doesn't happen at the moment,
23 but we are working with the Health and Social Care Board
24 and the department to try and get that to happen.
25 THE CHAIRMAN: Okay, but if I was in the Royal and said

1 I had a complaint to make, is there a poster or
2 are there leaflets within -- not just the Royal, but
3 other hospitals -- to make me aware of the existence of
4 the Patient and Client Council?
5 MAEVE HULLY: Yes, we have worked really very hard to try
6 and get that across. We just can't go in and put our
7 leaflets in there and our posters up in there without
8 the agreement of the hospital itself. Some of the
9 hospitals are more enthusiastic about having our
10 information available, others less so. I think there's
11 a bit of a concern if you put a leaflet that is
12 explaining people how to complain that you might
13 encourage people to complain.
14 THE CHAIRMAN: Yes, but you're a statutory body which is set
15 up to help people. So what you're describing is
16 a resistance from some other statutory bodies to let
17 people know about your existence and your role?
18 MAEVE HULLY: Well, I think there is a reluctance -- I think
19 in the beginning there was. I think as we have become
20 more established as an organisation and our role has
21 become clearer for people and actually quite often our
22 involvement can help the process rather than hinder.
23 I think people are more enthusiastic about sharing the
24 information that we have and sharing that with the
25 people who are using the services.

1 THE CHAIRMAN: Can I presume that sometimes if people come
2 to you with what they have in their mind as perhaps
3 a complaint, that you are sometimes able to reassure
4 them that there may not be anything to complain about?
5 Would that also be part of your experience?
6 MAEVE HULLY: Yes. In that situation, we would still think
7 it beneficial that the trust speaks to the person or the
8 person has some contact to be reassured by them because
9 we won't have the intimate details of the experience,
10 that would be held at trust level. So regardless of
11 what we think, really, we work with the person to get
12 what they feel they need as part of that process.
13 THE CHAIRMAN: I just want to get clear, in terms of patient
14 confidentiality, if I ask for your assistance in making
15 a complaint about how my child was treated, with my
16 authority, then you can have access to the information
17 about the treatment, can you?
18 MAEVE HULLY: Yes, we can ask for that information.
19 THE CHAIRMAN: Provided you have the consent?
20 MAEVE HULLY: Provided we have consent, yes.
21 THE CHAIRMAN: And that leads you then into involvement?
22 In terms of the trust policy that's up on the screen
23 at present, is it your experience that in fact it isn't
24 operated inflexibly so that from the cases in which you
25 have been involved there is some engagement beyond your

1 client being told the final outcome?
2 MAEVE HULLY: We would think it's patchy. It is not
3 automatic that families are involved in the process.
4 Quite often what happens, because a family comes to us
5 for support through that process, we can ensure that
6 they're involved. But if it is somebody who's trying to
7 navigate the system on their own without our support,
8 I think their experience would be that they have little
9 or no involvement bar the initial letter of complaint
10 and then the trust's response to it.
11 THE CHAIRMAN: Does that affect the quality of the
12 investigation and resolution of the complaint if the
13 family isn't involved?
14 MAEVE HULLY: I think there are a number of advantages to
15 having the people who complain involved in the process
16 the whole way through. Quite often what people will say
17 to us is that they rarely get an opportunity to speak to
18 the clinician, to the doctor or to the nurse who's been
19 involved, and quite often any dealings that they have is
20 with the managers or the bureaucracy behind them. And
21 quite often if it is a situation where a family can
22 speak to a clinician that has been involved and knows
23 them and their family, quite often they feel that the
24 quality of the resolution is much better, they can
25 understand what happened, why it happened, and they've

1 an opportunity to ask questions. I'm not sure that that
2 happens if the clinicians aren't involved.
3 THE CHAIRMAN: In Northern Ireland, if the complaint is not
4 upheld and the family doesn't get the resolution that
5 they want out of it, is there any other route? There's
6 no appeal mechanism in relation to complaints, is there?
7 MAEVE HULLY: No, although -- I mean, we -- if they come
8 through us -- can go back to the trust on their behalf
9 and say, "They still aren't satisfied with your
10 response", and, at their discretion, they will have
11 another look at it, and of course they can then complain
12 to the Ombudsman if they feel they've really not been
13 heard and aren't happy with the process.
14 THE CHAIRMAN: I think the figures for complaints to the
15 Ombudsman are really quite small, aren't they?
16 MAEVE HULLY: Yes, comparatively so.
17 THE CHAIRMAN: Mr Walsh, in your experience in Britain, the
18 patchiness that Ms Hully has described of involvement of
19 families through the complaints process, is that
20 mirrored in England?
21 PETER WALSH: Yes, it is patchy. There's plenty of good
22 practice, but perhaps by nature of the kind of charity
23 we are we see quite a lot of poor practice as well where
24 people haven't been, first of all, informed that there's
25 something that needs looking into and, even if they've

1 made a complaint, they aren't necessarily involved early
2 on in order to help shape the direction of that
3 investigation and establish facts as well.
4 THE CHAIRMAN: So if they're not helped, not involved in
5 establishing facts, it may mean that the complaint
6 report may be undermined by being factually wrong in its
7 analysis of what happened?
8 PETER WALSH: Yes, Mr Chairman, I have looked at a number of
9 complaints investigation reports, which on the face of
10 it are very thorough and very lengthy, very thick, but
11 they start on the premise of the facts related to the
12 investigation by those involved in the treatment
13 themselves. I'm thinking of one very emotive case I was
14 involved in, the death of a young girl, where the facts
15 given to the internal investigation by the staff was
16 that the parents didn't report the symptoms at Accident
17 & Emergency, which they later claimed they had.
18 Now, the whole investigation went forward on the
19 basis that they hadn't informed staff of the symptoms,
20 when in fact they maintained that they absolutely had.
21 So you ended up with an investigation report that drew
22 conclusions on what the family felt was a completely
23 false premise. An opportunity had been lost right
24 at the very beginning to say, "Look, is there a conflict
25 between the version of events and the facts we might

1 look into?"
2 THE CHAIRMAN: One of the consistent themes of the deaths
3 and events that we've been looking at is the lack of
4 involvement of the parents in the care of their children
5 in the first place. We've heard a lot of evidence,
6 which I think is now accepted across the board, that in
7 fact parents should be among the first resources that
8 doctors and nurses turn to because they know the child
9 best and, if a child is quiet, it might be the child is
10 typically quiet or it might be unusually quiet, which
11 should be an extra source of concern.
12 So on the same theme, the involvement of the parents
13 in establishing the facts of what went wrong should be
14 part of the investigation?
15 PETER WALSH: Absolutely, I would suggest. Another factor
16 that we find inhibits the quality of investigations and
17 then ensuing responses is that families, if they are
18 involved, are often doing it without any specialist
19 support and advice.
20 I'm a layman, Mr Chairman. If I was involved in an
21 investigation where very complicated clinical issues
22 were being discussed and I had no one I could turn to
23 who was independent, who I could trust to explain some
24 of the terminology, explain what they felt about the
25 credibility of some of the explanations being given, I'd

1 be severely disadvantaged and I wouldn't feel completely
2 empowered in the process. So it's a very difficult
3 thing for people to make a complaint, as we have heard,
4 but also difficult to play an empowered role unless
5 you have some specialist support through that process.
6 THE CHAIRMAN: Ms Hully, is there a way in Northern Ireland
7 of getting specialist support to help you with
8 a complaint?
9 MAEVE HULLY: Again, not routinely. If people come to us,
10 then we'll offer them advocacy and support through the
11 process. The trusts don't routinely.
12 THE CHAIRMAN: But your complaints assistants or managers,
13 who would offer that help and support, they themselves
14 wouldn't necessarily be qualified doctors or nurses?
15 MAEVE HULLY: No, but they would be qualified in supporting
16 people and making sure the language that's being used is
17 understood, that people are responding in the right time
18 frames and things like that. So not doctors and nurses,
19 but people who have had a lot of experience and can help
20 people.
21 THE CHAIRMAN: Okay. Mr Walsh, if the outcome of
22 a complaint isn't accepted by a family or seems from the
23 support of AVMA to be questionable, is there any
24 informal or formal route in England whereby that can be
25 developed?

1 PETER WALSH: Yes, of course there's the informal route.
2 You can try to go back to the organisation and say, "We
3 don't agree, you've got certain facts wrong". You can
4 request that they look at it again, sometimes they will,
5 sometimes they won't. They're under no statutory
6 obligation to.
7 In England and in Wales, there used to be, before
8 2009, what was called an independent review stage --
9 I can't remember if that was the case in
10 Northern Ireland as well -- where, in the case of
11 England, for example, you could go to the Healthcare
12 Commission, the national regulator in England, and they
13 might investigate your complaint independently of the
14 healthcare organisation.
15 The final stage was going to the Ombudsman. From
16 2009, the independent review stage, which although
17 people had problems with, many people found it a very,
18 very useful resource. Even to threaten taking the
19 complaint to an independent review stage often sparked
20 more seriousness and reflection by the organisation that
21 was being complained about and led to a better overall
22 response.
23 That's now gone, so the current system is you try to
24 resolve the complaint locally with the healthcare
25 providers themselves. If you're at loggerheads, you

1 can't agree, then you can apply to the Ombudsman to
2 investigate, but there's no guarantee either in
3 Northern Ireland or in England or Wales that the
4 Ombudsman will be able to take on that investigation.
5 They tend to have to, for resource reasons, ration the
6 number of cases that they actually take on for full
7 investigation.
8 THE CHAIRMAN: I think, Ms Hully, the mention of resources
9 might take me back to you. In terms of you being able
10 to fulfil the remit which you've been given since 2009,
11 do you have the resources to help people with complaints
12 and play the role that you would like to play in that
13 system?
14 MAEVE HULLY: Well, we have a budget of 1.9 million, we've
15 about 30 members of staff, six of which are dedicated to
16 our complaints function. Currently, because people come
17 to us through their own volition because they hear about
18 us and they want more support, we've supported people,
19 about 1,200 people over the last year at various stages,
20 maybe about 500 of them through the whole complaints
21 process. Others want support to write letters, others
22 want information about how to complain.
23 So currently, within our budget, we can cope with
24 that. Were this to expand greatly and there were to be
25 greater demands on our resources, then we would need an

1 increase in the current resources that we have in order
2 to be able to cope with that and we have flagged that up
3 to the Department of Health.
4 THE CHAIRMAN: Let's suppose, even if the -- from the
5 figures that you've given the inquiry, your numbers have
6 been increasing already, isn't that right, so that's --
7 MAEVE HULLY: Yes.
8 THE CHAIRMAN: -- helpful to the extent that that suggests
9 that there's a growing awareness of the existence and
10 role of the PCC.
11 MAEVE HULLY: Yes.
12 THE CHAIRMAN: But if the system is going to be perhaps
13 improved to allow more involvement of families with the
14 support of the PCC through the investigation, would that
15 in itself have a resource issue for you?
16 MAEVE HULLY: Well, I think any increase over and above our
17 current workload would require additional resources.
18 THE CHAIRMAN: Is that a way of saying that you're fully
19 stretched at the moment?
20 MAEVE HULLY: Pretty much.
21 THE CHAIRMAN: Okay.
22 We've been told on a number of times that the
23 experiences which the inquiry has been looking at from
24 the mid-1990s through to the early 2000s would be
25 perhaps more likely to be avoided now because there is

1 some more openness and willingness among doctors and
2 nurses to engage with patients and to say what has been
3 going on than there was before.
4 Can I ask you first, Mr Walsh, without things being
5 perfect now, has there been an improvement over the last
6 five to ten years in terms of the extent to which people
7 are more candid with families?
8 PETER WALSH: Yes, I think there has been an improvement.
9 There's much more awareness now of the need for
10 openness, honesty from the beginning. There's a great
11 deal of international evidence now, for example, that
12 shows that the earlier that an organisation is open and
13 honest about something that's gone wrong, the less
14 likely people are to complain or to litigate. And also,
15 the growth of the patient safety movement has placed
16 such emphasis on the need for learning. It's widely
17 acknowledged that unless organisations take early
18 acknowledgment that something may have gone wrong
19 seriously and do a root-cause analysis of why that may
20 have been the case, how it might be avoided, then we're
21 not going to make the advances in patient safety,
22 preventing those instances being repeated time and time
23 again.
24 So yes, things are better. There used to be an
25 organisation in England and Wales called the National

1 Patient Safety Agency, which I know also had a lot of
2 influence in Northern Ireland. In the early part of
3 this century they brought out guidance called "Being
4 Open". That in itself was a watershed. It did more
5 than simply preach to people, saying, "You really should
6 be open and honest", it actually gave practical advice
7 on how to go about that, how to organise the process of
8 disclosure, acknowledging that it must be the most
9 difficult job a health professional ever has to do in
10 their lives to face a family and say, "I was involved
11 in the treatment of your loved one and it may be that
12 through errors or omissions of our own there was the
13 wrong outcome".
14 So that's a very valuable resource and I believe
15 that's being looked at and used to some extent in
16 Northern Ireland as well. So things are better, but
17 they're by no means fixed, and we still come across
18 a worrying number of examples of a complete failure to
19 be open and honest.
20 THE CHAIRMAN: Right. We'll come on to the statutory
21 candour issue in a few minutes.
22 I should have asked you, Ms Hully: you've been with
23 the council since 2009; is that right?
24 MAEVE HULLY: Yes.
25 THE CHAIRMAN: Prior to that, did you have experience in the

1 system or did you come in from outside the system?
2 MAEVE HULLY: I'm a paediatric nurse by training.
3 Immediately prior to Patient and Client Council, I was
4 working for Marie Curie Cancer Care. My experience as
5 a manager of that service in a hospice setting was that
6 we too did get complaints, but where we got clinicians,
7 doctors and nurses, involved with families over the
8 complaints, which was quite often around drug regimes
9 for people at the end of their lives.
10 The experience that Mr Walsh has described, one of
11 feeling -- understanding of what had happened and
12 understanding the decisions that were made that actually
13 families felt reassured about that.
14 THE CHAIRMAN: Right. Then on the same theme, is your
15 experience in the last five to ten years one of some
16 improvement on the willingness of health professionals
17 to be open with patients and families?
18 MAEVE HULLY: I think that's difficult to answer globally.
19 I think individuals perhaps, but I think we wouldn't
20 have the evidence within the Patient and Client
21 Council -- because, of course, we see the complaints.
22 We wouldn't have the evidence to be able to comment as
23 to whether there has been a significant change in
24 attitudes. We would of course be aware of the
25 international evidence that -- but from our day-to-day

1 work we wouldn't have the evidence to comment on that.
2 THE CHAIRMAN: It has been described to me, from a number of
3 witnesses in the hospitals, to say breaking down this
4 defensiveness is one of the most difficult things in the
5 health system, there has been some improvement, but
6 continuing to make improvement is difficult. Is that
7 your experience?
8 MAEVE HULLY: Yes. Quite often families will say to us, "If
9 somebody just could have told me what was going on and
10 somebody had said they were sorry for what happened,
11 I wouldn't have felt I needed to continue with the
12 complaint or pursue it in the way that I did". So
13 I think families do feel sometimes that they are part of
14 a culture of defensiveness from doctors and nurses.
15 THE CHAIRMAN: At the risk of opening a very large can of
16 worms, how much do medical insurers and lawyers help or
17 hinder the system?
18 PETER WALSH: Perhaps I'll have a stab at that, Mr Chairman,
19 as we have quite a lot of interface, as well as with the
20 health professionals, with lawyers who specialise in
21 clinical negligence, for example. In actual fact, if
22 I may, can I draw your attention to the final paragraph
23 in the appendix that you brought to our attention?
24 Because that stipulates that usually if there's an
25 allegation of physical injury, then the complaint will

1 be put on hold. I think that speaks volumes about the
2 interface of potential litigation and complaints.
3 THE CHAIRMAN: What you're doing is referring to the screen.
4 It's the last paragraph, is it?
5 PETER WALSH: Yes.
6 THE CHAIRMAN: "Others [that's other complaints] may be
7 delayed due to [and we skip a few examples] because
8 a complaint is being investigated under another
9 procedure."
10 PETER WALSH: Correct.
11 THE CHAIRMAN: And what you're referring to is if there's
12 litigation, that may lead to the complaint investigation
13 coming to a stop?
14 PETER WALSH: That's correct, or put on hold. That is
15 a common experience. Now, we've talked about how
16 daunting it is for families to make a complaint or to
17 challenge the system to try and get to the truth. In
18 our experience, very often people will turn to lawyers
19 not because they were necessarily, at the beginning,
20 seeking compensation, but simply because they see that
21 as the only way of being empowered to really challenge
22 the institution to get to the bottom of matters and to
23 get some accountability.
24 Now, this procedure of putting complaints on hold,
25 sometimes even if you're just taking advice, you haven't

1 even started proceedings but you're considering taking
2 proceedings, is something that we've come across not
3 just in Northern Ireland but across the UK. In England,
4 we challenged that and persuaded the Department of
5 Health to change that procedure, which was with effect
6 from 2009. The reason being is that we believe that
7 works completely contrary to the spirit of openness and
8 honesty and people's rights and expectations as an NHS
9 patient.
10 For example, we asked: why should it be, simply
11 because I feel my family may need or deserve or be
12 entitled to compensation and are making the necessary
13 steps to determine that, that an NHS provider should
14 simply say, "Well, that's it then, we're not going to do
15 any more with you and respond to you in the way we would
16 any other NHS patient by responding to your complaint,
17 get your lawyer to speak to our lawyer"? It's now
18 accepted in England at least that that's not the way to
19 proceed in a modern, just NHS.
20 THE CHAIRMAN: It's also potentially counterproductive,
21 isn't it?
22 PETER WALSH: It is indeed. It puts people's backs up even
23 more. Even if they were still thinking about whether
24 they were going to take legal action or were undecided,
25 that kind of response usually would have the effect of

1 saying, "Right, I'm going to take every step I possibly
2 can to hold you to account".
3 THE CHAIRMAN: We'll hear tomorrow if that actually is what
4 happens here.
5 Mr Lavery, I'm not sure if you can help me off the
6 top of your head, but do you know, in Northern Ireland,
7 if, in the event a litigation is envisaged, whether that
8 brings a halt to the complaint process?
9 MR LAVERY: It's my understanding, Mr Chairman, that it
10 does, but I will check on that. If I could make one
11 observation, Mr Chairman? Once the litigation process
12 starts, because of the changes in Supreme Court practice
13 over the last number of years, it's not the case any
14 more -- and certainly from the defence point of view --
15 that a lawyer would put in a blanket denial defence and
16 put the onus then on the plaintiff to prove the case.
17 What we have now, Mr Chairman, is a much more open
18 system. The defence, once it comes in, must acknowledge
19 or must set out really what the defence is and which of
20 the allegations are denied, and it's much more open from
21 that point of view. Also when one comes to the end of
22 the process, we have disclosure that we didn't have
23 before. So whilst litigation does perhaps close off
24 that avenue, it's not the end of the road for families.
25 THE CHAIRMAN: No. I think we might pick up tomorrow if

1 there has been a change in England about whether going
2 down the litigation route puts a complaint on pause. If
3 that is no longer the case in England and Wales, or is
4 it just England?
5 PETER WALSH: It's certainly England. I'd have to
6 double-check Wales as well.
7 MR LAVERY: Part of the difficulty, of course, is that if
8 there are two separate procedures ongoing that one might
9 prejudice the other, and certainly that arose in the
10 terms of this inquiry. Once there was a police
11 investigation, this inquiry was put on hold. So there
12 may be difficulties from that point of view. And it can
13 prejudice both the plaintiff and defendant.
14 THE CHAIRMAN: I'm just saying we'll explore it tomorrow.
15 Thank you very much.
16 The sort of risks of one investigation prejudicing
17 another, can I presume that that was certainly at one
18 point a view which was taken in England, that you
19 couldn't run things parallel?
20 PETER WALSH: I believe there was an assumption made that
21 that was the case, but when people actually came to
22 think about it and looked at what the purpose of the
23 complaints procedure is, it's simply to give people the
24 facts. It is simply to give them the truth, the
25 findings of an investigation.

1 So my opinion is, Mr Chairman, that the only
2 prejudice that could hold for, for example, a clinical
3 negligence action is that the claimant would be availed
4 of more facts that might be helpful to them in their
5 claim. That's not what I understand prejudice of a
6 legal proceeding should be and that any of us should be
7 entitled as a right to have all the factual information
8 that's available, whether or not we're seeking
9 compensation.
10 The other thing I'd say about the legal process,
11 of course, is that while it's true to say that the
12 process is much less adversarial than it used to be,
13 it is only designed to establish whether there is
14 liability and causation and compensation should follow.
15 So it wouldn't give people the explanations, the
16 apologies, the commitments to put things right that the
17 complaints procedure is supposed to deliver. So that
18 would all be being put on hold whilst what is still
19 a relatively adversarial system -- and a difficult
20 system for people to even access -- runs its course.
21 THE CHAIRMAN: We've had an issue, Mr Walsh, which I'm not
22 sure you've been alerted to, which is about a claim for
23 privilege during one of the inquests here. After one of
24 the children we're concerned about, Raychel, died in
25 2001, an inquest was called, the coroner got an expert

1 report which was critical of nursing in some aspects and
2 the relevant trusts, not the Belfast Trust, but the
3 relevant trust obtained an expert's report with a view
4 to seeing whether the coroner's expert was correct or
5 whether his view might be challenged.
6 The trust's expert provided a report to the trust,
7 which effectively confirmed the coroner's expert's view,
8 but that report was not provided to the inquest. As
9 a matter of law, the trust is entitled to assert
10 privilege for that, it is a privileged document, but the
11 issue which concerns me is in whose interests would the
12 trust withhold that report? And that goes back, it
13 seems to me -- and this is an issue we'll certainly be
14 debating tomorrow because both the Department of Health
15 in its responses for this week and the Belfast Trust in
16 its responses for this week have effectively stood over
17 the practice of claiming privilege. And I don't
18 challenge that practice as a matter of law, but what
19 I challenge is the decision to exercise the discretion
20 to claim privilege, because the effect of it is that
21 what was withheld from the coroner was a report which
22 confirmed that his expert was right and that there were
23 failings in the treatment of Raychel.
24 Do you know if that is an issue which has been
25 debated or one which has emerged as an area of concern

1 in England and Wales?
2 PETER WALSH: Yes, it is, Mr Chairman. One of the
3 specialist services my charity provides to people
4 affected by medical accidents is a specialist service to
5 support them at inquests into healthcare-related deaths.
6 So we have quite a lot of experience of the coronial
7 system, certainly in England and Wales. This issue has
8 come up, it also came up in the context of the
9 Mid-Staffordshire public inquiry. In one of the
10 documents I submitted to you there's a brief resume of
11 the case of John Moore Robinson. The chairman to that
12 inquiry had some very strong things to say about the
13 provision of information that's available at a trust
14 level to the coroner. In that case, a damning internal
15 report was suppressed, not just from the family, but
16 from the coroner himself who was conducting the inquest.
17 So there are moves to look at that. I'm not
18 a lawyer, Mr Chairman, so I couldn't comment on what
19 people are entitled to do under law. But I think most
20 of us who can look at it from an ordinary person's or
21 layperson's point of view in terms of right and wrong,
22 ethics and morals, whilst someone might be permitted to
23 claim privilege for something under the law, it doesn't
24 mean that they should do that. I find a suppression of
25 that kind of information very disturbing in terms of why

1 it's being done and in whose interests.
2 THE CHAIRMAN: I won't pretend that when I was a lawyer in
3 practice that I wouldn't have advised clients to obtain
4 reports and then, if they weren't favourable to that
5 client, not to rely on them or not to provide them. But
6 sitting here in this position, in this inquiry, it leads
7 me to wonder whether -- it takes you back to the root of
8 what each trust is for. It's to provide care for
9 patients and if it has a report which shows that the
10 care was defective in some way, then the withholding of
11 that report from the coroner, as in Raychel's case --
12 and inevitably therefore from Raychel's family -- was
13 more about protecting the trust than protecting the
14 public interest.
15 Can we move on to another issue about the training
16 of doctors and nurses in areas about how they deal with
17 families and how responsive they are to families'
18 concerns? I'm talking at undergraduate level and in
19 practice. Is there scope for providing some training to
20 doctors and nurses to effectively explain to them what
21 the benefits are of being open with families and
22 patients, perhaps more than any such training exists at
23 the moment? Do you have any views on that, Ms Hully, or
24 do you have any experience of it from your own nursing
25 training?

1 MAEVE HULLY: Yes. It would be from a personal perspective.
2 I think there is -- I think it is improving, I think
3 it is better. I think part of the issue is not
4 necessarily with undergraduates, but actually once they
5 become graduates and are working then they are caught up
6 in the culture of wards and senior people within wards,
7 and therefore what they have learnt or experienced in
8 their training becomes hard to put into practice if
9 you're working within an environment where that isn't
10 encouraged?
11 THE CHAIRMAN: Where there's a hierarchy and you're lower
12 down in the hierarchy?
13 MAEVE HULLY: Yes, and are wanting to be open and honest,
14 but finding it quite difficult because that's clearly
15 not what's happening elsewhere. Again, that would be my
16 opinion.
17 THE CHAIRMAN: In practical terms, I take it from what
18 you've said that you've been out of active nursing for
19 some time?
20 MAEVE HULLY: Yes.
21 THE CHAIRMAN: In practical terms, I wonder how realistic
22 it is to expect that a nurse, even an experienced nurse,
23 will say to a patient in terms, "The doctor made
24 a mistake", or say to a patient's families, in terms,
25 "The doctor made a mistake". Does that really happen at

1 all?
2 MAEVE HULLY: No, I think that would be really very, very
3 difficult, but I think you can have an environment in
4 a ward where you have an opportunity to discuss cases
5 and you could say to your senior, "I'm a bit concerned
6 that happened. What can we do about it?" So it would
7 be unrealistic for a junior nurse to say a doctor hasn't
8 performed adequately, but you'd expect within her
9 registration that she would advocate for the patient and
10 say to somebody more senior, "I'm a bit more concerned;
11 what do you think we should do?"
12 THE CHAIRMAN: Each nurse and each doctor, at whatever
13 level, their primary duty is to the patient; isn't that
14 right?
15 MAEVE HULLY: That's right.
16 THE CHAIRMAN: So what you're describing is a system in
17 which you encourage the junior doctor or the junior
18 nurse to raise the concern within their hierarchy, but
19 then you also rely on the people at the top of that
20 hierarchy to go to the family and to say what has
21 happened or what might have gone wrong?
22 MAEVE HULLY: I think that's a system that could and should
23 work. I'm not sure it does work because I think quite
24 often you have a system that isn't as open and
25 transparent as you would want it to be.

1 THE CHAIRMAN: When you were training as a nurse or when you
2 were practising as a nurse, was there ever a way in
3 which anybody who'd been on the wrong end of medical
4 practice would come in and say to you, "Look, you have
5 to understand when things go wrong, as they did with me
6 or with a member of my family, these are the
7 consequences so please be open with us". Does that sort
8 of input from a victim perhaps ever come into your
9 training?
10 MAEVE HULLY: It didn't come into my training, but we are
11 involved with both the universities in terms of the
12 undergraduate medical and nursing training as an
13 organisation now and doing some training with them
14 around the role of our organisation, our experience of
15 complaints and how, from the patient's perspective, we
16 think that could be improved on and the role of the
17 clinician within that, and indeed we bring to those
18 sessions people who have been through the system. So
19 service users who have been through the system.
20 THE CHAIRMAN: Just so that I understand it clearly, those
21 sessions are with trainee and practising doctors and
22 nurses?
23 MAEVE HULLY: Undergraduates only, yes.
24 THE CHAIRMAN: Are you aware of any equivalent to this? You
25 know the thing I'm getting at.

1 PETER WALSH: Yes, indeed. It is very patchy. We also get
2 invited --
3 THE CHAIRMAN: Is "patchy" just the catch-all word for
4 everything?
5 PETER WALSH: Sorry, it's not the first time it's been used.
6 THE CHAIRMAN: We've been using it before you arrived today,
7 Mr Walsh, don't worry. On the good side of it, where
8 have you seen it work?
9 PETER WALSH: On the good side of it, we, for example, are
10 being invited in as a charity -- either myself or my
11 staff -- to give talks to undergraduates as part of
12 their training. But it tends to be where a tutor is
13 particularly enlightened and wants to actually progress
14 that part of people's training as opposed to a standard
15 part of every health professional's training. We think
16 that's vitally important that as many leading health
17 professionals do get it as part of the core training.
18 There are two elements of it in actual fact. One is
19 how being open is always the right thing to do from
20 a professional as well as an ethical point of view, but
21 it requires certain skills and qualities and
22 understanding in order to do it. But the other element,
23 quite frankly, is preparing health professionals for
24 what can be a devastating moment in their own personal
25 professional career, the so-called second victim

1 syndrome.
2 In our experience, where a doctor or a nurse has
3 been involved in a medical accident that's caused
4 serious harm, it can be devastating to them as well.
5 And there's a worrying lack of support for those people
6 who find themselves in that situation, not only to do
7 the open disclosure work with the patient or family, but
8 coping as an individual with the fact that they've come
9 into that profession to help people and make them
10 better, but they've been involved in an incident that
11 sadly has gone very wrong.
12 That's why we think there needs to be a more
13 holistic approach, not simply threatening people with
14 a stick "you must do the right thing", but providing
15 them with the training, the support and, in some cases
16 the protection, the so-called protection of
17 whistle-blowers. Again, in our experience, usually
18 a health professional will want to do the right thing
19 and it's the system, the management or in-house lawyers
20 that somehow get in the way of doing what would, you
21 hope, be the natural thing for any health professional
22 to do.
23 THE CHAIRMAN: Right. When you say you're invited in,
24 that's from some people who might be regarded as
25 enlightened in their approach, that in effect means

1 you're going to be invited in for some undergraduate
2 courses and some universities, but not others?
3 PETER WALSH: That's correct.
4 THE CHAIRMAN: If that was made a standard part of the
5 curriculum of nursing and doctors' training, it would
6 help?
7 PETER WALSH: It would help, indeed, significantly.
8 THE CHAIRMAN: The other area where you have been reported
9 in the press and which maybe ties in with this is on the
10 duty of candour. Let me preface this by referring for
11 a few moments to the Francis report. This is the report
12 by Robert Francis QC on the Mid-Staffordshire NHS
13 Foundation Trust.
14 In his report, he deals with complaints handling.
15 I think we have covered, I think in general, the areas
16 which he has touched on there. But in terms of candour,
17 he has made the following recommendations. One is that:
18 "There should be a statutory obligation to observe
19 a duty of candour on healthcare providers who believe or
20 suspect the treatment or care provided to a patient has
21 caused death or serious injury."
22 And by "healthcare provider", I understand him to be
23 referring to doctors and nurses.
24 PETER WALSH: Actually, organisations.
25 THE CHAIRMAN: The next recommendation is the statutory duty

1 on all directors of healthcare organisations. So he has
2 it in two parts: one is that all healthcare providers --
3 which I interpret for this as meaning doctors and
4 nurses -- and then a statutory duty on all directors,
5 which are, I think, directors of the trust boards --
6 PETER WALSH: Yes.
7 THE CHAIRMAN: -- and any others who are involved as well;
8 is that right?
9 PETER WALSH: Yes.
10 THE CHAIRMAN: That recommendation is framed in terms of
11 events which have caused death or serious injury. In
12 chapter 22 of his report, when he was exploring this, he
13 said that his view was that this should not be extended
14 to what are, rather crudely, called near misses. He
15 said at paragraph 22.157:
16 "While the arguments in favour of extending a duty
17 of candour to patients to require disclosure of near
18 misses are powerful, the inquiry does not agree this is
19 necessary. While such disclosure may in some cases be
20 desirable, in others it is likely to confuse and
21 distress and produce no discernable benefit to either
22 the patient or the public interest."
23 Do I gather from your reported comments that this is
24 one area in which you would prefer to go further than
25 Mr Francis has recommended?

1 PETER WALSH: In actual fact, Mr Chairman, no. We concur
2 with him that the disclosure of near misses should be
3 discretionary.
4 THE CHAIRMAN: Okay.
5 PETER WALSH: It's really when harm may have been caused
6 that we think it really has to be mandatory.
7 THE CHAIRMAN: Do you agree with him on mandatory disclosure
8 of death or serious injury?
9 PETER WALSH: Well, there's been a bit of a debate in
10 England about what Francis meant by the word "serious".
11 The government currently are planning to restrict
12 a corporate duty of candour on organisations in England
13 to what they describe as fatal or severe injury cases.
14 The words, although similar, are important because
15 when they say severe injury, they're referring to
16 a specific NHS definition of severe, which, in short,
17 effectively means permanent serious disability. And we
18 believe that the spirit of what Robert Francis was
19 talking about was, in that word "serious", what an
20 ordinary person would deem as serious.
21 THE CHAIRMAN: So "serious" could mean something which was
22 serious, but from which the patient has made a recovery?
23 PETER WALSH: Exactly, Mr Chairman. So in one example we've
24 given, if something went wrong in surgery and, as
25 a result, I was temporarily disabled for a year or

1 several years, but eventually recovered, despite the
2 fact that I may have lost my career, been unable to care
3 for my dependants for the entirety of that time, it
4 wouldn't have been sufficiently severe to have mandated
5 the open disclosure of that incident to me.
6 THE CHAIRMAN: Okay. So is this something we should keep an
7 eye on to see how the debate unfolds?
8 PETER WALSH: It is. The Secretary of State will be making
9 an announcement, I understand, on Tuesday as to his
10 formal response to the Francis recommendations. We have
11 made strong representations why we think the current
12 plan of restricting it to severe or fatal cases is
13 impracticable as well as undesirable in that, in effect,
14 it would legitimise the cover-up of all incidents deemed
15 by the healthcare provider not to meet that threshold of
16 "severe." And secondly, the practicality of it, that
17 instead of having doctors and nurses and management
18 automatically doing the natural right thing to do, to
19 tell someone, "Something's gone wrong, we don't know the
20 full outcome yet, we're going to do our best to make it
21 better and you will get the full information as soon as
22 we have it", you'd have doctors, and potentially
23 lawyers, crawling over a case, to determine, "Do we have
24 to disclose?"
25 Again, they'd be within their legal rights in that

1 scenario to say, "Well, we don't think it meets that
2 criteria, therefore we won't tell the patient or family
3 anything".
4 THE CHAIRMAN: It seems to me there is inevitably legitimate
5 room for debate on what "serious" means, but something
6 is always going to be undefinable. The "serious" will
7 leave an area of discretion, but it increases the
8 obligation to report if you reduce from severe to
9 serious.
10 PETER WALSH: Yes, and there's another word that comes into
11 play, again it begins with S, "significant". In the NHS
12 definition of moderate harm -- which is where we think
13 the threshold should be for requiring by statute that
14 there's disclosure -- the description of that is
15 "significant harm or injury".
16 THE CHAIRMAN: Through whose eyes, Mr Walsh?
17 PETER WALSH: Again, it would be through eyes of a health
18 professional, and that's the way it's actually worded in
19 the draft regulation that I've seen. The point,
20 I think, is that it's much more easy for someone to make
21 a judgment about whether an injury is truly significant
22 as opposed to insignificant and very transient than
23 it is to make a very complicated and difficult judgment
24 at an early point of time when you'd normally expect
25 a discussion to be taking place about whether it's

1 significant but not severe enough to meet a very
2 particular definition of permanent disability.
3 THE CHAIRMAN: Are there any ideas or lessons from outside
4 the UK or any examples of how a similar system has been
5 introduced?
6 PETER WALSH: Yes. There's some really interesting
7 international work. Only last week we hosted
8 a conference that was hearing about the work being done
9 in the United States, led by a doctor called
10 Dr Timothy McDonald, which he calls his "Seven pillars
11 of good practice in open disclosure". What they have
12 found is by really hammering home the point to everyone
13 in their organisations, that being open and honest early
14 on is the right thing to do, they have very, very
15 significantly reduced the costs of litigation, the
16 number of complaints, and significantly enhanced -- or
17 made better, I should say -- the experience of families
18 who sadly lost people or individuals who have been
19 harmed by managing in an intelligent way an open
20 disclosure process and supporting their staff in doing
21 that.
22 THE CHAIRMAN: Is the point about reducing complaints that
23 you don't have to complain if you have already been told
24 what has happened?
25 PETER WALSH: That is the case sometimes, yes. As I said

1 earlier, if you very early on get told the truth in
2 an honest and a sincere way, have things explained to
3 you and you have a sense that people acknowledge that
4 something needs to change as a result, in our experience
5 most people would be satisfied. Some people may need
6 and be entitled to compensation as well, so at the
7 moment they have no option but to take legal advice and
8 potentially take legal action, but a large number of
9 those cases would be avoided because people have got the
10 answers and the result they really wanted.
11 THE CHAIRMAN: So you wouldn't be like some people who sue
12 because they perceive it's the best or the only way for
13 them to find out what happened? That category of people
14 doesn't get involved in litigation, the people who would
15 get involved in litigation under this scenario would be
16 people who have actually suffered some sort of
17 compensatable loss?
18 PETER WALSH: Yes, that's right. Again there's
19 international evidence, as well as our own experience as
20 a charity, which is that the majority of people don't
21 want to take legal action. We actually, when we advise
22 them, we appraise them of how difficult and stressful
23 a process that is and potentially costly, and if they
24 can get resolution without turning to the law, most
25 people will, but of course there'll always be some

1 people, quite legitimately and understandably, who have
2 to turn to the law because that is the only way of
3 getting help, for example with coping with permanent
4 disability of yourself or a child, and that remains
5 a legitimate right.
6 THE CHAIRMAN: Ms Hully, do you have any views on this?
7 The council must be aware of this debate going on.
8 Do you have a personal view or a council view on it?
9 MAEVE HULLY: Well, we'll only ever talk where we have an
10 evidence base to do so. We haven't asked people across
11 Northern Ireland about this statutory duty of candour.
12 But what we do know from our work is that people do want
13 the system to be more open, they want it to be more
14 transparent, and they want to be involved early when
15 things go wrong, they do want to know about them. But
16 I think it would be interesting to find out exactly what
17 people would feel, whether or not they agree with that
18 becoming a -- I suspect they probably would.
19 THE CHAIRMAN: One could get the impression that the
20 statutory duty is being imposed because it's not good
21 enough to rely on what has emerged as a patchy,
22 inconsistent system.
23 PETER WALSH: Yes. I think what's emerged, Mr Chairman,
24 is that of course everybody in the NHS is in favour of
25 openness and transparency, but it's a little bit too

1 easy to talk about motherhood and apple pie and say
2 of course openness and honesty is a good thing. What
3 people have realised is it's not being practised in the
4 real world as consistently as we would like. That's
5 because there are very mixed messages. On the one hand
6 people are told openness and honesty is a good thing and
7 there's guidance about it, but the fact there isn't
8 a rule, anything in statute, that says, "You cannot
9 cover-up, you cannot put the interests of your
10 organisation, for example, before the public interest or
11 your duty to be open and honest to patient or their
12 family". The very fact that that rule doesn't exist --
13 most members of the public when I speak to them find
14 that astonishing. People simply assume that there must
15 be some statutory rule somewhere that says that has to
16 happen. In actual fact, as we know, there isn't, and
17 that really came across very, very starkly at the
18 Mid-Staffordshire public inquiry.
19 So in the case of John Moore Robinson, for example,
20 it wasn't found that anyone had broken any rule by
21 suppressing that internal report from the family or even
22 the coroner because no such rule saying that they had to
23 existed.
24 THE CHAIRMAN: Yes. The senior coroner for Northern Ireland
25 gave evidence here and said that he had shared expert

1 reports which he received at inquests through his time
2 as a coroner and had assumed that he was also being
3 given that benefit by trusts and was rather taken aback
4 to learn that he hadn't.
5 There's one other aspect to this which was
6 disappointing. It is in one of the cases we were
7 looking at, namely Claire's: a consultant who had been
8 asked for his help in treating Claire and had gone, to
9 be fair to him, to give some help on three separate
10 occasions and had then gone home at about 5.30 or 6 pm
11 at the end of his day's rota. He wrote in a draft
12 statement for the inquest that he regretted the fact
13 that, before he left shift, he had not referred Claire
14 to the paediatric intensive care unit, because the next
15 thing that he knew about Claire was that he was called
16 into the hospital in the early hours of the following
17 morning and it was too late to save her.
18 But it was suggested to him by a senior officer in
19 the trust that he might remove that sentence from his
20 inquest statement because it was for the coroner to make
21 findings about whether Claire should have been referred
22 earlier rather than the doctor himself. So it seemed to
23 me to be an example in this context of somebody who was
24 at least expressing regret that he might have done more
25 at the time, but who was then -- he wasn't directed to

1 remove that line, but in fact he did remove that line
2 from his statement. I presume that's something which
3 would ... I'm not sure -- I have to make a decision on
4 this, but at least technically it might be right that
5 it is for the coroner to make these findings, but one of
6 the purposes of inquests is to find out what went wrong
7 and to try to ensure that it doesn't happen again and
8 a volunteered expression by a doctor of "I might have
9 done more" might be helpful.
10 PETER WALSH: Certainly one would think so, Mr Chairman.
11 We would think so. I think it's also an example of the
12 very, very difficult situation that doctors and nurses
13 find themselves in in these circumstances. Because in
14 theory, every doctor and nurse is bound by their
15 professional code, which says that they should explain
16 to their patient any incident that may have caused harm
17 regardless of how serious it is, in actual fact.
18 So you can find yourself in an impossible situation
19 where your professional ethics and your code, through
20 which you might be held to account and disciplined by
21 the regulator, is telling you to do one thing, but your
22 employer is very strongly telling you to do something
23 different. And that's another reason why we think
24 absolute clarity about what is required would be in
25 everybody's interests.

1 THE CHAIRMAN: When you mentioned professional codes, it
2 might be striking that the GMC codes and the NMC codes
3 didn't have the effect of making any nurse or doctor
4 feel that they had to explain to the families what had
5 gone wrong. Do you think that's a weakness in the codes
6 or a weakness in the way in which the codes were
7 followed?
8 PETER WALSH: I think it's more a question of the way the
9 codes are followed. What the codes say, I think, are
10 what the man and the woman from the street would expect
11 them to say, which is that you need to be honest with
12 your patients when something has gone wrong. However,
13 our experience is -- and I hesitate to use the word
14 "patchy" -- but the GMC and the NMC have been unreliable
15 and inconsistent in actually upholding that particular
16 standard. It's difficult, of course, because by the
17 nature of the breach of that standard, it's sometimes
18 difficult for it to come to light. But in one test
19 case, we took a judicial review out against the GMC over
20 their refusal to investigate allegations of a cover-up
21 in the death of -- a very famous case of Robbie Powell
22 in South Wales. Their justification for not
23 investigating even the complaint was that their
24 five-year rule, so-called five year rule, had been
25 invoked. So the incident about which the allegations

1 related was more than five years old, which may become
2 a factor in some of the cases that have been discussed
3 at this inquiry, of course.
4 So the GMC's default situation is that they will not
5 investigate cases about allegations of incidents which
6 are more than five years old unless there are
7 exceptional circumstances. Our fear about that stance
8 is that it sends a very worrying message that the more
9 successful someone might be in covering something up for
10 as long as possible, the more likely it is that they're
11 effectively off the hook. And in fact the GMC never did
12 investigate that case.
13 THE CHAIRMAN: So if we take a very stark, hypothetical
14 example of a death, which is clearly as a result of
15 inadequate medical treatment, that's not disclosed to
16 the family, the knowledge is held by, let's say, two or
17 three doctors, but they keep quiet about it and the
18 family stumble over it six years later, the GMC line
19 is: it's too late to complain because it's more than
20 five years since the incident occurred?
21 PETER WALSH: That's the default situation. They do have
22 discretion to waive that. The NMC, interestingly, don't
23 have a five-year rule, so if you're a nurse or
24 a midwife, you can't hide behind that rule. The GMC
25 would say they do have discretion, they can waive it in

1 exceptional cases, but one has to ask: what is the
2 purpose of that in the first place? Surely there's
3 a public interest, notwithstanding how long ago the
4 incident took place, of such a serious allegation being
5 investigated.
6 THE CHAIRMAN: There are legal equivalents, Mr Walsh, where
7 various claims can be brought -- specifically brought by
8 statute outside a time limit on the basis that the time
9 limit doesn't run if the event has been covered up.
10 It's put specifically in terms of misrepresentation or
11 fraud or withholding of information. But that's the
12 sort of scenario that might be more usefully applied.
13 Just while we're on the GMC and the NMC, the extent
14 to which a complaint to them is useful appears to be
15 rather limited, doesn't it, because they can only deal
16 with a complaint against Dr X or Nurse Y rather than
17 take an overall perspective? Is that right, Ms Hully --
18 MAEVE HULLY: Yes.
19 THE CHAIRMAN: -- insofar as nurses are concerned?
20 MAEVE HULLY: Yes.
21 THE CHAIRMAN: In fact, we had an example of it here. There
22 was a nurse in Conor's case who was struck off by the
23 NMC, which then made some critical comments about
24 Craigavon Trust and it was suggested to me that I should
25 disregard the NMC's critical comments about the trust

1 because they were outside the remit of the NMC to make.
2 The reason I'm going down this line is because I'm
3 looking at what the alternatives are to a statutory duty
4 of candour, so the NMC and GMC are unreliable,
5 inconsistent in the standards that they set and only
6 have a limited remit in any event because they deal with
7 an individual rather than the organisation?
8 PETER WALSH: Yes, that's right, Mr Chairman. The codes of
9 practice, incidentally, they're not in themselves
10 statutory, there's no obligation on the regulators to
11 take action against a doctor or a nurse, even if there
12 is evidence that they may have breached that part of the
13 code. The other thing is, as you've rightly said, it
14 doesn't apply to the wider system, the organisation that
15 may have been the main reason why a doctor or nurse
16 wasn't able or didn't feel able to disclose. So one of
17 the things the English government have asked is for the
18 GMC, NMC, et cetera, to think about how they could beef
19 up their systems, but even if they did, it means that
20 a risk manager, complaints officer, an in-house lawyer
21 who was involved in suppressing information wouldn't be
22 covered by that code unless they themselves were
23 registered by the GMC or NMC, which is why Francis and
24 the government now are looking at the statutory duty on
25 the organisation as a whole.

1 THE CHAIRMAN: Right. I noticed, Ms Hully, that,
2 immediately following the statutory duty of candour
3 recommendations, Mr Francis had turned his eye on
4 nursing. He has a section about there being a focus on
5 the culture of caring. What he suggested was that there
6 should be an increased focus in nurse training,
7 education and professional development on the practical
8 requirements of delivering compassionate care
9 in addition to the theory. So he was suggesting
10 a system which ensured the delivery of proper standards
11 of nursing, which would include that in the selection of
12 recruits to nursing they had to possess appropriate
13 values, attitudes and behaviours.
14 So he was suggesting:
15 "The training of nurses should be more than the
16 nurses' ability to learn the necessary medicine and
17 apply it to patients, but that the concern for patients
18 and their attitude to patients should be part of that."
19 How does that accord with your experience of nurse
20 training before you qualified and since qualification?
21 Was that missing or present?
22 MAEVE HULLY: Well, I think that particular debate has been
23 around nursing for some time, and indeed around
24 healthcare and the public for some time. I think
25 recruitment of people to nurse training is really very

1 important and the people need to go into nursing for the
2 right reasons. But I think also it is very important
3 that nurses are given the right skills in order to do
4 that. So it's about marrying up the right people with
5 the right training in order to get the right product at
6 the end.
7 THE CHAIRMAN: Right.
8 MAEVE HULLY: I think that what we hear about are a few
9 individual nurses for whom their practice wasn't
10 everything you'd want it to be. I suppose the other
11 side of that is that there's hundreds and thousands of
12 nurses every day who are providing a really good
13 service. So it's really -- I don't think this service
14 should be defined by the few that aren't doing it
15 properly, but rather by the majority who do.
16 THE CHAIRMAN: And if your council does get more involved,
17 as you're trying to, and does get more involved in
18 training of nurses and doctors, you can be part of
19 bringing in this increased awareness of the need to have
20 sometimes a better attitude to patients and to families?
21 MAEVE HULLY: Yes, and one of the other things that, as an
22 organisation, we're advocating is the role of patients
23 and service users in recruitment of staff, both for
24 training and -- for undergraduate training, but also
25 within some senior posts within the trusts as well.

1 THE CHAIRMAN: Tell me a bit more about that.
2 MAEVE HULLY: We think it would be quite nice,
3 notwithstanding all of the policies around recruitment
4 of staff, but that if panels -- and they do this quite
5 a lot within Mental Health Services anyway, that if
6 they're appointing a senior post, that they actually
7 have a person with an enduring mental illness as part of
8 the interview panel. So when people are recruited to
9 posts, at some level, people who are on the receiving
10 end of the services have had an input into the qualities
11 and the skills they would like to see from the person
12 they are appointing. And it's proved to be very
13 successful. So we too would like to see some evidence
14 of that here in Northern Ireland.
15 THE CHAIRMAN: Right.
16 MR LAVERY: Mr Chairman, I wonder, is this an appropriate
17 time just to come back to something you had raised
18 earlier about whether or not a complaints process comes
19 to an end when litigation is instigated?
20 THE CHAIRMAN: Sorry, I was corrected about it being put on
21 hold. That was Mr Walsh's term, actually, whether it
22 was put on hold.
23 MR LAVERY: It may be of some assistance, Mr Chairman, if
24 I did bring to your attention departmental guidance
25 which came out on 1 April 2009 in relation to complaints

1 in health and social care. There's a paragraph, 1.29,
2 in that and that could be made available if necessary.
3 But it states, under "legal action":
4 "Even if a complainant's initial communication is
5 through a solicitor's letter, it should not be inferred
6 that the complainant has decided to take formal legal
7 action."
8 Then at 1.30 it says:
9 "If the complainant has either instigated formal
10 legal action or advised that he or she intends to do so,
11 the complaints process should cease. The
12 chief executive or designated senior person should
13 advise the complainant or any person named in the
14 complaint of this decision in writing."
15 1.31 then says:
16 "It is not the intention of the HSC complaints
17 procedure to deny someone the opportunity to pursue a
18 complaint if the person subsequently decides not to take
19 legal action. If he or she then wishes to pursue their
20 complaint through the complaints process the
21 investigation of their complaint should commence or
22 resume. However, any matter that has been through the
23 legal process to completion cannot then be investigated
24 under the HSC complaints procedure."
25 THE CHAIRMAN: So what you're saying is the line the trust

1 takes is specifically endorsed by the department?
2 MR LAVERY: There is guidance from the department on that,
3 and I should say -- and my instructions are preliminary
4 in this record -- the Belfast Trust do not necessarily
5 always follow that guidance, and if there is
6 a complaint, particularly in terms of an SAI, they will
7 continue that investigation. That's the preliminary
8 instructions I'm getting on that point and obviously
9 tomorrow the Belfast Trust will be addressing the
10 inquiry and they can elaborate on that if necessary.
11 THE CHAIRMAN: You might then be interested that the
12 department will be here on Friday, so they can address
13 it to.
14 MR LAVERY: Indeed, thank you, Mr Chairman.
15 THE CHAIRMAN: So if that's the up-to-date information,
16 we'll confirm that. It looks as if the Department of
17 Health in Northern Ireland is a bit out of line with
18 what the Department of Health in London is now doing in
19 terms of litigation holding or stopping complaints.
20 PETER WALSH: That's right.
21 THE CHAIRMAN: Can you help me, Mr Walsh? How long ago was
22 it roughly that the position was changed in England so
23 that a complaint would no longer be put on hold if
24 litigation was envisaged?
25 PETER WALSH: 2009.

1 THE CHAIRMAN: And has the system come crumbling to a halt
2 because of that?
3 PETER WALSH: No, it hasn't. There have been some glitches
4 where some NHS organisations hadn't caught up with the
5 fact that the rules had actually changed and they were
6 still giving complainants the wrong information. People
7 were coming to us saying, "They won't investigate our
8 complaint because you've put us in touch with a lawyer
9 and we're exploring legal action". But we have just
10 recently, in actual fact, persuaded the
11 Secretary of State to issue unequivocal guidance
12 reminding the NHS trusts in England that they must
13 investigate complaints even if there is legal action
14 considered or actually ongoing.
15 THE CHAIRMAN: We might be able to find this ourselves this
16 afternoon, but could I ask you, when you finish here, if
17 you could possibly give us that --
18 PETER WALSH: Certainly.
19 THE CHAIRMAN: -- or give us the reference for it and we can
20 follow it up?
21 I'm going to take a break for a few minutes because
22 I think I've covered the areas that I outlined in the
23 notes that you received and I circulated on Friday. So
24 I'll pause for a few moments to see if there's anything
25 else that I want to cover before we conclude this

1 session, and we'll also leave the representatives of the
2 families to speak to them to see if there's anything the
3 families want developed or raised beyond what we have
4 done already.
5 (12.20 pm)
6 (A short break)
7 (12.40 pm)
8 THE CHAIRMAN: There's one or two points we've been asked to
9 tidy up and one or two points that I need to raise,
10 which I didn't really develop adequately before.
11 Ms Hully, can I take you the inquiry's exchanges
12 with you? A document which we had received was the
13 report of a workshop conducted by the Health & Social
14 Care Board from May 2013, the topic being "Improving the
15 complaints process".
16 In its findings, there are some suggestions that
17 maybe the role of the PCC wasn't clearly enough
18 understood and so on, so I just wanted to ask you about
19 that. Accepting that the outcome of a workshop will
20 depend on who goes to the workshop and perhaps, by
21 definition, the people who go to a workshop are people
22 who might be less satisfied than other people who aren't
23 attending, one of the points which was made -- and it's
24 at 344-001-009, which is page 6 of this report. Under
25 the heading "Support "at paragraph 3, in the second

1 paragraph under that heading, it was stated:
2 "The majority of attendees indicated that there is
3 a lack of information available in regards to the role
4 and responsibilities of other bodies such as the RQIA,
5 the Commissioner for Complaints and, in particular, the
6 Patient and Client Council. In regards to the PCC, the
7 majority of service users either did not know that the
8 Patient and Client Council exists or that they have an
9 advocacy role in supporting complainants. While the PCC
10 was established in 2009, service users did not know that
11 their role includes providing advice and support, for
12 example drafting letters ..."
13 Earlier this morning we discussed your efforts to do
14 two things, one was to have leaflets or information
15 about the existence and role of the council put up in
16 various places, including hospitals, and your
17 information was that some trusts had been more
18 supportive and helpful than others in that front. Do
19 I take that to mean there are some hospitals in which
20 information and leaflets about the council are
21 available, but other hospitals where that step still
22 hasn't been taken?
23 MAEVE HULLY: A couple of things. We take seriously any
24 expression of dissatisfaction with the service and
25 therefore included in that is the details from this

1 workshop. In terms of raising awareness, there's
2 a number of things that we have been doing. We probably
3 have some leaflets in all trusts and information posters
4 available in all trusts. In some departments, it's
5 better displayed than others, I think it would be fair
6 to say. We have sent all of our information to all of
7 the trusts and asked them to display it in places where
8 people are, for example outpatients, emergency
9 departments, wards. Some trusts have embraced that more
10 than others.
11 THE CHAIRMAN: The other point that you made this morning is
12 that you're trying to agree with trusts that it is
13 a standard paragraph in their acknowledgment that
14 a complaint has been received that they refer the
15 complainant to the existence and role of the PCC.
16 MAEVE HULLY: That's correct. We're trying to do that on
17 a regional wide basis, so we're currently working with
18 the Department of Health and the Health & Social Care
19 Board so that they will instruct the trusts to do that
20 in their correspondence with the people who complain.
21 THE CHAIRMAN: But that has not yet come to fruition, has
22 it?
23 MAEVE HULLY: No, it hasn't happened yet, no.
24 THE CHAIRMAN: Can I assume that there is no resistance to
25 that being done?

1 MAEVE HULLY: I think it's fair to sigh there's no
2 resistance. We're just at the stage of the process by
3 which we make sure that that happens.
4 THE CHAIRMAN: That will have the benefit that at least
5 people who have made a complaint are then made aware of
6 your existence and your role, so somebody who's taken
7 what you earlier described as the big step of making
8 a complaint will know that they're not alone, they get
9 support. The importance of the leaflets and posters in
10 hospitals is that it will help people to make the
11 complaint in the first place, isn't it?
12 MAEVE HULLY: That's right, yes, how do you go about it.
13 One of our leaflets is called "How do I complain?" and
14 that describes people and again that describes the role
15 that we play in that process and in fact gives people an
16 opportunity to contact us if they want some help to do
17 that.
18 THE CHAIRMAN: So on one view it's actually more important
19 to get your existence advertised within the hospitals
20 because that will encourage people to make complaints
21 and perhaps make them with your assistance? Getting
22 your role specifically referred to in the acknowledgment
23 of receipt of the complaint is valuable, but it's
24 perhaps equally important, if not more important, to get
25 the leaflets prominently displayed in the hospitals?

1 MAEVE HULLY: I think that's right. But you know, the
2 raising of awareness is multifaceted. We do that, but
3 in addition to that we're out and about and people in
4 local communities -- telling them about what we do and
5 how we're doing it. We have a membership scheme with
6 12,000 members. So we wouldn't want to rely on one
7 single action to raise awareness; we think it's really
8 important that we're getting our message to people right
9 across Northern Ireland in lots of different ways.
10 THE CHAIRMAN: If we look at the next paragraph, it says:
11 "There was an agreement that there is a requirement
12 for additional advocacy services within Northern Ireland
13 or at least clarification of the roles of bodies which
14 may provide support."
15 Well, presumably if there was more prominence given
16 to your existence and to your role, that would help with
17 that concern?
18 MAEVE HULLY: Yes.
19 THE CHAIRMAN: Okay. It then goes on to say:
20 "There were concerns about the independence of the
21 complaints process, for example members of staff who
22 have been involved in the care of the patient were also
23 the investigating officers."
24 That absolutely should not be the case, sure it
25 shouldn't?

1 MAEVE HULLY: No.
2 THE CHAIRMAN: A complaint cannot properly be investigated
3 in any way by somebody who's provided the care to the
4 patient in question.
5 MAEVE HULLY: Absolutely, yes.
6 THE CHAIRMAN: If that is an accurate description of what
7 occurs sometimes, that's a major failing in the
8 investigation of complaints, isn't it?
9 MAEVE HULLY: Yes. We are not aware of any, in any of the
10 work that we've been doing with people who are
11 complaining, that the person doing the investigation is
12 the person who's been named in the complaint.
13 We haven't got any experience of that in our work.
14 THE CHAIRMAN: Right. If I go on to the next page, 010,
15 please. Paragraph 5 talks about learning from
16 complaints. It says four lines down:
17 "Unfortunately, service users feel that they are not
18 informed of the learning gained from making complaints,
19 thus complaints still have negative connotations and
20 complainants subsequently feel that they are seen as
21 troublemakers."
22 I think that's summarising part of the discussion
23 we've already had this morning.
24 If I take this back as an aspect of Raychel's case:
25 when Raychel died, Altnagelvin Trust very quickly -- and

1 without external overview or pressure -- put into place
2 some improvements in their systems. Unfortunately, when
3 the family came to meet the trust, including the trust's
4 senior executive, they really weren't told about that.
5 It added to their negative view of the trust that the
6 trust had made improvements, improvements in fact which
7 included prompting the establishment of the regional
8 working party, but the family didn't know about that and
9 they weren't therefore told that anything had been
10 learnt from Raychel's death. Would that be an example
11 of -- and I should complete that by saying that
12 Mrs Ferguson's sister gave evidence and said that if the
13 family had been told that, it would have provided them
14 with some degree of consolation that something had been
15 learnt and something was being done better. Is that the
16 sort of thing that families should be told but aren't
17 being told by the process as it currently operates?
18 MAEVE HULLY: I think families would very much welcome
19 knowing -- people say two things around complaints. One
20 is "We would like to know what happened" and the other
21 is "We want to make sure it doesn't happen to anybody
22 else" and one of the ways of doing that is by ensuring
23 that there's learning from the complaints. I think
24 families would really welcome understanding what that
25 has meant, both at a local ward level in terms of

1 learning, but right across a trust, and again
2 regionally, how people are learning from complaints and
3 how that learning has been shared.
4 THE CHAIRMAN: Right. Could we go on then to page 011,
5 please? Under heading 7, Ms Hully, the first main
6 paragraph says, about five or six lines down:
7 "There was a strong emphasis that there is
8 a requirement for an independent element within the
9 complaints process. Many service users were unaware
10 that independent laypersons are available and may assist
11 in the resolution of complaints at an early stage."
12 Do I take it that the reference to independent
13 laypersons is not to the Patient and Client Council?
14 MAEVE HULLY: No, I don't think it is.
15 THE CHAIRMAN: Right. Well then, to your knowledge of the
16 complaints system, what is the extent of the
17 availability of independent laypersons in investigating
18 complaints or assisting families with complaints?
19 MAEVE HULLY: I think it's very limited.
20 THE CHAIRMAN: Right. Is it provided by some trusts but not
21 others?
22 MAEVE HULLY: Yes, and I think also -- does it refer to ...
23 People sometimes bring people with them to complaints,
24 for example from voluntary organisations? Does it refer
25 to that also?

1 THE CHAIRMAN: Voluntary organisations like who?
2 MAEVE HULLY: Well, some of the mental health organisations
3 provide advocacy support through complaints.
4 THE CHAIRMAN: Right. We can perhaps develop -- this is
5 an HSCB paper and they will be here on Thursday, so
6 I might develop it with the HSCB and perhaps with the
7 Belfast Trust tomorrow about the role of independent
8 laypeople and complaints to see if we can pin down
9 exactly what that's referring to.
10 One other thing then. This document went on to make
11 some recommendations, and if I could turn to page 016.
12 Recommendation 10 is that:
13 "There should be a regionally agreed method of
14 disseminating learning from complaints, that should be
15 developed by the Health & Social Care Board and by the
16 Public Health Agency. This should include the
17 coordination of an annual regional complaints workshop
18 event and agreed ad hoc or scheduled communications such
19 as newsletters."
20 I'm struck by the idea that this regionally agreed
21 method would not include the PCC. It's to be developed
22 by the Health & Social Care Board and by the Public
23 Health Agency, but this did not seem to envisage a role
24 in its development for the Patient and Client Council,
25 which is expressly stated to be the independent voice of

1 the patient.
2 MAEVE HULLY: Yes. I mean, we would have our own mechanisms
3 by which we would make the trusts aware of our findings
4 with the complaints that we are dealing with.
5 THE CHAIRMAN: And as an appendix to your response to the
6 inquiry, you have sent us your six-monthly report
7 covering the period April to September on the complaints
8 support service.
9 MAEVE HULLY: Yes.
10 THE CHAIRMAN: And in that you have a section "Outcomes and
11 key themes arising from complaints". And you have given
12 examples of actually a case where a complainant's mother
13 or a client's mother had died in hospital following an
14 emergency admission and there was some fault
15 acknowledged and apologies made, which were accepted by
16 the client, and so on. Is there not an obvious prospect
17 for that complaints support service report to form part
18 and parcel of this recommendation 10?
19 MAEVE HULLY: I think it certainly could. I think what
20 recommendation 10 is referring to is the totality of
21 complaints across health and social care, of which
22 we would only see a small part in the Patient and Client
23 Council. So while our institute understandably forms a
24 part of that, I think this is referring to a regional
25 workshop that's looking at all of the complaints right

1 across the system, which amount to about 6,000.
2 THE CHAIRMAN: And the reason why you only see a small
3 proportion is because most complaints are made and have
4 an outcome, which is independent of the Patient and
5 Client Council; is that right?
6 MAEVE HULLY: Yes, we would only reflect the people who have
7 come to us for help and support through the process.
8 THE CHAIRMAN: Right.
9 MAEVE HULLY: So if we haven't been involved in the
10 complaints process, then we wouldn't necessarily know
11 all of the different complaints that are being made.
12 THE CHAIRMAN: So you would be able to speak on the basis of
13 whatever cross-section or proportion of complaints
14 you have been involved in?
15 MAEVE HULLY: That's right.
16 THE CHAIRMAN: But surely your input would be bound to help
17 the board and the PHA?
18 MAEVE HULLY: I think our experience is, even though ours is
19 a snapshot, it's reflective of the whole complaints
20 process anyway, the main themes that we're seeing are
21 mirrored in the totality of the complaints.
22 THE CHAIRMAN: Okay. Has any issue been raised with you
23 about the way in which you're seen as being independent
24 of the trusts and the service providers? Has that ever
25 arisen?

1 MAEVE HULLY: As to whether we are independent or not?
2 THE CHAIRMAN: Yes.
3 MAEVE HULLY: Yes, I think people do, because we're part of
4 the system inasmuch as we're an arm's length body from
5 the Department of Health, people do ask us about our
6 independence. I think our response to that is two
7 things: our independence comes from the voice that we
8 reflect, which is that of the people that we speak to
9 and the evidence that we gather, and I think also the
10 system has set us up to be an honest broker or a
11 critical friend within the system, therefore it has been
12 our experience that the system has listened to what
13 we have to say and made changes in accordance to the
14 information we've been able to give them because it's
15 been based on evidence that we've gathered from people
16 who are using the services.
17 THE CHAIRMAN: Can I ask you one final point? I mentioned
18 to you earlier, in Raychel's death in Altnagelvin, that
19 there was a patient advocate system, which had already
20 been established before Raychel's death, but to say the
21 least it didn't work satisfactorily in her case. Do
22 trusts still have patient advocate systems?
23 MAEVE HULLY: Some of them do. I don't I don't know to what
24 extent they're available and I don't know to what extent
25 people use them.

1 THE CHAIRMAN: Do you have any overview of how effective
2 those systems are for the people who do use them?
3 MAEVE HULLY: Again, we tend to see people in the complaints
4 process who have been frustrated by this system and
5 aren't getting the answers that they want, so we're
6 unlikely to see people for whom the complaints process
7 has been a positive experience.
8 THE CHAIRMAN: Right. But you don't have even anecdotal
9 experience of how well or otherwise the patient advocate
10 system was working?
11 MAEVE HULLY: I think some of them do work quite well;
12 I think others not quite so much.
13 THE CHAIRMAN: Okay. I think there was a query from one of
14 the families about the -- can either of you give an idea
15 of the number or proportion of the complaints which are
16 upheld? Complaints can be upheld to some degree, if not
17 totally. Do you have even a rough estimate? The
18 Roberts are looking for that information.
19 PETER WALSH: Work in England has only just started, funnily
20 enough, to start compiling feedback on whether trusts
21 deem that a complaint has been upheld or not. And it's
22 very early days, it's very, very incomplete.
23 Anecdotally, our experience is that the vast majority of
24 complaints certainly cease at the local resolution
25 stage. That's often assumed as meaning that they've

1 been resolved to everyone's satisfaction when in actual
2 fact sometimes it's just people have lost the energy to
3 go back and challenge, go to further meetings, write
4 more letters and so forth. So it's hard to put a figure
5 on it, chairman, but there are an awful lot of
6 dissatisfied complainants.
7 In England, when we had the system I referred to
8 earlier of independent review by the Healthcare
9 Commission, there were approximately 9,000 applications
10 for an independent review. So in other words, people's
11 complaints hadn't been upheld to their satisfaction and
12 they were seeking independent review. That's a very
13 small proportion of the overall complaints, but it's
14 still very, very significant.
15 THE CHAIRMAN: It's a big number.
16 PETER WALSH: Yes.
17 THE CHAIRMAN: Is there any way in Northern Ireland,
18 Ms Hully, of measuring the outcome of complaints in
19 terms of numbers or proportions or has any thought been
20 given to developing such a system?
21 MAEVE HULLY: We would know for the complainants that we
22 support, that we would help, you know, because that's
23 our role, that there's a high level of satisfaction
24 eventually in the outcomes in the complaint. The trusts
25 would have to speak individually for how many of theirs

1 they upheld or otherwise.
2 THE CHAIRMAN: We can talk about two slightly different
3 things, can't we, whether a complaint has been upheld or
4 whether there is a satisfactory outcome because the
5 satisfactory outcome might be the family understanding
6 that in fact there isn't something to complain about,
7 but they now know why there's not something to complain
8 about, which is different from the complaint being
9 upheld and apology being given.
10 MAEVE HULLY: Absolutely, the terminology is very important.
11 I'm not sure we're always talking about the same things
12 when we talk about them in those terms.
13 THE CHAIRMAN: That must make it very difficult to tick
14 a box, "complaint upheld" or "not upheld"?
15 MAEVE HULLY: Absolutely.
16 THE CHAIRMAN: We've been looking at the role of an
17 independent adviser or helper within the complaints
18 system. Could I ask you, Mr Walsh, about the role or
19 remit of an independent adviser within the serious
20 adverse incident system? Does that happen in England
21 and Wales, is there an independent adviser, counsellor,
22 whatever?
23 PETER WALSH: In England and in Wales, there is, if you
24 like, the equivalent of the Patient and Consumer Council
25 in terms of helping people with their complaints.

1 What isn't always available is a more specialist
2 sort of advice that might be deemed necessary, certainly
3 in the more complex, complicated cases, and the serious
4 adverse incidents. Obviously, my charity sees a number
5 of those, but that's only where either the patient or
6 the family themselves or the advice agency that's
7 helping them has sought our input. And in those cases,
8 very often we're able to add value either by explaining
9 terminology and giving a second opinion, if you like, on
10 some of the answers and explanations that have been
11 given in investigations so far, advising on the terms of
12 reference of the investigations and giving advice on the
13 responses people get, which can be "That looks entirely
14 credible and people have given you a thorough
15 explanation and, for what it's worth, we can't see any
16 other questions or challenges that should be raised",
17 but also quite often we look at these responses and
18 say," Well, that's all well and good up to a point, but
19 people haven't looked at A, B and C, and we need further
20 investigation of these following issues", and can
21 empower people in that process, which is very daunting,
22 even with the help of a generic advocate who understands
23 the complaints procedure and the way the Health Service
24 is operated, but perhaps don't have the medico-legal
25 expertise to bring to bear on it.

1 THE CHAIRMAN: Right. The scope for such an independent
2 adviser, that would not need to be taken up in all
3 cases. Would it be a comparatively small number which
4 needs the specialist input?
5 PETER WALSH: I really think it would be relatively small.
6 NHS complainants carry a very wide spectrum, of course,
7 from general dissatisfaction, parking, cancelled
8 appointments and rude receptionists, which are all
9 important. This kind of more specialist help would only
10 be necessary in cases where harm is suspected to have
11 been caused and there's a more complicated web of
12 clinical and possibly medico-legal issues to untangle.
13 THE CHAIRMAN: And in Northern Ireland, I shouldn't forget,
14 I think, Ms Hully, that your remit -- because it's our
15 health and social care system, whereas in England social
16 care is the responsibility of Local Authorities, here it
17 comes under the same department as health and your
18 Patient and Client Council covers both health and social
19 care.
20 MAEVE HULLY: That's right.
21 THE CHAIRMAN: Which means you have a wider remit than an
22 equivalent body in England in the Health Service might
23 have.
24 MAEVE HULLY: That's correct.
25 THE CHAIRMAN: Okay. I hope I've covered the issues that

1 I was asked to go back over and some additional ones
2 which I wanted to cover from myself.
3 Mr Lavery?
4 MR LAVERY: I do have two matters that I wish to bring to
5 your attention. First of all, Mr Chairman, the Health &
6 Social Care Board have a policy for the management of
7 complaints, and that is to be found in their website.
8 That can be made available later if it hasn't been made
9 available already.
10 Paragraph 11 of that policy states with regard to
11 the role of the Patient and Client Council:
12 "Advice should be made available at all stages of
13 the HSC complaints procedure about the role of the
14 Patient and Client Council in giving individuals advice
15 and support on making complaints. Details of other
16 advocacy or support organisations can also be
17 identified."
18 THE CHAIRMAN: That helps. I think the real issue that I've
19 been exploring this morning, partly on the basis of
20 Ms Hully's own evidence and partly on the basis of the
21 HSCB workshop in May this year, was that in fact the
22 existence of the Patient and Client Council wasn't as
23 widely known as one might have hoped it to be known.
24 MR LAVERY: Yes.
25 THE CHAIRMAN: In some ways you could say it's

1 a comparatively new organisation, having been
2 established in 2009, and I guess, like all new
3 organisations, it took a bit of time to find its feet
4 and to get going. A lesson from this inquiry is how
5 important it is for people who are in great distress
6 about events which have happened and overtaken their
7 families to have every available reference to support
8 and advocacy that is available. If the government has
9 gone to the commendable trouble through legislation to
10 establish a Patient and Client Council, it's fundamental
11 that the existence and the role of the council is made
12 known to everybody who's in these term circumstances.
13 MR LAVERY: Yes. Of course, that's accepted and understood,
14 Mr Chairman. In fact, that leads me to the second issue
15 that I was going to bring to your attention. We have
16 managed to obtain a copy of the leaflet which has been
17 referred to, and that can be made available to the
18 inquiry later. But if I can just say, Mr Chairman --
19 it is under the heading "You have made a complaint.
20 What happens next?" and it says:
21 "Our complaints department staff can provide you
22 with more information."
23 And this leaflet then says:
24 "Alternatively, the Patient and Client Council can
25 provide free and confidential advice, information and

1 help throughout this complaints process."
2 So that leaflet appears directly to refer
3 a complainant to the Patient and Client Council, and
4 that leaflet would be available in the hospital.
5 THE CHAIRMAN: Right.
6 MR LAVERY: It's actually sent out to complainants when they
7 make a complaint. That leaflet is sent out with an
8 acknowledgment letter from the trust.
9 THE CHAIRMAN: When you say "from the trust", I think
10 Ms Hully's point is that, as I have now clarified it
11 since the break, that the leaflets are generally
12 available within hospitals. There's an issue in some
13 hospitals about how easily available and how obviously
14 available they are, and so if what you have described
15 that the Belfast Trust is doing is sending that leaflet
16 out as part of the acknowledgment of a complaint, that's
17 excellent, but I think Ms Hully's experience is that her
18 organisation is trying, in conjunction with the
19 department, to ensure that it is a part of the standard
20 form of acknowledgment of each complaint that the
21 complainant is advised of the existence of the Patient
22 and Client Council. So if the Belfast Trust is up to
23 speed on this or ahead of field in this, I'm more than
24 happy with that, but we know that the events that we are
25 concerned with happened also in Craigavon, Altnagelvin

1 and the Erne, so it's important for some reassurance to
2 people outside Belfast that the existence and role of
3 this important body is known.
4 MR LAVERY: I accept that, Mr Chairman.
5 THE CHAIRMAN: If that's happening in Belfast, I'm well
6 pleased, thank you.
7 Mr Walsh, Ms Hully, thank you very much for coming.
8 There's nothing further that I want to go through with
9 you. If there's anything that either of you want to say
10 before you leave, you're free to do so, but you don't
11 have to add anything if you've covered the ground you
12 want to.
13 MAEVE HULLY: I'm happy enough, thank you.
14 PETER WALSH: If I could say just two brief things,
15 Mr Chairman?
16 THE CHAIRMAN: Please do.
17 PETER WALSH: In answer to your question about the effect of
18 a lack of honesty on the people we help. I think I was
19 a little bit factual or formulaic in my response talking
20 about the implications for litigation and complaints and
21 so forth I neglected to say that in our experience,
22 a lack of openness and honesty adds the most grievous
23 insult to injury that's already been caused to the
24 extent that it has enormous emotional and sometimes
25 psychological effects on the people who haven't received

1 an open and honest answer, which simply could have been
2 avoided had there been openness.
3 The other thing I wanted to say was in relation to
4 independence. We've talked briefly about the need for
5 the complaint not to be investigated by the people who
6 are the subject of the complaint. However, the Stafford
7 inquiry and also the subsequent Clywd/Hart report on
8 complaints in England both found that there was a strong
9 argument, not just for independent advice for the
10 complainant, but also actual independence in the
11 investigation. Certainly, in serious cases, adverse
12 incidents, cases of serious harm and death, the
13 investigation shouldn't be conducted solely by staff of
14 the organisation concerned, but that a completely fresh,
15 independent view should be brought in to oversee an
16 input into those investigations. We think that would
17 add a tremendous amount to the process. Sometimes if
18 you're too close to an incident and a system, even with
19 the best will in the world, it's difficult to see the
20 wood for the trees, and we see that very often with, for
21 example, responses to claims for negligence, where the
22 initial response is denial, but when you get an
23 independent expert report and people reflect upon it,
24 they recognise, "Oh yes, we were seriously at fault
25 about this".

1 So the importance of bringing in people from outside
2 the organisation to the investigations themselves,
3 I think, is the point I want to leave with.
4 THE CHAIRMAN: Could we explore that a bit, Mr Walsh? In
5 Northern Ireland that might mean the Belfast Trust
6 bringing in somebody from another Northern Ireland
7 trust, and there's some degree of independence in that,
8 but is that what you're talking about?
9 PETER WALSH: Well, in a number of parts of the UK
10 already -- and possibly in Northern Ireland for all
11 I know -- that kind of arrangement has been made where,
12 at the very least, you see someone from another
13 organisation. Of course, the challenges in
14 Northern Ireland in terms of everyone being closer
15 together and knowing each other is perhaps bigger than
16 it is in somewhere like England.
17 THE CHAIRMAN: It is a strength and a weakness in the
18 system?
19 PETER WALSH: Yes. So one thing to think about would be
20 even going further afield, so bringing in someone from
21 Scotland, England, Wales to actually take part in an
22 investigation so there's no perception of, leave alone
23 real, conflict of interest involved.
24 THE CHAIRMAN: If I understand that suggestion, that might
25 be reserved for something of particular gravity?

1 PETER WALSH: Yes. I mean, I don't think it would be
2 realistic to expect it for every single complaint. The
3 system would buckle. But in serious complaints and
4 adverse incidents that are the subject of a formal
5 investigation would be a good example, that that would
6 seem good practice. That's what the reviews in England
7 are calling for.
8 THE CHAIRMAN: Yes. Thank you very much indeed.
9 (The witnesses withdrew)
10 TIMETABLING DISCUSSION
11 We'll finish today, but two things. Mr Lavery,
12 I think I see some of your team for tomorrow is here.
13 So I hope you have a feel for how I intend to run
14 tomorrow. There's a different tenor to today than there
15 has been to the hearings over the last many months and
16 I hope that we can have an exchange of views in that
17 way.
18 Mr Walsh and Ms Hully didn't want to do this, but if
19 they had wanted to, they could have made an opening
20 statement. Does the trust have a view about whether it
21 might do that tomorrow or is that still left open?
22 MR LAVERY: There has been an indication that Mr Donaghy did
23 want to make an opening statement, but I will take final
24 instructions -- yes, he does wish to make an opening
25 statement.

1 THE CHAIRMAN: We'll do that. I'm happy to start at 10,
2 10.30, whatever people prefer.
3 MR LAVERY: We're in your hands, Mr Chairman.
4 THE CHAIRMAN: Let's start at 10 o'clock. We may as well
5 get started as let the morning drift on.
6 Mr McMillen, on the department's position on
7 Professor Scally, Professor Scally is still available
8 for Wednesday if required. I'm going to write back to
9 you immediately after lunch and set out, as I did in
10 Conor Mitchell's case in Craigavon, what my response is
11 to your letter because I want to ensure that we're not
12 at cross-purposes. The letter I've received dated
13 today -- which I know is almost exactly the same as one
14 which I had been alerted to by you on Friday -- leaves
15 me with one or two points I want to tidy up with you
16 before I make a decision. But we have to decide,
17 effectively overnight, if Professor Scally is going to
18 travel because, if he is going to travel, he will have
19 to fly tomorrow night to give evidence on Wednesday
20 morning. But we'll see from the exchange of letters if
21 that's necessary.
22 MR McMILLEN: Indeed, Mr Chairman, yes.
23 THE CHAIRMAN: Beyond that, we had to postpone Dr Carson
24 because, unfortunately, as you know, Mr Stewart was
25 involved in the pile-up on the motorway on Friday

1 morning. My inclination is I still want to hear from
2 Dr Carson in this sequence of events about the role of
3 the RQIA. If he was available on Thursday, I could take
4 him with the Health & Social Care Board. It would make
5 Thursday a longer day, but if we don't have to hear from
6 Professor Scally and we only call Dr Carson, we're going
7 to run into another short day and I'm anxious to avoid
8 sitting five short days in which we start and are
9 finished by lunchtime. I'm not sure that is a great use
10 of resources.
11 MR McMILLEN: I will make enquiries as to his availability.
12 I suspect he will be available on Thursday.
13 THE CHAIRMAN: It will be a matter of convenience between
14 Dr Carson and the Health & Social Care Board about who
15 goes first. It doesn't matter to me. Thank you very
16 much, tomorrow at 10 o'clock.
17 (1.17 pm)
18 (The hearing adjourned until 10.00 am the following day)
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