Witness Statement Ref. No. 062/2

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: Clive Gowdy

Title: Mr

Present position and institution:

Retired

Previous position and institution:

Permanent Secretary, Department of Health, Social Services and Public Safety

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement of 6th July 2005]

Chairman, Belfast Charitable Society - 2010 to present
Chairman, Advisory Panel, Volunteer Now - 2008 to present
Visiting Professor, University of Ulster - 2006 to 2012
Committee Member, National Trust Regional Committee - 2007 to 2010

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your Witness Statement of 6th July 2005]

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	
WS-062/1	06/07/2005	Witness Statement to the Inquiry

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

DETAILS OF YOUR CAREER HISTORY

(1) State the dates on which:

(a) You became Permanent Secretary of the Department of Health, Social Services and Public Safety (DHSSPS).

28 March 1997: Appointed as Permanent Secretary of the then Department of Health and Social Services (DHSS), which subsequently became the Department of Health, Social Services and Public Safety under The Departments (Northern Ireland) Order 1999.

(b) You ceased to hold that position.

30 July 2005: Retired due to ill health.

(2) Describe your career history prior to becoming Permanent Secretary of the DHSSPS.

January 1997-March 1997: Chief Executive, HPSS Management Executive
January 1994–December 1996: Director of Personnel, Northern Ireland Civil Service
February 1991–December 1993: Under Secretary, DHSS
October 1990-February 1991: Acting Permanent Secretary, DHSS
September 1990-October 1990: Under Secretary, DHSS
1987-August 1990: Under Secretary, Department of Economic Development
1983-1987: Executive Director, Industrial Development Board
1980-1983: Assistant Secretary, Department of Commerce
1979-1980: Principal, Northern Ireland Office
1978-1979: Secretary, Investigatory Commission into NIHE Contracts
1976-1978: Principal, Northern Ireland Office
1973-1976: Deputy Principal, Department of Finance
1972-1973: Assistant Principal, Central Secretariat
1970-1972: Assistant Principal, Ministry of Finance

(3) Describe your career history since ceasing to be Permanent Secretary of the DHSSPS.

Retired from paid employment. Engaged in voluntary and charitable activities.

(4) In your capacity as Permanent Secretary, were you also Chief Executive of the Management Executive?

If not, please identify the Chief Executive(s) of the Management Executive during your time as Permanent Secretary.

Following my appointment as Permanent Secretary, Mr Paul Simpson was appointed as the Chief Executive of the HPSS Management Executive. However, with the election of the Labour Government in May 1997 the policies and organisational arrangements throughout the UK underwent some changes. The emphasis on the creation of a market-driven health system diminished and there was greater emphasis on the delivery of central policy imperatives. The Management Executive was discontinued and its functions absorbed within the traditional structure of the Department. Mr Simpson (who was already a career civil servant) became a Deputy Secretary within DHSS with particular responsibility for policy and operational matters within the HPSS and the authority vested in the post of Chief Executive was absorbed into the role of Permanent Secretary. Similar change took place in England, where the combination of the Chief Executive and Permanent Secretary roles came fully into effect in 2000. Unfortunately, I cannot recall precisely when we made this change in Northern Ireland but I believe that it preceded the change in England.

(5) Please answer the following questions regarding the Management Executive:

(a) Please explain the role of the Management Executive.

The Management Executive was primarily established to act as the operational arm of the DHSS. It was concerned to oversee and support the establishment and performance of the Trusts and other operational Health bodies within the HPSS in Northern Ireland. As such, it was charged with ensuring that contemporaneous Government policies in relation to health and social care matters, such as the operation of the internal market in healthcare and the delivery of services, were properly implemented.

(b) Please explain what specific responsibilities were entailed in the role of Chief Executive of the Management Executive.

The Chief Executive was responsible for overseeing the implementation of the health and social care policies which Ministers wished to pursue and delivering on the Department's statutory duty to secure the provision of health and social services for the population of Northern Ireland. This broad set of responsibilities embraced, inter alia, a number of key issues:

- the development of appropriate measures and programmes;
- dissemination of information and instructions;
- monitoring the delivery of objectives;
- interacting with the various health and social care bodies on their performance;
- securing and providing appropriate levels of funding;
- ensuring proper stewardship of public monies;
- maintaining proper lines of governance and accountability; and
- keeping Ministers informed and briefed on significant issues.

(c) When did the Management Executive cease to exist?

As indicated in my response to Q4 above, I cannot recall precisely when this occurred.

(d) What was the Management Executive replaced by?

The functions exercised by the Management Executive were absorbed within the Department. As the post-1997 Labour Government developed its health and social care policies, the Department modified its structure to meet the new demands of Ministers.

ACCOUNTABILITY ARRANGEMENTS IN THE HPSS

(6) You have referred in your first witness statement **(WS-062/1, page 12)** to the accountability arrangements in the HPSS.

Mr William McKee, former Chief Executive of the Royal Group of Hospitals HSS Trust, has told the Inquiry **(Ref: transcript day 76, 17th January 2013, page 6 lines1-4)** that *"in 1993/1994 ...and subsequently for many years I was specifically not held responsible for clinical safety, clinical quality, clinical matters."* He confirmed **(Ref: transcript day 76, 17th January 2013, page 16 line 4)** that the Board of the Trust had no such responsibility either. His evidence was that the Trust only became responsible for clinical quality in January 2003 when a circular was issued by the DHSSPS advising Trusts that they now had a duty of quality**(Ref: transcript day 76, 17th January 2013, page 7 lines 13-19 and page 8 lines 1-9).**

However, Mr Hugh Mills, former Chief Executive of the Sperrin Lakeland Trust, was asked by the Chairman if the Trust reported Lucy Crawford's death to the Western Board in 2000 *"because the Trust felt that it had a responsibility for clinical care"* and replied *"Oh, certainly the Trust had a responsibility for clinical care."* **(Ref: transcript day 110, 17th June 2013, page 45 lines 18-20)**. Arising from this, please answer the following:

(a) Do you agree with Mr McKee that, prior to the issue of HSS(PPM) 10/2002 on 13th January 2003 **[Ref: 306-119-001]** and the coming into operation of the statutory duty of quality in Article 34 of the Health and Personal Social Services (Quality Improvement and Regulation) Order 2003 in April 2003, the Royal Group of Hospitals HSS Trust had no responsibility for clinical care? Or do you agree with Mr Mills that in 2000 the Sperrin Lakeland Trust did have responsibility for clinical care? Please give reasons for your answer.

It is, of course, correct to say that there was no specific statutory duty for the quality of clinical services on Trusts, their Boards or Chief Executives prior to the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003. It might also be argued that previously the historical perception within the Health and Social Services system was that clinical matters were for the clinical professionals. However, it does not follow that Trusts or their Boards or Chief Executives had no responsibility for clinical care or clinical outcomes prior to the commencement of the Order.

For one thing, the Management Executive made clear in the 1993 Circular METL 2/93 **(Inquiry ref. 323-001)** that "The primary accountability of Trusts is for the quantity, quality, efficiency of the service they provide." It is hard to see how this could be interpreted as excluding any corporate accountability or responsibility for the clinical care or clinical outcomes delivered to the patients. In fact, the raison d'être of the Trusts concerned was to deliver effective clinical care to sick or injured people and it is rather difficult to see how they might argue that they had no interest in, or responsibility for, the quality of the service they were providing.

Secondly, the historical deference to the clinicians was well in retreat by the 1990s and early 2000s. Events such as the Beverley Allitt trial (1993), the Bristol paediatric cardiac surgery inquiry (1998-2001), the inquiry into the retention of human organs at Alder Hey (1999) and the trial of Dr Shipman (2000) had undermined much of the

mystique of clinicians and had shown that greater corporate responsibility had to be exercised by Health Service organisations in relation to the quality of the clinical care provided by them.

Thirdly, it was in the late 1990s and early 2000s that the issues of risk management and clinical governance were being developed and were becoming increasingly part of the systems in place within the Health and Social Services. These were matters on which Trust Boards and Chief Executives were in the lead for their organisations and they necessarily had to involve the clinical services and the role of the clinicians.

Fourthly, the concentration of Ministers on the delivery of services against targets and policy objectives brought hospital managers into direct contact and negotiation with clinicians on the performance of their services. No Trust Board or Chief Executive could afford to argue that these were purely matters for clinicians and for which they bore no responsibility.

Fifthly, issues of public, media or political debate or controversy often involved the delivery or outcomes of clinical services. Ministers expected the Trusts to be aware of what was happening within their organisations and to be in a position to provide briefing on the matter in question. It would have been regarded as unacceptable, or indeed wholly negligent, for a Trust Chairman or Chief Executive to have pleaded ignorance on the grounds that he or she had no responsibility for the quality of the clinical care provided within his or her organisation.

(b) What did you consider to have been the major changes brought about by Circular HSS(PPM) 10/2002 in relation to the reporting of adverse incidents?

This circular was designed to strengthen the drive to develop solid clinical and social care governance arrangements throughout the HPSS. The onus placed on the family of HPSS organisations was to act rigorously and timeously in reviewing, enhancing and monitoring the performance of their organisation against high standards of performance in the delivery of their services. It was made clear that adverse incident management was an integral part of this process and the culture should be one of openness and honesty where poor performance, adverse events and near misses could be raised and dealt with through appropriate action. It made clear that these matters should be shared within and, where appropriate, outwith the organisation to enable lessons to be learned but stopped short of imposing a duty of reporting such matters to the Department or other external body. The circular did, however, introduce the monitoring of clinical and social care governance in HPSS organisations by the Regulation and Improvement Authority and gave it the role of helping organisations to tackle serious or persistent shortcomings in clinical or social care service delivery.

(c) Who did you consider had responsibility for clinical care in Health Service hospitals in Northern Ireland prior to the issue of HSS(PM) 10/2002 and the coming into operation of Article 34?

The Chairman, Chief Executive and Board of the relevant Trusts in overall terms and the clinicians in terms of the actual delivery of that care.

(d) How did that responsibility arise? For example, did you consider it to be statutory, or by virtue of a circular or direction, or by custom and practice? Please give details of any relevant statute, circular or direction.

The 1993 Circular METL 2/93 (**Inquiry ref. 323-001**) stipulated that the Trusts were accountable for the quantity, quality and efficiency of the service they provide. Their responsibility therefore embraced the standard of clinical care provided by their organisation. However, the actual delivery of clinical services is a matter for the clinicians and they have a responsibility to do so competently and in line with the appropriate standards and state of knowledge in their profession.

(e) To whom did you consider that those who had responsibility for clinical care in Health Service hospitals in Northern Ireland prior to 2003 were responsible?

The Trusts were ultimately responsible to the Minister for the services they provided. That responsibility was generally exercised through the Department. It was also the case that they had a responsibility to the Health and Social Services Boards who commissioned their services.

(f) Describe what arrangements were in place to ensure that those responsible for clinical care in Health Service hospitals in Northern Ireland discharged their responsibilities prior to 2003.

Accountability reviews were conducted by the Department with the Trusts each year to scrutinise their performance across the range of their business. While these reviews did not focus specifically on standards of clinical care, they did examine the delivery of services and the achievement of outcomes and objectives. Bilateral meetings were also held between the Trust and their respective HSS Board.

(g) If Trusts were responsible for clinical care prior to 2003, what was the purpose of the duty of quality in Article 34 and what difference did it make?

The clinical failings and misdeeds of the previous decade across the UK, together with the development of policy thinking on risk management and governance, led to the conclusion that a formal framework for clinical and social care governance backed by a statutory duty of quality was required. The policy intention was place a clear, consistent and unequivocal obligation on Health and Social Services bodies to focus their attention on the standards of clinical and social care practice provided within their organisation and to ensure that all staff took responsibility for the quality of care they provided. My clear perception was that this was a seminal development which brought the importance of quality of performance into sharp relief and joined clinical and managerial staff in the pursuit of high quality care and treatment.

(7) You have described the Department's responsibilities thus: *"The Department is responsible for carrying out the wishes of Ministers. Its primary functions are in relation to the formulation and implementation of policy and legislation The Department sets the framework, priorities and targets within which the HPSS must operate and maintains a high level overview of the performance of the HPSS. As appropriate the Department issues guidance and direction to the HPSS and ensures that there are effective governance systems in place."* **[Ref: WS-062/1, p.12]**

Mr Thomas Frawley, the former General Manager of the Western Health and Social Services Board, has told the Inquiry that the Department was responsible for *"holding whole system to account"* **[Ref: WS 308/1 page 11]**.

Arising from this, please answer the following:

(a) Do you agree with Mr Frawley that the Department was responsible for *"holding whole system to account"*? Please answer for the period during which you were Permanent Secretary. Please give reasons for your answer.

Yes. The Department had a responsibility to ensure that the whole system was delivering what Ministers wished and that the health and social care needs of the population of Northern Ireland as a whole were being addressed.

(b) If it is the position that that the Department was responsible for holding the system to account, please explain how the Department did so.

There were a number of ways in which the system was held to account:

- Accountability reviews were held with all of the Health and Social Services bodies each year.
- Chief Executives were formally designated by me as Accountable Officers and required to account to me in relation to financial matters and the use of public monies.
- All HSS organisations were required to provide responses to issues raised with the Minister or on matters being examined by officials.
- Regular meetings were held with all Chief Executives as a group.
- Meetings were held with the Chairs and Boards of each of the HSS organisations each year.

(c) Whether or not you agree that the Department was responsible for holding the system to account, please describe what arrangements were in place in the period during which you were Permanent Secretary to enable you personally and/or the Department to know what was going on in the HPSS and of issues affecting the HPSS.

As above, there were a number of ways in which both I and the Department endeavoured to keep in touch with matters in the HPSS:

- Departmental officials had close working contact with the various HPSS bodies on a daily basis.
- I made a point of visiting all HPSS bodies and meeting with their Boards each year.
- I held regular meetings (roughly 2 or 3 per year) with all Chief Executives as a group to discuss current business matters.
- There were accountability reviews with HPSS bodies each year.
- I made contact with Chief Executives and Chairs whenever necessary on significant matters affecting their organisation.
- I had close working contact with my senior management team in the Department and they alerted me to issues relating to the HPSS bodies they had encountered in their contact with them.

(8) Dr Paddy Woods has told the Inquiry **[Ref: 323-001a-001]** that formal accountability meetings took place between the Department and Sperrin Lakeland HSS Trust twice per year usually mid-year and end of year. He has advised that individuals who might have had responsibility for the oversight of Sperrin Lakeland in 2000 and who might have received reports of issues affecting the Trust would have included yourself, Paul Simpson, John McGrath and Alan Gault. Arising from this:

(a) Please confirm whether you were involved in accountability meetings with the Sperrin Lakeland Trust during the period 2000-2002.

I have no recollection of being involved in such meetings during this period and the Department has been unable to provide any information on these matters.

(b) Where did those meetings take place?

I have no recollection of these meetings and the Department has been unable to provide any information on these matters.

(c) Who represented the Trust at those meetings in the period 2000-2002?

I have no recollection of these meetings and the Department has been unable to provide any information on these matters.

(d) Please give examples of matters discussed during those meetings.

I have no recollection of these meetings and the Department has been unable to provide any information on these matters.

(e) Outside of formal accountability meetings, did you personally receive reports of issues affecting Sperrin Lakeland Trust in the period 2000-2002? Please give examples of the sorts of issues which were brought to your attention.

While I cannot recall receiving any specific reports of issues affecting Sperrin Lakeland during this period, it is likely that this would have been the case. There were ongoing issues around such matters as the provision and location of specific hospital services in the area and the siting of a new hospital.

(f) Were issues concerning clinical care ever raised by the Trust or discussed with the Trust either within or outside the formal accountability meetings? Please give examples.

The siting of a new hospital in the Fermanagh/Tyrone area was a significant policy matter which raised many issues about the provision of clinical services for the local population and was the subject of substantial discussion with the Trust.

(g) You have told the Inquiry (**WS-062/1, page 2**) that you first became aware of the death of Lucy Crawford in February 2004. Arising from that;

(i) Please confirm whether you were made aware by the Sperrin Lakeland Trust during the period 2000-2002 of any untoward deaths occurring following treatment in the Trust's hospitals?

I have no recollection of any such deaths being brought to my attention by this Trust.

(ii) Would you have expected the Sperrin Lakeland Trust to have made you or the Department aware of the untoward and unexplained death of a seventeen month old child following treatment at the Erne Hospital? Please give reasons for your answer.

Yes. In light of the untoward and unexplained nature of the death, I would at least have expected the Trust to notify the Chief Medical Officer. Such a death would have been a rare and disturbing event and as such would have been of

professional interest to the Chief Medical Officer and her staff. There would have been concerns as to what had happened in clinical terms and whether there were features of the case with wider ramifications. If the case was such that it was likely to be of wider public interest or concern, then the Trust should also have informed my office so that the Minister could be informed.

(h) Did the Sperrin Lakeland Trust at any time during the period 2000-2002 make you or the Department aware of any of the following:

(i) The allegations of clinical incompetence made against Dr O'Donohoe by Dr Asghar in June 2000 **[Ref: 036a-099-212 to 036a-099-214 and 036a-004-009 to 036a-004-010]**

I was not notified of these allegations and as far as I am aware no other member of the Department was informed.

(ii) The Trust's decision to request the Royal College of Paediatrics and Child Health (RCPCH) to assist in investigating those allegations **[Ref: 036a-009-016 to 036a-009-018]**

I was not notified of this decision and as far as I am aware no other member of the Department was informed.

(iii) The first report of the RCPCH representative Dr Moira Stewart **[Ref: 036a-025-052 to 036a-025-060]**

I was not notified of this report and as far as I am aware no other member of the Department was informed.

(iv) The meeting between the Trust's Medical Director Dr Kelly and Dr Moira Stewart on 1st June 2001 **[Ref: 036a-027-066 to 036a-027-068]**

I was not notified of this meeting and as far as I am aware no other member of the Department was informed.

(v) The external review report of the RCPCH by Dr Stewart and Dr Boon **[Ref: 036a-153-318 to 036a-153-323]**

I was not notified of this report and as far as I am aware no other member of the Department was informed.

(i) Would you have expected that the Trust would have made you and/or the Department aware of any or all of the events set out in (h) above? Please give reasons for your answer.

I would have expected the Trust to have informed the Department of all of these events. In relation to the allegations of clinical incompetence, these raised potentially serious issues about the performance of one of the few consultant paediatricians in that area and had potential ramifications for the provision of service there. The Chief Medical Officer should have been informed. This is also the case in respect of the other matters since the contact with the RCPCH and the issues around the investigation and subsequent report were of material interest to the Chief Medical Officer.

ADDITIONAL QUERIES

(9) How and when did you first become aware of the death of Claire Roberts?

I cannot give a precise date but I believe that it was after my retirement.

(10) What steps were taken by your staff to investigate if there were any further deaths from hyponatraemia in Northern Ireland?

This was a matter being dealt with by the Chief Medical Officer and her staff.

(11) Would you have expected the Department to have been contacted regarding the deaths of Adam Strain, Claire Roberts or Lucy Crawford?

The decision to notify the Department on any specific issue or case is largely a matter of judgement for the Trust concerned and will depend on the information available and conclusions drawn at the time. From the information now available on these deaths I would certainly have expected the Trusts to have informed the Department of all of them.

(a) What would you have expected had any of those deaths occurred:

(i) post-February 2003 and the publication of the circular HSS(PPM) 10/2002

The advent of the guidance in this circular should have lowered the threshold for notification of adverse incidents and made it more likely that a decision would have been made in each of these deaths to notify the Department.

or

(ii) after the publication of HSS (PPM) 06/04?

All of these deaths would clearly have been within the definition of a serious adverse incident and would have required the Trusts to notify the Department.

(b) Would you have expected the Department to have been informed of the statement produced by the RBHSC following the Inquest of Adam Strain? **[Ref: 011-014-107a]**

The "Draft Statement" issued by RBHSC in 1996 was of such general application as to be of interest and significance to other hospitals likely to be treating young patients. In the circumstances in which this statement was made I would have expected it to have been at least copied to the Department and, ideally, to have been the subject of some prior discussion with the Chief Medical Officer because of the regional implications and the desirability of wider dissemination.

(12) What was done by the Department following the report of Healthcare Risk Resources International consultants in 1999 that there *"might have been a significant level of under-reporting of adverse incidents"*? **[Ref: WS-062/1, p.4]** Please provide a copy of that report.

(a) How was this report followed up? What was done as a result of the report?

The Department commissioned HRRI to undertake a survey of the preparedness of HPSS bodies to deliver sound risk management. The survey provided the Department with baseline information on all of the dimensions of risk management across the HPSS, including the reporting of adverse incidents, and this provided further impetus for the work of developing the policy guidelines on risk management

and governance which were set out in the "Best Practice, Best Care" consultation paper in 2001.

I understand that the Department has been unable to locate a copy of the HRRI report.

(13) During your time as Permanent Secretary, what policies were there for the dissemination of guidelines / protocols from the Department down to Boards / Trusts?

The policy was a pragmatic one. Where the Department judged that there was a need to issue direction, guidance or information to the HPSS as a whole, or in part, the matter would be set down in a circular letter and issued to the relevant Chief Executives, Chairs or Chief Professional Officers as appropriate. Such circulars had a fairly standard format and were given a specific reference number to identify them subsequently.

(14) How was the implementation of such guidelines and protocols by Boards and Trusts examined / assessed / monitored?

Many of the directions and guidelines issued were not subject to any specific monitoring. It was assumed that, as responsible and accountable bodies, the HPSS organisations concerned would act in accordance with them. Where it was considered necessary or appropriate, however, responses or confirmation of action might be required and deadlines for reply might be set. It was a matter of judgement when to adopt this latter approach.

(15) How would the Department be made aware of issues / areas that required dissemination of information / protocols? In particular, how would Boards / Trusts make the Department aware of such issues?

Awareness of the need to issue such circulars came in a number of ways:

- The Minister might ask for the issue of information or instruction to the HPSS bodies.
- The Department might wish to set out a particular policy direction for the HPSS.
- The Department might judge that guidance or direction was required to ensure appropriate or consistent action by HPSS bodies.
- The Department might wish to issue information, guidance or direction to the HPSS similar to that issued to NHS bodies in England
- HPSS bodies might request guidance from the Department on matters of concern to them.

The HPSS bodies would do the latter by letter, through meetings with the Department or in more informal contact with Departmental officials.

(16) How would the Department be involved in the dissemination of materials amongst Boards / Trusts?

There was a well-established system of the issue of circulars from the Department. These would generally go to the Chief Executive and it would be for him or her to disseminate as appropriate within his or her organisation.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: *D C Gowdy* D. C. Gowdy **Dated: 30 August 2013**