RESPONSIBILITY FOR QUALITY OF CARE

(i) From the establishment of the different Trusts in the early to mid-1990s until 2003, who was responsible for the quality of care provided to patients? How was that responsibility fulfilled? (This will build on the evidence given already by, inter alia, Mr McKee, Dr Carson, Mr Mills, the witnesses from the Western Health and Social Services Board and Professor Scally).

(ii) How did the Department know what was going on in hospitals prior to 2003 in terms of the quality of health care?

(iii) What , and when, did the Department know about the deaths of Adam, Claire and Lucy?

(iv) Since 2003, how have the Trusts exercised their statutory duty to provide quality care? Who have they been answerable to and how has that line of reporting worked?

(v) What have been and are the respective roles and contributions in this area of:

- **The Trusts**
- **The Department**
- **The Health and Social Care Board**
- **The Public Health Agency**
- **RQIA**
- **The Chief Medical Officer**
- **The Chief Nursing Officer**

(vi) How are new guidelines/practices which are developed elsewhere in the United Kingdom considered and adapted for use in Northern Ireland? How do they find their way into the training of doctors, nurses and allied health professionals , whether under graduate or post graduate, and into clinical practice?

(vii) What further changes, if any, are required to improve the service?

ACTIONS OF DOCTORS, NURSES AND TRUSTS

(i) Has there been an increase in reports of serious adverse incidents and other adverse clinical incidents within Trusts?

(ii) How effectively are such incidents now reviewed? To what extent do they now involve families? How are the findings disseminated?

(iii) Are there more reports to the GMC/NMC ?

(iv) Are there now more reports to the Coronial service than before?

(v) How likely is it that a doctor (in the RBHSC) will report to the (Belfast) Trust and to the GMC the actions of another doctor?

(vi) How likely is it that a nurse or junior doctor or allied health professional will report to a Trust and to the GMC/NMC the actions of a senior doctor (consultant) or senior nurse?

(vii) If the GMC/NMC investigates only the actions of a doctor or nurse from a disciplinary perspective, who will examine failings in the system which contributed to or go beyond the failings of an individual doctor or nurse?

(viii) If there is now more reporting of serious adverse incidents, or other adverse clinical incidents, and/or doctors and/or nurses, what has brought about this change? What has been the contribution of, respectively, Departmental and Trust policy to this change and what has been the impact on the culture surrounding reporting of such incidents?

(ix) What is the relationship between the management respectively, of litigation, complaints and incident reporting, arising from clinical incidents, and how are lessons learned from each?

CHIEF MEDICAL OFFICER AND HYPONATRAEMIA GUIDELINES

(i) What did the then CMO and/or the Chief Nursing Officer and/or their senior officials know about the deaths of Adam, Claire or Lucy before June 2001?

(ii) What exactly led to the establishment of the working party which prepared the hyponatraemia guidelines? Was it only the report of Raychel's death or was there also significant information about other events?

(iii) What led Dr Campbell, as CMO, to say what she said publicly in 2004 about the deaths of the children with whom the Inquiry is concerned?

(iv) Using Conor's case as an illustration, how were the 2002 guidelines disseminated? How was their implementation monitored and enforced by each Trust and by the Department? How have the guidelines been reviewed, updated and enforced subsequently?