Opening Statement to the Hyponatreamia Inquiry

Thank you Mr Chairman for inviting my colleagues and me to the Inquiry today.

Let me begin by categorically stating that the Belfast Trust - on behalf of the former Royal Hospitals Trust - regrets most sincerely the pain and suffering experienced by the families of Adam Strain, Claire Roberts, Lucy Crawford, Raychel Ferguson, and Conor Mitchell and apologises for all the shortcomings in care at the Royal Hospitals that have been identified either prior to this inquiry or during the hearings.

I am in front of you today as a Chief Executive and as a parent. The unqualified agony and pain felt by the parents of these five children cannot be underestimated. The abject sorrow and grief felt by the families, I know, has not lessoned with the passing of time. In fact, I fully accept it is as raw today as it was then, exacerbated by the actions of the three Trusts involved. For the part Belfast Trust has played in prolonging this agony, I am deeply sorry.

Chairman, I am aware through this inquiry that how litigation has been handled by Belfast Trust has added to the hurt and grief felt by the families. While I will outline later in this statement how litigation is dealt with now, I wish to apologise unreservedly to the families for the unacceptable delay in the Belfast Trust accepting liability.

It is clear that important aspects of the care and treatment afforded to the children at Royal Belfast Hospital for Sick Children – in particular, fluid management - was poor. When the parents entrusted their most precious children into our care, when their children were at their most

vulnerable, their parents rightly expected their children to have had the best and the safest care possible. They also rightly expected their children to be made a priority. This did not happen and for that we are deeply and sincerely sorry.

Communication with families was not sufficiently transparent. Our medical and nursing staff missed the opportunity to reflect on what may have gone wrong and consequently there was a lack of communication with the wider acute hospitals network in Northern Ireland and the Department of Health. The evidence presented shows that training in fluid management in children was inconsistent, record keeping was incomplete, and our governance was not sufficiently developed or robust. I also accept that reflective clinical practice and candour, which is how we work today, was clearly missing. I will discuss further these issues in the context of how we work today later in this Statement.

Chairman, I want to assure you that in all my years as a Chief Executive, the Inquiry into Hyponatraemia-Related Deaths in Children in Northern Ireland has had the most significant impact on my Trust in terms of the learning from it. There is no member of staff who has remained untouched by the Inquiry's impact.

I also want to assure you that the Trust now has the necessary framework and mechanisms in place to implement the recommendations of this Inquiry when required.

While I understand that you will wish to have a more detailed discussion this morning on a number of issues I thought it would be useful if I touched on some of the main issues which have been highlighted during the Inquiry.

Clinical Governance

From the outset of the Belfast Trust in 2007 an integrated approach to governance was taken, ensuring that clinical and wider organisational risks were managed within a single integrated Assurance Framework. This Assurance Framework has been continuously developed in the intervening years, taking account of new thinking at a regional and national level. The most recent iteration of the Assurance Framework took account of lessons from the Francis Report into the events at Mid Staffordshire Hospital. Belfast Trust has worked hard to develop robust clinical governance arrangements within our Assurance Framework.

The key elements of clinical governance in Belfast include clinical audit, incident reporting, education and training, appraisal and the development of evidence based practice to ensure safe and effective care. We also introduced clear and robust arrangements for the management of concerns about doctors and dentists.

Openness/Candour

Underpinning our risk management and clinical governance arrangements is a determination to engender and encourage a culture of openness and fairness, where staff feel able to report events whether these are near misses or actual adverse incidents. This is an ongoing process that builds on the lessons of the past and present. We have engaged actively with staff representatives and professional bodies to develop our risk management and clinical governance arrangements. This is exemplified by the development of both our Trust Health and Safety Annual Report and the Quality and Safety Improvement Plan. We also have engaged with the users of our service in the delivery of

our risk management and clinical governance arrangements. For example, the involvement of lay people in clinical audit design, and the use of patient feedback in revalidation of doctors.

We also review the deaths that occur in our Trust. High level data is reported at our Trust Board however we have not been content with this and have developed a system in Belfast whereby every death in hospital can be recorded and reviewed by clinical teams. We are in the process of implementing a bottom up approach where all our doctors are linked to a specialty Morbidity and Mortality meeting. We have developed an IT system that makes the recording of deaths straightforward. In the Children's Hospital all deaths are now reviewed irrespective of whether there have been any concerns about the quality of care. These meetings are now recorded and a culture of openness and candour is being actively encouraged. Chairman, I believe this is a real and practical example of the sea change that has occurred in the way the health service in Northern Ireland works. It particularly demonstrates the active engagement of our doctors and other clinical professionals in providing information upon which the Trust can learn and act. It encourages the culture of openness, candour and reflection that is being promoted nationally through reports such as that of Robert Francis QC. We have an open approach to dealing with the Coroner and are committed to providing him with all relevant information.

Chairman having followed the oral hearings of this Inquiry and listened to your discussion yesterday with representatives from Action against Medical Accidents and the Patient Client Council I believe this is an area where we need to improve. To that end I would wish to offer to meet with the families to firstly highlight any further learning that they can assist the Trust to identify and secondly to provide reassurance about the lessons

we have learned and action taken to prevent other families experiencing the same trauma.

Litigation

The Belfast Trust has always had an open approach to Coroner's inquests seeking to support the Coroner in establishing the facts of any case. We have always shared expert reports and information. We have learnt from the events of this Inquiry and are updating our arrangements to ensure a proper separation of coronial and medical legal functions. We already seek to ensure that the process of litigation does not prevent us from supporting patients and families and helping them to resolve issues and concerns. We often have an ongoing relationship with patients and recognise the need to maintain a therapeutic relationship with them, ensuring their confidence in the service they receive while any legal process is ongoing. This can only be achieved through dialogue, openness and honesty.

Serious Adverse Incidents

We have a robust process for reporting, investigating and learning from Serious Adverse Incidents. The Trust reports approximately 100 per year. These are all reviewed at an SAI Review Board. We have recently strengthened our corporate arrangements by establishing a Learning from Experience Steering Group, chaired on my behalf by the Deputy Chief Executive. This group will have oversight of adverse events, SAIs, mortality data and external reviews of our service. The group builds on our existing arrangements and will report to the Executive Team (Directors) and Trust Board.

Conclusion

Chairman I realise that you will want to explore these issues further with the panel. I wish to finish by once again offering the Trust's heartfelt apologies and condolences to the families.