Thursday, 14 November 2013

(10.00 am)

THE CHAIRMAN: Good morning. Mr Compton, just before I ask your panel to start, I want to tidy up three pieces of other business which has been left hanging for the last few days.

The first issue is that I received, from the Directorate of Legal Services, a request from Dr Crean, who was asking permission to make a supplementary statement. It arose because of something I'd said here on 30 October about what Dr Crean had known about Claire's death and what he knew about Lucy's death.

Mr Lavery, this point was made to me in relation to what appears at page 149 of the transcript on 30 October. I just want to say to you that I will correct this in writing. My summary of what Dr Taylor knew isn't challenged, but my summary of what Dr Crean knew has been challenged and, on looking back over the transcripts, his challenge to my rather crude summary is correct and I will acknowledge that formally by issuing a note.

MR LAVERY: That's very much appreciated. Thank you, Mr Chairman.

THE CHAIRMAN: Secondly, there has been an issue I have been considering in the last few weeks in relation to

Claire's medical records. A point arose during the hearings about subsequent alterations to those records. It was accepted that additions had been made to the records and the issue which has concerned the Roberts family is when those additions were made and whether those additions are in fact legitimate, but regrettably untimed and undated additions, or whether there's something more sinister to them.

The inquiry obtained a forensic expert's report on those records, which was then circulated to the parties in September. We've received submissions and, in particular, we have received a submission on behalf of the Roberts family, urging us to seek a further forensic analysis, a different forensic analysis. Mr Ferguson, I do not intend to do that. I understand the concerns of Mr and Mrs Roberts. I understand that there is no complete answer to the issue that they raised in the forensic analysis, which I have received, but I do not think that there is a sufficient basis for going out and seeking another forensic analysis.

MR FERGUSON: Very well, sir.

THE CHAIRMAN: The third point is preparing the way for submissions. I haven't previously asked for submissions in Claire's case because there were some outstanding issues and the recent departmental section, including

this week's evidence, may also be the subject of submissions.

What I'm inviting the parties to do is, if anybody wants to make submissions either in Claire's case or in the departmental section, then those submissions should be with me by 5 December, which is three weeks from today. Okay?

MR UBEROI: Sir, just on the first point, if I might just briefly say this: I have made written submissions and I'm confident that you have my submissions on what Dr Taylor knew and didn't know and when. I don't have before me the exact extract which you're referring to. But if I might place this on record: if it's the extract which I can recall, one of the thoughts that crossed my mind was that while Dr Taylor may have known as a fact that Claire Roberts had died, that's very different to knowing that hyponatraemia was causative of death. So I simply wish to place that on record, but I'll review the extract to which you specifically alluded and, in general, I'm confident you have my submissions on what Dr Taylor knew or didn't know and when.

THE CHAIRMAN: Thank you, Mr Uberoi.

In terms of the final submissions then, there has been an exchange between Dr Haynes, who was an inquiry expert, and Professor Ian Young about some issues

relating to Lucy Crawford. Those will be circulated in the next few days, which will assist anybody who has any outstanding points to make about the aftermath of Lucy's death.

One final issue about submissions is this: you will remember, when we were looking at Claire's death and in particular the whereabouts of Dr Steen, that we went to the High Court to obtain an order allowing us to look at some other medical records which might have shed light on Dr Steen's whereabouts.

Those records are contained in file 150, which was given out on a strictly limited basis to the parties, limited because those records relate to other patients who are not the subject of the inquiry. One of the limitations imposed was that when this part of the hearing about Claire was complete and submissions had been made, those files would be returned. That condition of receipt of the files has to be complied with. So when the submissions or any submissions are returned by 5 December, we expect that all copies of file 150, and the few additional papers which were then added to it, will be returned along with the submissions. And anybody who chooses not to make a submission in Claire's case, but has a copy of file 150 will be expected to return that as well.

Is that clear? Okay. So that deals with those issues.

Mr Compton, thank you for coming with your colleagues today. I think I have received a helpful advance notice of the statement which you intend to make and I think you intend to introduce your own panel.

JOHN COMPTON: Yes.

THE CHAIRMAN: Let me give you the floor then.

Opening statement by MR JOHN COMPTON

JOHN COMPTON: Thank you very much indeed.

Good morning. Thank you for affording the Health & Social Care Board the opportunity to contribute to the additional governance segment of this inquiry. My purpose this morning, and that of my team, is to explain and provide assurance in terms of how systems now operate and have improved within health and social care since the tragic deaths of the children being considered by this inquiry.

Firstly, may I introduce the panel that is with me today. I am John Compton, I'm chief executive of the Health & Social Care Board and I have held the post since the inception of the board in 2009.

To my right is Dr Carolyn Harper, Director of Public Health in the Public Health Agency and she is medical director on the Health & Social Care Board. She provides medical advice to me and to the board of the

health and social care system.

To her right is Mary Hinds. She is director of nursing and allied health professionals in the Public Health Agency and director of nursing on the Health & Social Care Board. She provides nursing advice to me and to the Health & Social Care Board. She's currently on secondment to the Northern Trust as a senior director of a turnaround team.

To my left is Mr Michael Bloomfield. He's acting director of performance and corporate services at the Health & Social Care Board. He's responsible for overseeing the efficient administrative systems within the board.

The composition of the panel reflects the close working relationships between Health & Social Care Board and Public Health Agency, and in particular, in relation to matters concerning safety and quality of services. My colleagues and I will seek to respond to any questions or points that require clarification during the proceedings this morning.

It may be helpful for me to provide some context to the inquiry in relation to the roles and responsibilities of the Health & Social Care Board and how it works collaboratively with the Public Health Agency and Health and Social Care Trusts to provide

safe, high-quality services.

The Health & Social Care Board was established in April 2009. It replaced the four previous local area Health and Social Services boards. The Public Health Agency was also established in April 2009. The responsibilities of the previous four local area health and social care boards are transferred to the regional Health & Social Care Board and the Public Health Agency.

The Health & Social Care Board has a range of functions that can be best summarised under three broad headings: commissioning or securing the provision of health and social care services for the needs of the local population, including monitoring the delivery of these services to ensure health and social care needs meet establish safety and quality standards; secondly, to performance manage and service improve how health and social care is delivered to ensure that organisations meet the relevant health and social care objectives, targets and standards, including those set by the minister; and finally, in terms of resource management, to ensure that the best possible use of resources of the health and social care system, both in terms of quality, access and value for money to the taxpayer.

Underpinning all of these functions is our statutory duty of the quality in respect of the services we

commission. We discharge that duty through a range of processes to ensure that services commissioned and those delivered within the available resources meet established safety and quality standards. Our colleagues in the Public Health Agency work closely with the Health & Social Care Board by providing professional input into the commissioning process. In regards of social care, the director of social care, an employee of the board, provides expertise in this arena, as does the director of integrated care, who ensures the delivery of general practice services in Northern Ireland.

As arm's length bodies, the Health & Social Care Board and the Public Health Agency are directly accountable to the department in terms of the commissioning of health and social care services which are provided by the Health and Social Care trusts. In this regard, there is a close working relationship with the Department of Health and the department's colleagues.

Trusts are accountable to the Health & Social Care Board for the delivery of services and the delivery of these against relevant objectives, targets and standards. However, outside the three key areas I have described, where accountability is to the Health and Social Care Board, they are directly accountable to the

department for all aspects of organisational governance and assurances. The HSCB works with the trusts in an open way, where information is shared to provide and promote a supportive approach to resolve issues as and when they may arise.

The Health & Social Care Board is made of five executive directors and eight non-executive directors. Four other directors from the senior management team attend the board meetings and board committees. The Patient Client Council is also in attendance at our monthly board meetings. The board has a number of committees, including a governance committee that seeks assurance on all aspects of organisational governance, including on the safety and quality of services commissioned by the board. This is chaired by a non-executive director.

Since the establishment of the Health & Social Care Board and the Public Health Agency in April 2009 and the significant reorganisation that has occurred since the tragic deaths of the children that this inquiry is considering, there is now a much more consistent, straightforward approach to the management of safety and quality issues, in particular when adverse incidents occurred.

The Health & Social Care Board is the focal point

for that serious adverse incident process. In this regard, there are a range of reports received by the Health & Social Care Board, which enable it to have an overview of the safety and quality of the health and social care services. These include the procedure for reporting serious adverse incidents, the receipt of early alerts, information regarding the patient experience and details of all health and social care complaints.

Robust procedures exist to receive and process this information in order that any appropriate immediate action can be taken and that any regional learning identified is shared across the region to improve the delivery of services. In addition to this, there's, of course, day-to-day professional-to-professional and service manager to commissioner arrangements and routine lines of communication.

Notably, as a further measure of safety of hospital services, the Health & Social Care Board has published hospital standardised mortality rates for the past three years, benchmarked against rates within trusts in England and independently produced and reviewed by an organisation commissioned to undertake this work, CHKS. This analysis indicates the death rates in all trusts in Northern Ireland are within or better than expected

levels. In addition, a wide range of other performance indicators in relation to the safety and quality of services are regularly reported to the board at its monthly meeting. This would include waiting times for cancer services, fracture services, healthcare-acquired infections and hospital waiting times.

In relation to complaints, under the revised 2009 complaints procedure, the Health & Social Care Board became responsible for having an oversight of all health and social care complaints, including monitoring complaints processes, outcomes and service improvements. The board receives information relating to approximately 6,000 complaints each year from all trusts and family practitioner services.

The number of complaints has risen from 4,733 in 2009/10, to 5,998 in 2012/13. We are aware that, taken together, the categories of staff, attitude and communication represent the greatest number of complaints, some 1,700, and that is above complaints about care and treatment at 1,562.

We have, at the request of the department, undertaken an evaluation of the effectiveness of complaints across health and social care and produced a report with 14 recommendations aimed at improving effectiveness of the procedure. One of these

recommendations is seeking to address the high number of complaints received regarding staff attitude and communication by promoting positive attitudes.

We are also aware from engaging with service users that there's still much work to be undertaken in relation to addressing the reluctance of some service users to complain and raising the awareness of how to make a complaint.

The board is currently working with health and social care organisations such as the Patient and Client Council and the department in terms of promoting the awareness of the procedure and taking forward the recommendations of the evaluation report.

From 2012, 17 independent lay advisers have been appointed by the Health & Social Care Board to assist in the resolution of complaints. These laypersons come from various professional backgrounds, for example former healthcare professionals, former police officers, prison officers, schoolteachers and civil servants.

Their role is not intended to act at conciliators or investigators; their involvement is to help bring about a resolution of a complaint by reviewing the investigation undertaken, providing assurances that action taken by the health and social care body was appropriate or making suggestions as to further steps

that could be taken by the organisation to resolve the complaint.

The layperson's role is about bringing independence, impartiality and trust to a situation where relationships may have been damaged. They are invaluable in communicating to the service users the outcome of investigations in language that is easily understandable. Laypersons have been involved in the resolution of 14 complaints regarding family practitioner services to date and have been involved with three trusts on a number of occasions in complaints resolutions. One of these has involved complex cases crossing both trusts and family practitioner services, where a layperson has coordinated the investigation being undertaken by the health and social care organisations to enable the complainant to have one point of contact in that process.

Other examples include the involvement and resolution of a number of complaints where the death of a loved one has occurred. Their role includes meeting both parties, reviewing complaints, documentation and providing suggestions and recommendations to effect potential resolution.

Recently, the Health & Social Care Board and the Public Health Agency have established an overarching

quality and safety experience group, which consider learning identified through arrangements for serious adverse incidents, complaints, patient experience and medicine safety, and determine the most appropriate way to put that learning into practice, monitor progress and seek assurance that practice has changed.

In particular, today I wish to highlight and focus on the arrangements that are now in place to handle incidents that fit the criteria of the serious adverse incident. There is now a well understood and consistent approach to the reporting and handling of serious adverse incidents. There is one point of reporting serious adverse incidents and that is to the Health & Social Care Board. The HSCB became responsible for the management and follow-up of serious adverse incidents in May 2010. The board works tirelessly to promote an open culture of reporting adverse incidents and is continually reviewing and improving that process.

It has recently in October 2013 produced a revised enhanced process for reporting serious adverse incidents, which I will refer to later. We encourage organisations to report incidents and work on the basis of "If in doubt, report". If in time the incident turns out not to be as significant as first thought or on further examination of the details of the reporting

organisation, it does not fit the criteria of the serious adverse incident, it can be de-escalated. The reporting of serious adverse incidents is increasing year-on-year, which is to be welcomed, and we meet with each trust individually to review the trust's reporting activity.

In total, 966 serious adverse incidents have been reported to the board since 1 May 2010. In the most recent year of 2012/2013, 320 serious adverse incidents were reported to the board. This represents an increase from the previous year when 262 were reported. Increasing our numbers is important because it indicates our greater appreciation of the whole SAI process.

The Health & Social Care Board consider these adverse incidents at the highest level. Every week, the senior management team, which I chair, reviews the serious adverse incidents that have been reported in the previous week. This ensures that the organisation knows at the most senior level what has been reported and provides extra assurance to the process, which I will outline for you.

The governance committee of the board receives reports on serious adverse incidents at each of its meetings. It is a standing item on the agenda. The full board itself receives a six-monthly report on

serious adverse incidents that have been reported, which includes the detail of learning that has been identified and shared with the wider health and social care system. These reports, as with all board papers, are in the public domain and placed on the board's website.

It may be helpful for the inquiry if I outline briefly the process that is in place to deal with each serious adverse incident. When a serious adverse incident is reported to the Health & Social Care Board, the reporting organisation is required to do so within specified timescales. That is within 24 hours of a death or within 72 hours of the incident occurring or of the organisation becoming aware of the incident occurring.

Professional officers known as designated review officers from the Health & Social Care Board and the Public Health Agency provide an initial assessment of the seriousness of the adverse incident when reported. These officers have a professional or an administrative background which is commensurate with the nature of the serious adverse incident and they will have the ability to engage with clinical or professional staff in discussion and the ability to challenge where necessary.

They have the experience of dealing with previous complex serious adverse incidents, complaints and

difficult family situations. They assess whether all immediate and required actions have been taken by the reporting organisation. They form an initial view on the level of the investigation being undertaken by that organisation.

For the more complex serious adverse incident, the DRO, as we will refer to them, is required to approve the membership of the team established by the reporting organisation to investigate the incident and to ensure, for example, adequate independence, where appropriate, and to agree the terms of reference of that team. There are specific timescales for reporting back to the board when an investigation is complete. This varies from four to 12 weeks and is dependent upon the level and complexity of the investigation needing to be undertaken.

The core role of the DRO is to ensure the robustness of the process. They will review the investigation, report and provide a challenge to the reporting organisation in terms of the adequacy of the investigation carried out. They will also review recommendations that have been made by the investigating organisation and identify potential learning from the process, which may be considered for wider dissemination across the total health and social care system.

Mindful of discussions earlier this week in relation to access by families to the DRO, while it is not common practice or part of the protocol, on occasion the DRO may meet with families if this is felt to be appropriate. In circumstances where the DRO is not satisfied with the approach of the trust, they can escalate to a director and ultimately to the chief executive of the Health & Social Care Board to ensure proper resolution.

Learning identified by the serious adverse incidents is considered by the serious adverse incident review group, chaired by the director of nursing and allied health professionals, at which the most appropriate and effective method of disseminating the learning is agreed. This may involve the issuing of a learning letter, examples of which are the importance of taking appropriate follow-up action on X-ray reports and the management of massive blood loss. It may be thematic reviews, examples of which may include a review of complaints and serious adverse incidents involving older persons, and a review of suicides undertaken, which we can expand upon if it would be helpful.

The learning may involve enhanced training, arranging regional workshops or bespoke pieces of work taken forward, for example, by the safety forum on

issues such as the standard use of early warning systems, assessing and tracing patients at risk of developing blood clots in their legs or the prevention of falls in nursing homes.

There's also an effective mechanism for following up and ensuring that actions contained in learning letters have been implemented. Organisations provide assurance to the multidisciplinary Health & Social Care Board/Public Health Agency safety quality alerts team, chaired by the medical director, to ensure that the requirements within the learning letter have been implemented and the action required has been taken. The safety group follows up with trusts until it receives satisfactory assurance, which has been signed off by the trust's chief executive.

Three years ago, the board took over responsibility for the SAI process. We decided it was time to carry out a review of how it was working and to identify ways in which it could be further strengthened. This led to a number of changes, for example in the reporting of suicides. With respect to this inquiry, it is worthwhile noting that the review recommended the inclusion of an additional criterion that all deaths of a child in receipt of health and social care services, including hospital and community services, will now be

required to be reported as a serious adverse incident.

This provides absolute clarity in terms of the reporting of a child death involved in health and social care up to the age of 18. The rationale for this was to make the reporting routine and to enhance the culture of learning and review. Obviously, this will increase the number of serious adverse incidents being reported as it will include the deaths of children where death was expected, for example a child with a life limiting or terminal illness.

Since the inclusion of the new criteria, eight child deaths have been reported to board as a serious adverse incident, seven of which relate to the new criteria. This compares with three child deaths reported in the same month, that is the month of October, in the previous year before the new criterion was included.

In addition, my colleagues, Mr Bloomfield and Mrs Hinds, have met with trusts to review their perspective in the SAI process. There is regular liaison between the Health & Social Care Board, the Public Health Agency and other key providers. We meet quarterly with the regulatory and quality, RQIA, organisation, with the Northern Ireland Postgraduate Medical and Dental Training Agency and similar meetings take place with the nursing training body.

In addition, we have recently written to the coroner to formally request that all coroner's reports that may have learning for health and social care will be sent to us routinely so we can review those and take any necessary action, as appropriate.

I very much hope that what I'm describing communicates to you and the public can gain assurance from the arrangements that are now in place that serious incidents are identified quickly and lessons learned are shared across the system to reduce the likelihood of similar incidents recurring.

I can assure you that all serious incidents reported to the board are considered at the highest level. I mentioned earlier the weekly process reviewing these at the senior management team meetings. This allows us to ensure that all directors are aware of the incidents and that we are sure these incidents are being handled and followed up by the appropriate professionals.

Providing health and social care is inherently complex and carries the risk of harm, and sadly adverse incidents involving patient safety will always emerge, particularly in the context of the thousands of patients being treated every day. For example, 4,000 patients in acute hospitals on any day of the week, over 300,000 patients admitted during the course of the year, 30,000

paediatric admissions in any given year and about 700,000 attendances at emergency departments.

The fact that we are seeing an increase in incidents emerge is positive as it reflects, I think, an increasingly open environment where staff feel supported in reporting to enable learning rather than blame. It is a journey that we have made in which we have made progress and it is a process of continuous improvement. I wish to assure the inquiry that this is treated with the highest priority by the Health & Social Care Board and our colleagues in the Public Health Agency.

As a system, when it goes wrong, it can have enormous and devastating repercussions on individuals and on families, which stay with them for the rest of their lives. This inquiry is a statement of that fact. What we are about is trying to ensure that this doesn't happen in the first place or that, at the very least, the risk of something being repeated is significantly reduced. We fully recognise the need to restore and maintain the public's confidence in the way in which we handle these complex matters.

We work closely with various external professional and expert bodies in an attempt to continually compare, review and enhance our services. For example, from the UK perspective, with the Health Foundation or

internationally with the Institute for Health Improvement.

Managing risk in health and social care requires clarity. Total perfection in the delivery of health and social care is not attainable. What is attainable is the relentless review and improvement in procedures and processes to continually strive to deliver as high a quality service as we possibly can.

Thank you, chairman. We as a panel, of course, are happy to provide further clarification on my introduction.

MR JOHN COMPTON
DR CAROLYN HARPER
MRS MARY HINDS
MR MICHAEL BLOOMFIELD

Questions from THE CHAIRMAN

THE CHAIRMAN: Thank you very much, Mr Compton.

Let me take up some issues with you in the context that the information which I've received from you, from your team, from the Belfast Trust, from the Patient and Client Council and from the department all indicates to me that the procedures which are now in place are substantially better than procedures which existed at the time when the events which concern the inquiry took place, which is roughly 1995 to 2002/2003. Okay?

JOHN COMPTON: Yes.

THE CHAIRMAN: What the families have repeatedly said is that they understand that mistakes will be made because doctors and nurses are as human as everybody else is, but what they need in order to gather some consolation from their miserable experiences is some evidence that the new procedures actually work in practice and that the procedures are therefore put in place and followed in a way which makes them less dependent on having a response which is offhand. Never mind somebody who's trying to cover something up, it's the offhand, glib response or failure to take on board what a concern is which is one of the central issues for the inquiry.

Can I start with the complaints system? I heard quite a bit of evidence about this on Monday and Tuesday. On Monday from Mr Walsh of Action Against Medical Accidents and Ms Hully of the Patient and Client Council, and then on Tuesday from the Belfast Trust team. Could I start with the Belfast Trust policy, which was introduced in 2010 and which is currently under review? We can bring it up on screen, I think, in front of you at 332-014-016.

I won't take you to it, but page 1 of this sequence says that this is the Belfast Trust policy in place from

2010, it's got a review date of this year, so it is currently being reviewed.

The one concern I want to raise about it is the way in which, on the face of this policy, the involvement of the complainant or the family is very limited. If you see, the purpose of the investigation is to ascertain what happened and improve services, and then to gain resolution for the complainant.

If you go to the fifth paragraph, which starts:

"Once the investigation is complete, the investigator should prepare a draft response. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement. It should then be ratified by the complaints director or nominated person before being forwarded to the complaints department for formatting and forwarding to the director for final signature."

The policy, on its face, is silent about involvement of the family beyond the family having made the complaint. I understand from the evidence that I heard on Monday and Tuesday that in fact the practice has overtaken the policy in some cases anyway in the Belfast Trust in that there is or there can be more involvement of the complainant, there can be discussions backwards and forwards with the complainant as the

investigation or resolution moves forward. I'm picking on this, but this is a Belfast Trust policy which is also in keeping with the departmental line as I understand it.

JOHN COMPTON: Yes.

THE CHAIRMAN: Since this is under review at the moment, wouldn't it be better if there was something written into the policy to reflect that, at least in some complaints, there should be active engagement with the family or the complainant before the complaint is resolved?

JOHN COMPTON: I think as a matter of principle it should always be that there's active involvement with the family. I don't believe that the successful resolution of a complaint which excludes a family can come to really a successful conclusion. My understanding -- and I will ask my colleague to make some comments in a moment -- is that in practice there is contact with families during the complaints resolution process, and it may be much more helpful to be more explicit about that in terms of how policies are produced and presented.

THE CHAIRMAN: If that's what happens, that's fine, and if the practice has improved since the policy was put in place, then that's actually quite encouraging because it

shows that people aren't just sticking to the letter of the policy, and that works. But since the policy is under review, then I think it would seem appropriate for the better practice to be reflected in an improved policy.

JOHN COMPTON: I would agree. Perhaps my colleague would just ...

MICHAEL BLOOMFIELD: Mr Chairman, I'd certainly agree that if the practice is the greater involvement of complainants, that's certainly to be welcomed, and we believe that is the case. The department's policy does, however -- the 2009 complaints policy issued by the department on which all organisations then develop their own local policies and procedures to be consistent with that, it does make clear within it that the complainant should be involved from the outset and that they should assess what action might best resolve the complaint and at each stage keep the complainant informed. That is clearly the expectation, it's within the department's policy and I think if the Belfast Trust is currently reviewing their own procedure, that should more directly reflect that.

THE CHAIRMAN: Yes, because what I wouldn't want is that in some complaints somebody who's handling the complaint goes by the letter of this document on screen and then

says, "Well, I followed the policy. What are you complaining about now?"

JOHN COMPTON: I think there are two points I would make. I'd agree with you that you don't want to have any lack of clarity for the individual involved, but I think it's also very important that we communicate very openly and transparently to those who are making the complaint that they are centrally involved in terms of the resolution of that complaint. I think the two sides of the coin are very important here.

THE CHAIRMAN: Can I ask you then, at page 5 of the paper that you've just read, you refer just over halfway down to the fact that:

"Seventeen independent laypeople have been appointed by the Health & Social Care Board to assist in the resolution of complaints."

That's a fairly recent development, so you might not be able to say how that has helped or advanced the resolution of complaints, but do you have any early examples or even anecdotal examples of how that has helped?

JOHN COMPTON: I'm confident that it has helped. Again, I would maybe ask Mr Bloomfield.

MICHAEL BLOOMFIELD: Yes, it is indeed, Mr Chairman, a relatively recent development. Those 17 independent

laypersons were appointed in 2012. The majority of occasions on which they have been used to date have been involved in complaints involving GP practices, but there have, as the chief executive outlined in his opening remarks, been four occasions when they have been working with trusts, including a particularly complex one with two trusts and a GP practice involved.

The early indication and the feedback that we receive, and we do -- the complaints staff in the board meet with the independent laypeople. The feedback that we get both from them and from the organisations that have used them is that it is a very positive intervention and they are improving relationships and confidence between both parties and helping with a local resolution, which is the focus of the complaints procedure.

THE CHAIRMAN: How are they trained to fulfil this role?

MICHAEL BLOOMFIELD: There was training organised after the 17 individuals were appointed, training was provided for them back in 2012.

THE CHAIRMAN: I don't need all the details, but as a sort of rough summary what did that training involve?

MICHAEL BLOOMFIELD: It was primarily making sure they were very familiar with the complaints procedure and the role that they have within it, which is not about carrying

out an investigation, but it is about improving confidence and communication between both parties, and it's largely around the skills to do that.

THE CHAIRMAN: Yes. One of the issues which was mentioned by Mr Walsh of Action Against Medical Accidents on Monday is that his organisation is sometimes called in, mostly in England, to assist in training and to assist from time to time with complaints by, for instance, taking an overview about how a complaint has been handled and whether the suggested outcome or resolution of the complaint is appropriate. What his organisation can bring to that is their experience of advocacy from their perspective, but also their experiences of helping people who have been on the wrong end of the Health Service, who have suffered in either patient care or the way that a complaint has been handled before.

I've been wondering over the last few days whether there isn't room in the system, if they're willing to do it and if they feel able to do it, for people like Mr and Mrs Ferguson or Mr and Mrs Roberts, or other people who have had similarly unhappy experiences with our health system, to be asked to contribute to things like training in order so that people who are going to handle these incidents have a closer understanding of how things can go terribly wrong.

JOHN COMPTON: We would be more than happy to work in that regard and I would point out a couple of examples where we have done so. Recently we had quite a significant seminar on emergency departments. People will well understand the pressure that emergency departments are under. We had staff from every emergency department in Northern Ireland together and we had a family came to talk about their experience and they described very straightforwardly how they had been to an emergency department on two occasions. On the first occasion, they had a fantastic experience and they described what made it fantastic. On the second occasion they went, they had what they would describe -- and I think what could be described -- as a fairly awful experience and they explained why it was awful. They had the opportunity to talk in that very open environment with the staff and have a -- there was interplay between them and the staff about what would make it better, what were the sorts of issues that we needed to think about and reflect on and learn from the personal experience. So I think we would be very keen to promote that and have promoted it and to do it more systematically, I think, would be important.

THE CHAIRMAN: Mr Compton, when you talk about the staff there, the staff who this family were talking to, were

they nurses and doctors?

JOHN COMPTON: Yes, there was a range of senior clinicians who were running the emergency department, senior nursing personnel and senior on-the-ground management staff. The people who would be in the emergency department on a day and daily basis in terms of the running of that department.

THE CHAIRMAN: As lawyers we typically underestimate the stress that people feel coming into court because we're in court all the time and we don't recognise the stress that people have coming into our environment and I suspect the same must happen on a fairly regular basis with people who come in to -- that the nurses and doctors who are treating them may not always be sufficiently alert to how stressful the very fact that somebody is there is for that person.

JOHN COMPTON: I would agree that that is a factor. For each individual it's a very personal experience and can be a very challenging experience if things are complicated and difficult for a member of their family. The Patient and Client Council were involved in that particular arrangement and helped facilitate, if you like, the family who came to talk to staff.

In other areas, particularly in the social care area and areas of mental health and older people, we probably

have a more regular and ingrained advocacy role, using people to speak to our staff, and at times some organisations will actually employ -- and we have examples of people being employed in organisations in terms of, for example, mental health where former patients are employed in an advocacy role to help the staff cover the very point you make.

THE CHAIRMAN: Okay.

MICHAEL BLOOMFIELD: Mr Chairman, perhaps if I could just add to the point you made and the particular suggestion that you had? Mr Compton outlined in his opening statement the evaluation of the complaints procedure that was undertaken and we established through that that there are a number of individuals and patients who perhaps have an unsatisfactory experience, but decide not to make a complaint, or indeed those who do make a complaint, but are not happy with how that process has been managed. So one of the recommendations coming out of the evaluation from the complaints procedure is to develop a mechanism to receive user satisfaction feedback, and I certainly think any ways in which we could strengthen that process and get direct feedback from those who have been involved would be very helpful.

THE CHAIRMAN: Yes. I'm not here to sort of push that it is necessarily Mr and Mrs Ferguson or necessarily Mr and

Mrs Roberts, but people who have been through those pretty awful experiences can give your staff a valuable insight into how easy it is for things to go wrong --

JOHN COMPTON: Yes, absolutely.

THE CHAIRMAN: -- and how, once they go wrong, it seems terribly difficult to turn them round again.

JOHN COMPTON: Yes, absolutely.

THE CHAIRMAN: Unless there's any follow-up point on complaints, let me move on to serious adverse incidents.

Could I bring up on screen, please, 331-010-013? This is the new definition of an adverse incident, which was introduced last month, in October, with the change being that, at 4.2.2, it involves any death of a child in hospital and elsewhere.

JOHN COMPTON: Yes.

THE CHAIRMAN: The effect of that is that in the context of this inquiry, the deaths of all the children, but particularly the deaths of Lucy and Claire, which were not the subject -- sorry, Claire's case was certainly not the subject of any investigation -- could not be dismissed in the way that they were in 1996 because the death of a child in the Royal Belfast Hospital for Sick Children would now become, by definition, an adverse incident, which would fall to be investigated.

JOHN COMPTON: Yes.

THE CHAIRMAN: Okay. Mr Donaghy, when he was here on Tuesday, suggested that there might already be some issue about the breadth of that definition and how to necessarily apply it to every child who was dying, including children who were dying because nature took its inevitable course and I think he was suggesting that there had already some preliminary discussions about whether that definition is ... While he understood the spirit of it, whether it may in fact be too broad.

Is that correct?

JOHN COMPTON: There's an ongoing debate, yes. I think it's important to say that this emerged in discussion and consultation with ourselves and with the medical directors across the whole of Northern Ireland. So it wasn't, if you like, imposed centrally or from a top-down sort of arena. I think we were all aware of the fact that it would naturally include the reporting of children for whom, as you've indicated, nature would take its course in terms of the particular conditions that they might suffer from.

On the other hand, I think we felt it was best to do this and then, after a 12-month period, review where we were, look at how this is all working, and of course if there needs to be change, there will be change. For example, in the same review we have changed how we

handle adult suicide. It used to be that anyone who had contact with the health and social care system, who died within two years as a result of an active suicide or self-harm, was reported as an SAI. The evidence and review of that shows that in fact 12 months would be a much more appropriate timetable to have in that regard, and so the adverse incident criteria has been reviewed to reflect that. So we will continue to look at it, but it seemed to us a sensible step to take and we'll see what the learning throws up during the course of the first 12 months.

Again, I would indicate that it doesn't -- we have a grading criteria in terms of how the adverse incident is looked at, so in a situation where there was an inevitability about the death, then we would expect that to be looked at at the lower end of serious adverse incident through to its most extreme version.

THE CHAIRMAN: And in effect, something which is an adverse incident can, after an initial review, cease to be an adverse incident?

JOHN COMPTON: Absolutely.

THE CHAIRMAN: In effect, it's not just downgraded in terms of level, but it is filtered out of the system, isn't it?

JOHN COMPTON: Completely. That is correct. And we also

want to be clear that in terms of looking at the whole adverse incident, that it may not be to do with the clinical condition per se, it may also be to do with the learning that was developed in the events. That might be something that would be broader and would be helpful in terms of communicating that information on a broader front.

THE CHAIRMAN: So that, just to tease that out, it would mean that the fact that a child had died of leukaemia that doesn't mean that there isn't something to learn, if there was an incident or some unfortunate episode about the way in which the parents are spoken to --

JOHN COMPTON: Yes.

THE CHAIRMAN: -- or whether it's the way the last few days or hours were handled?

JOHN COMPTON: Absolutely.

THE CHAIRMAN: So on that approach, subject to whatever emerges over the first 12 months of this working, it would seem, at least at my remove, to be appropriate to continue to include it and just to filter out, at a fairly quick speed, the cases which are do not actually need any investigation?

JOHN COMPTON: That's our intention.

THE CHAIRMAN: Okay. In terms of picking up on lessons to be learnt, part of the experience of this inquiry

is that the first two deaths occurred within the Royal of children who had only been treated in the Royal. The third death was of a girl in Fermanagh who ultimately died in the Royal, but in effect by the time she was transferred from the Erne to the Royal, there was no hope for her. And then in 2001, when Raychel's important treatment took place in Altnagelvin, and again by the time she came to the Royal it was too late for the doctors there to be able to help her.

As I understand it from the Belfast Trust, apart from investigating the serious adverse incidents with the input or overseeing role of the designated review officer, they will internally, within the Royal or within the Belfast Trust, analyse those events and therefore should be alert to whether there are trends or patterns which need to be picked up on. So if there's something that's gone wrong maybe twice or maybe three times in the Belfast Trust, they can pick up on that.

JOHN COMPTON: Yes.

THE CHAIRMAN: Does the fact that all the incidents come in to you enable the board to pick up on if there's an incident in, say, Belfast and then there's an incident in Altnagelvin, to tie the threads together from those? And if there is, what is that mechanism?

JOHN COMPTON: I believe we're much better placed to do so

because it's coming into, if you like, one organisational position and we're reviewing all of those incidents as they come through. We would expect to look at the conclusions that will come in terms of the nature of the serious adverse incident, and again, because of the close involvement we have with professionals in public health and nursing, that that would give us the opportunity to, if you like, join the dots, as it were, in terms of making sure that an event that happened in Belfast, which had a material implication for the totality of the service, was communicated to the totality of the service or vice versa, or that if two events occurred that looked as if they had key learning for each of the things that we would do that. Hence the issue of letters, hence the learning forum that I referred to in terms of the issues where we would bring people together to say, "We're observing an issue here, we want to talk about this issue and what the implications would be for us and how best -- is there a material common feature here or is there not a material common feature here?"

And I think when you have it all in one place, you're much more able to see that as far as all that is concerned.

THE CHAIRMAN: In the context of this inquiry, even if I set

aside Adam's and Claire's deaths, Lucy's in 2000 certainly raised questions, even on its own, which might have been picked up in time to have an effect on how Raychel was treated in 2001.

JOHN COMPTON: Yes.

THE CHAIRMAN: So something can be thrown up by a single incident, which has broader learning?

MARY HINDS: Can I perhaps add? I chair the regional serious adverse incident review group and at that group, all SAIs are reviewed for regional learning, and you're absolutely right, we have incidents where the DRO is clear that there is regional learning from one episode where harm has been caused to a patient and I give you an example --

THE CHAIRMAN: Please.

MARY HINDS: -- of the chest drain insertion, where a trust highlighted an SAI to us and actually was so concerned about the SAI in terms of their understanding and that it had potential regional learning that they actually came to see Michael and myself to highlight their concerns. The learning from that was discussed at the regional group. Part of what we're trying to do is to turn this from not only being a reporting system, but into a responding system, a system that responds to the incidents that we see and the incidents that we hear to

make it better for the next patient that comes along.

So what we did in that case is, on the basis that people learn better if they work out the problem together and come up with a solution together, there is a regional policy collaborative that's a group of practitioners from throughout Northern Ireland came together to agree a regional policy for chest drains. We have a uniquely, I think now, regional, consistent training, led by a trust and resources given to that training to ensure that there's a consistency of approach across the whole organisations. Progress reports are received from the trust and Dr Harper shared a learning letter highlighting the issue of insertion of chest drains to all trusts.

Carolyn, I don't know if you want to add about the assurance mechanism.

DR CAROLYN HARPER: The safety alerts team that was referred to in the opening comment is the group that oversees implementation of actions required within learning letters, for example, or letters issued from the department requiring certain actions to be taken. The RQIA reports and their inspection reports are also overseen by that group as well as the reports from some of the national confidential inquiries that are published and the recommendations around safety and

quality and improvements within those.

So that group will seek explicit assurance from trusts where we think that the issue is of such material concern that we need to have that assurance back. So we may ask, for example -- and just to give you some examples. SAIs relating to incorrect activation of policies and protocols around responding to massive blood loss, a patient losing large amounts of blood. That came through as an SAI. A learning letter was issued and we sought confirmation from trusts that they would ensure that all staff who work in areas where that is a possibility undergo annual test drilling of that protocol to actually test the protocol in practice. That's one example.

Others -- for example in relation to follow-up of chest X-ray reports and SAIs that related to those, and again incomplete follow-through of abnormal chest X-ray results. We sought and received assurance from the trusts that they now have audits of practice, both by the reporting radiologist and audits of the quality of their reports as well as audits of the action taken by junior doctors when they review the results of chest X-ray results that they see.

Those are some examples. There are many. We issue around one learning letter a month. But as I mentioned,

there are other reports as well: the RQIA reports, national confidential inquiry reports. There's quite a volume of activity that we now process through that team.

THE CHAIRMAN: Does that become part of the problem? Because if people are snowed under with alerts and advices and reports, there's actually the risk of something being missed among everything because so many of the people who have to keep up-to-date on this are already pressed enough on the wards, treating the patients as they come in and out. Is it part of the challenge that you have, which is to produce all this in a sufficiently defined but also coherent form that it is put into practice?

DR CAROLYN HARPER: Yes, and we're very mindful of that and in our continued liaison with the trusts they have flagged that to us. In response to that we are very judicious in our use of the learning letters. We write them in a style that makes it as applicable and understandable as possible to the front-line practitioner, but also to the service managers and those responsible for organising the services and supporting staff in doing the right thing. So we're mindful of that because, you're right, you can lose the wood for the trees within all of it. So we take a measured

approach to that and are as explicit as possible and are careful in terms of how we ask for the assurance back and that we ask it in a way that trusts can give that assurance. I think they have certainly found the protocol that we introduced since April 2012 a more coherent and coordinated and structured and helpful approach.

THE CHAIRMAN: The reason that we are alert to this at the inquiry is that one very important and very positive action which was taken by Altnagelvin Trust and Dr Campbell, as CMO, after Raychel's death was to establish a working party on hyponatraemia, which produced guidelines, which were then issued in 2002. There's then a gap about how that was followed up because they were due to be implemented and each trust was then supposed to monitor how they were implemented.

It looks, at least on the basis of one case, Conor Mitchell's case in Craigavon, that the guidelines weren't actually implemented at all there or were barely implemented. And when Dr McAloon then wrote out to follow-up how the guidelines had been followed up, in some cases it took six or seven months for a reply to come through at all. Have you tightened up on that in terms of requiring implementation?

DR CAROLYN HARPER: Yes, and through that safety quality

alerts team we meet fortnightly. We have a schedule of reviews to make sure that anything that we have issued or assurances sought are completed and closed out, and we won't close an alert unless we have received sufficient assurance from the trust that the required actions have been implemented.

THE CHAIRMAN: Okay. In terms of the involvement or the knowledge of a family about what is going on in the investigation of a serious adverse incident, if I take Raychel's case. Raychel died as a result of treatment in Altnagelvin in 2001. Altnagelvin did a lot of good work internally immediately and reported Raychel's death to the CMO, which led to the working party. The trouble was that Raychel's family weren't told that. And they have made the point to me, which I accept, that at least if they'd been told what was happening as a result of Raychel's death, it would have given them some consolation at that time that action was being taken and mistakes had been realised and so on.

We discussed a few minutes ago the involvement of the family or representatives of a family in the complaints process. How are families involved in any way in the investigation of a serious adverse incident?

DR CAROLYN HARPER: The trust certainly would explain the process to the family in the first instance, explain

what the process is, what it involves. The protocol, the policy around investigation of SAIs includes a section on involvement of families. That, I think, practice, in terms of actual practice on the ground, the trusts again increasingly -- and in some degree, in response to challenge from our DROs or designated review officers, who look also for involvement of the family during the investigation process. But practice now would typically be -- and increasingly moving to involving the family through all the stages of the investigation and the trust or the investigating organisation keeping the family fully informed of progress, sharing the draft report, talking them through the findings, the recommendations, talking through them the final report and providing a final report and including in that then feedback in terms of actions taken by the trust in response to the investigation.

THE CHAIRMAN: So if they see in the final report something which they think is either factually wrong or an inadequate conclusion, they have the chance to respond to that before the report is finalised?

DR CAROLYN HARPER: Yes, they would do.

THE CHAIRMAN: Okay. I think, as Mr Compton's opening summary indicated, I had raised the issue earlier this week of the families' access to the designated review

officer. I think I understand the practice is that that doesn't actually happen.

DR CAROLYN HARPER: It's not routine, but it is available and it has -- I can think of two examples where a family was dissatisfied with the investigation conducted by the trust and the trust then referred the family through to the board and we put them in contact with the designated review officer and Mrs Hinds then, as the lead director for the SAI process. Maybe Mary, if you want to add anything.

MARY HINDS: Carolyn's right, it's not part of routine procedure, but the door's always open. We have facilitated that. I have had one request to meet me personally. We left the door open that I was more than happy to meet the individuals concerned. They ended up choosing not to avail of it, but the door is open to anybody to come to talk to us.

THE CHAIRMAN: But how do they know the door is open?

MARY HINDS: The trust, in that particular set of circumstances, had talked through the process of the SAI, had explained the role of the DRO, and the family then asked if they could speak to the DRO. It was when the family weren't altogether happy at that point in time that we were approached to see if I would speak to them. I, of course, said I would speak to them, they

ended up being happy as the trust managed to resolve the situation for them with the DRO.

THE CHAIRMAN: Okay. There's one small point which emerged yesterday when Dr Carson was contributing to this discussion. You produce a six-monthly report on all SAIs; isn't that right?

JOHN COMPTON: Yes.

THE CHAIRMAN: On my reading of it, that highlights some particularly important points, but then also gives an indication of the work you're going to do in the next period. For instance, the example I have referred to before this week is that you were going to review all SAIs involving people over 65 to see if there were trends or patterns in them.

JOHN COMPTON: Yes.

THE CHAIRMAN: Does the RQIA see that six-monthly report?

MARY HINDS: Yes, they do. RQIA are part of the regional serious adverse incident group and that goes to all members of the group, indeed they form the report, they help write the report. It also goes to our public board meeting and is on the public website.

THE CHAIRMAN: Right.

JOHN COMPTON: I think we're acutely aware of the need in that context to stay in close working relationship with other organisations in the health and social care system

who have a clear interest in this arena of work, Patient and Client Council, RQIA and other bodies.

THE CHAIRMAN: Right. One other issue, one other aspect of this is the early alert system. In what circumstances is an early alert raised and who is it raised with?

MICHAEL BLOOMFIELD: Early alerts are raised directly and submitted directly from the reporting organisation to the department, copied to the board and to the Public Health Agency. It is primarily focused on, as it suggests -- it is giving an early alert, an early warning to the department of a particularly significant issue that has arisen that the department and indeed the minister would wish to be aware of.

Many, indeed most, early alerts are subsequently followed up as serious adverse incidents. And an arrangement that the board and the Public Health Agency have introduced over the last year or so is, whenever early alerts are received, we treat them initially exactly the same as we do a serious adverse incident, so we will appoint a designated review officer for the early alert. If it subsequently is submitted as a serious adverse incident, that process takes over, but there are a small number of early alerts that would be submitted that don't meet the criterion for a serious adverse incident, but they're still managed through

the -- the early alert is still managed through on the same basis to ensure any learning is identified. But they are reported primarily and initially to the department.

THE CHAIRMAN: Am I right in thinking that this early alert system, this isn't part of the SAI protocol, sure it isn't?

MICHAEL BLOOMFIELD: No, it's additional.

THE CHAIRMAN: Is there an early alert protocol or practice or is it ad hoc?

MICHAEL BLOOMFIELD: There is an early alert protocol, it's a departmental protocol. There's a standard template on which they need to be reported, to who and within what timescale.

THE CHAIRMAN: Can you give us a few examples of circumstances which have led to an early alert? I'm not asking for individuals' names, but if you could describe a couple of examples.

JOHN COMPTON: They might cover a whole range of things. For example, recently, about 18 months ago, we had a major fire in Altnagelvin, and that was an early alert because we knew that that would not only cause maybe major difficulty in the delivery of services in that hospital, but we might have to stand up the whole of Northern Ireland on a major contingency arrangement,

depending on the number of patients who had been transferred out of it, out of the hospital in Derry at that point in time. So it's that sort of issue that is an early alert.

Or where there's a very significant event which may become a matter of public involvement very, very rapidly or very quickly. That also would become an early alert if that affected an individual's health circumstances.

THE CHAIRMAN: Okay.

MICHAEL BLOOMFIELD: Perhaps issues such as alleged abuse or neglect in a residential home, issues such as that would be reported as early alerts as well as significant clinical issues.

THE CHAIRMAN: Thank you.

Within the Belfast Trust, and I think more generally, I've been told over the last few days about a far greater emphasis on morbidity/mortality audit than there was before. And again, it's one of the unhappy aspects of the evidence that this inquiry has heard that it's not clear to me on all the evidence that any of these children's deaths were the subject of an audit, either in the way that audits were done at the time and certainly not in the way audits are done now.

I understand now that all of these morbidity/mortality meetings are now minuted, which

wasn't the case before. There were issues about whether people would speak out freely at them, but they are all now minuted and this is with a view to learning lessons, which seems to be almost perhaps a parallel route to the serious adverse incident, but this one was within the hospital. Is there any lead-in from morbidity/mortality meetings in the hospitals to the work which you do?

DR CAROLYN HARPER: I suppose in a general sense, the morbidity/mortality meetings are kind of the first line of review. It's part of that journey to make reflection on practice and review of practice a day-to-day part of the culture. And I think it's a very welcome and important development for clinical teams to routinely review their practice. It was established practice, certainly, in the likes of paediatrics and neonatal services and around maternity services, and now rolling out to other specialties as well.

I think it helps reinforce that culture and that onus on doctors, nurses and other professionals to continuously review their practice. And the developments at a national level and requirements on doctors specifically now to complete an enhanced appraisal each year and an enhanced appraisal which requires them to demonstrate and provide explicit evidence that they have conducted case reviews, and

in addition that they have completed audits of their practice and that they have sought feedback from their patients and feedback from colleagues in terms of their practice. All of that is part of that culture of moving to making reflection and review and learning routine.

THE CHAIRMAN: Right. And since the Health & Social Care Board has a responsibility, which is summarised in the paper which Mr Compton read:

"For monitoring the delivery of services to ensure that the health and social care meets established safety and quality standards."

And since there's also a performance management and service improvement element, then it's important to the Health & Social Care Board that morbidity/mortality meetings are conducted and that there is that discussion, which leads to services being improved or at least maintained if not improved; is that right?

JOHN COMPTON: Absolutely.

DR CAROLYN HARPER: Yes.

JOHN COMPTON: That's in fact why we took the decision to begin to publish the standard mortality rates across Northern Ireland. If you like, that, at one level, is the apex of all of this so we put into the public arena -- and have put into the public arena for a three-year period -- those figures, in fact.

Just coincidentally, our board meeting is running today and this year's figures are being discussed at the board meeting today.

THE CHAIRMAN: What has been the effect of publishing those?

JOHN COMPTON: I think it's all about changing a culture. It's all about openness, it's all about saying that we want to be able to publish where we are, to examine where we are and what we're doing and to learn from it. And I think it's been quite an important milestone, if you like, in terms of that cultural change, because a lot of what we talk about in terms of handling serious adverse incidents and all of that, you can do much better if you've a better system. But you want a culture that wants to work in that system and I think we increasingly have a culture that accepts that system and wants to work in the system. So for me it's a very important part in that journey.

THE CHAIRMAN: Well, in a sense that leads into what might be my final point, which is about the culture, because I've been told a number of times during the hearing -- and I think Dr Carson's rather uncomfortable by the fact that I'm continually quoting him on that because he seemed to me to be somebody who was actually quite open about what some of the problems have been, which is about the service trumpeting its successes, but not

being willing to face up to its shortcomings. That's, I think, part of the context in which Mr Francis has recommended a statutory duty of candour in his report in Mid Staffs.

JOHN COMPTON: Yes.

THE CHAIRMAN: Certainly an element of that seems to be about changing the culture. I want to ask you two things about this. The first is about the extent to which that culture is changing and the second is about the Francis recommendations.

On the first point, you'll understand the families here inevitably think that they were on the receiving end of a culture which was just not good enough by any analysis. To what extent do you think the culture is changing or has changed?

JOHN COMPTON: I think it has changed quite extensively over the last decade. I'm sure if we all found ourselves back 10 years ago, the world would feel an entirely different and, indeed, slightly alien place to the sort of culture that exists today. There is just definitely more openness and more transparency as a consequence of a whole range and raft of events that have occurred over that 10 years. Is it perfect? I wouldn't sit here and say it's perfect. I wouldn't say that. But I would be confident to say that we have made quite significant

strides in terms of changing that culture.

I think the fact that we have more serious adverse incidents reported to us, we have more complaints reported to us, we put standardised mortality rates in the public domain, we have mortality meetings and professional groups, the regulation by which assessment takes place for professionals at all levels now in terms of their accreditation and their continued registration, all of that has created a different atmosphere and a different environment. But it is a journey, it is a journey.

THE CHAIRMAN: Is this reflected in the training that nurses and doctors receive now? Is that different, with respect, from when you two of you were qualified?

MARY HINDS: Yes. Nurse training is certainly different, so it is. You'll be pleased to know that in the University of Ulster, for instance, users and people who have had both positive and negative experiences of our service meet directly with student nurses in their training. And as a mechanism by which they can have their voice heard, some of them are actually filmed and on DVD, because I think being in front of a class of students can be quite daunting, as you referred to earlier, so the organisations are finding very creative ways of actually ensuring that our nurses are educated in a very

different way.

Professional ethics is central to their training. The Nursing and Midwifery Council a number of years ago produced a document called "Raising and escalating concerns". Again, for instance, the University of Ulster have taken that document, given it to their student nurses, given them actual names, telephone numbers and contact points should they see something in their practice that they are concerned about and they have that ability to raise that concern.

My registration just happened to be up this month and yesterday I got my reregistration from the Nursing and Midwifery Council and in it was a booklet about how I am expected, as a registered professional, to raise my concerns because one of the first things in my code of conduct is that I have to behave in a way that enables the public to trust nurses. So it is reinforced in numerous ways, both at pre and at post-registration level in nursing.

THE CHAIRMAN: And when it's raising and escalating concerns, is that in effect saying, "If you raise it with the nurse in charge of the ward and you don't get a response which you think is adequate", it's advising you on how to take it further?

MARY HINDS: It's advising you on what to do next, yes.

THE CHAIRMAN: Has doctors' training moved on in an equivalent way?

DR CAROLYN HARPER: Yes, particularly in the aspect of the communication skills and interpersonal skills and team working skills of doctors. There is a greater emphasis within their training on that aspect of their practice as well as the technical competence. That is very welcome because often the safety, quality errors or incidents occur when there is a miscommunication or poor team working or poor relationships. That is welcome.

And as I mentioned, in terms of medical appraisal for consultant staff and other senior staff, they're all required now to seek and report and reflect on feedback from patients, from their patients and from colleagues. That is part of the appraisal process.

In terms of doctors in training, they go through an annual assessment, and there's an assessment panel, and again they have to demonstrate skills and competency on the communication and the softer side as well as the technical expertise.

THE CHAIRMAN: If I take an old stereotype of a doctor who is brilliant, but has absolutely no people skills, can't talk to a patient, wouldn't begin to know how to talk to a family, is that sort of stereotype acceptable any more or not? You still want brilliant doctors, but it's no

longer acceptable for them not to communicate, is it?

DR CAROLYN HARPER: And it would be more explicitly addressed now through that appraisal process and the system -- within any organisation that employs doctors, there's a system of appraisal, feeding through from the individual doctor, through their clinical director, to the medical director of that organisation, who's the responsible officer for the organisation. Each organisation that employs a doctor has now a responsible officer and there are a series of tiers then of reporting of responsible officers. So for example, the responsible officer is the medical directors of the trusts. I am their responsible officer and, in turn, the Chief Medical Officer is my responsible officer.

So it goes all the way up the chain of command, so to speak, and the responsible officer has to, on a five-yearly basis now, give a positive recommendation or not, as it may be, in terms of that doctor's practice and it includes the patient feedback and colleague feedback.

THE CHAIRMAN: Right. The second element then: do you have a view or do you want to express a view, personal or collective, about the Francis recommendation, about the duty of candour?

JOHN COMPTON: I think we would want -- I suppose,

organisationally, we will be reflecting on whatever comes through in the Francis side when it goes through to the Department of Health in England. I think there's always a tension between regulating to do something and actually ensuring that it happens on the ground and it is about securing that balance, I think, that is the issue here.

So I think the two words that come to my mind mostly are one of proportion and one of balance, and I think that -- provided there's proportion and there's balance, of course it's the correct thing to have a sense where the candour is more straightforward, more part of the culture, more evident. I suppose history has taught me that you can't always regulate everything that you would like to happen and there is a danger sometimes, if you're not careful with that proportion and balance, about the bureaucratisation of something and you lose sight of the objective you're trying to achieve. So it's quite a delicate balance.

THE CHAIRMAN: It is, but it struck me, Mr Compton, that in the same way that people are still sexist or bigoted, despite the fact that there's sex discrimination legislation in employment legislation, but the fact that that legislation exists plays a part in changing people's attitudes or at least in changing their

conduct.
JOHN COMPTON: Yes, I agree, and that's the part about balance and proportion. It's not, I think, an all-or-nothing type of thing. That is the point that I would make.
THE CHAIRMAN: So it may fit in with the direction which you have already described helpfully this morning about the way in which things are going, that the culture is changing extensively? It might be Mr Francis' frustration about what he saw in Mid Staffs, which are more recent events than the ones I'm concerned with, but it shows that even as the culture changes there were huge problems in Mid Staffs which he thinks really requires you to have the statutory duty as the ultimate stick.
JOHN COMPTON: Yes, I understand that fully, yes.
THE CHAIRMAN: Okay. I'm going to take a break for a few minutes. I think I've pretty much reached the end of my questioning. I'll leave for a few minutes and you can consider whether there's anything more you want to say beyond what we've discussed this morning and I will see if there are any questions from the floor.
(11.33 am)
(A short break)
(11.40 am)

THE CHAIRMAN: There's just one query from the floor I have been alerted to. The question is really this: is there a contradiction between the suggestion that the culture is improving on the one hand and the fact that the number of complaints is increasing on the other?
JOHN COMPTON: I would see the two things as entirely consistent. Actually, if you're improving the culture, then you're opening yourself much more readily to the opportunity to people to make complaint. Also, again, as I've indicated in my statement, if you look at the total scale of what we're dealing with in terms of the numbers of people who deal with health and social care on a daily and annual basis, still it is a fact that the number of, for example, compliments that would be received in the system far outweigh the number of complaints. So for me it's a demonstration that we are more open and more willing to learn.
THE CHAIRMAN: When Mr Leckey, the senior coroner, was here a few months ago, he said one of the things that's changed that he's alert to is the fact that -- and he regarded this as a positive thing -- people do now challenge more what has happened to them, people are now more questioning of people in authority and people to whom there might have been some deference or hesitation about challenging in the past.

JOHN COMPTON: I'm sure that's correct. And again, it's a good thing. It's important that there is a sense of proportion in their relationship. It's not about doing to people, it's about working with people to incorporate them into decisions that affect their lives materially. So I think that's a good thing.
THE CHAIRMAN: Okay. I think those are all the questions that come from the floor. Is there anything else? You don't have to say anything more, Mr Compton, or your colleagues, but ...
JOHN COMPTON: Just thank you for the opportunity to speak to the inquiry today and I hope we've communicated our genuine sense of seeking to improve the system.
THE CHAIRMAN: Thank you very much indeed, you have.
(The witnesses withdrew)
Ladies and gentlemen, that really brings an end to today's session. We'll sit tomorrow morning, but not until 10.30. We'll have the panel from the department and then I will close the public hearings after that.
Mr Uberoi?
MR UBEROI: Before you rise, may I briefly expand on a point I raised earlier in response to your opening point this morning? I have had the opportunity to review the extract to which you were referring. On reviewing it, it is plain that the sting of what you are doing is

questioning Dr Darragh on whether, with hindsight, he would have preferred clinicians to have shared knowledge of particular cases with him at the working party. On that point, Adam Strain is obviously in a separate category, in my submission. On the other cases of Claire Roberts and Lucy Crawford, it is very much challenged that Dr Taylor could or would have known that those deaths were the result of hyponatraemia.
As I mentioned this morning, you have my submissions which go into this in detail -- I believe that is at paragraphs 22 to 45 -- but in a nutshell his involvement in Claire Roberts' care was very limited and, furthermore, if the treating clinicians hadn't really put their finger on hyponatraemia being causative of death, it's rather unfair to suggest that Dr Taylor could or should have done. And secondly, for the reasons I have gone into, it's highly unlikely that Lucy Crawford was ever presented at a mortality meeting.
Sir, I'm confident you have my submissions on the question of what Dr Taylor knew and when, but I simply wished to place it on record.
THE CHAIRMAN: Thank you very much. 10.30 tomorrow.
(11.45 am)
(The hearing adjourned until 10.30 am the following day)

I N D E X