Witness Statement Ref. No. 349/1

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: John Hunter

Title: Mr

Present position and institution:

Retired

Part-time Chair of the Chief Executives' Forum

Previous position and institution:
[Please provide your position in 1995, 1996, 2000, 2001 and 2003]

1995, 1996: Chief Executive of the HPSS Management Executive

2000,2001: Permanent Secretary Department of Social Development

2003: Permanent Secretary Department of Finance and Personnel

Membership of Advisory Panels and Committees:
[Identify by date and title all of those in 1995, 1996, 2000, 2001 and 2003]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the children's deaths]

None

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

Ref:	Date:	

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 Chief Executive, Health and Social Services Executive DHSS.

1990

(b) You ceased to hold that position.

1997.

(2) Describe your career history:

(a) Prior to becoming Chief Executive.

Under Secretary DHSS 1988-1990; Director General International Fund for Ireland 1985-1988.

(b) Since ceasing to be Chief Executive.

Director of Personnel NICS 1997-2000; Permanent Secretary Departments of Social Development 2000-2003 and Finance and Personnel 2004-2007. Retired 2007.

(3) Provide a copy of your job description and outline the duties and responsibilities of this position.

I do not have a copy of my job description. I was the Chief Executive for the Management Executive and Accounting Officer for the HPSS.

(4) When did the Health and Social Services Executive cease to exist?

I do not know.

(5) Why did the Health and Social Services Executive cease to exist?

(6) I do not know.

(7) What replaced the Health and Social Services Executive?

I presume the Department absorbed the duties of the Executive, which was always part of the Department, with the Permanent Secretary assuming the Accounting Officer responsibilities.

ACCOUNTABILITY ARRANGEMENTS IN THE HPSS

(8) Describe the accountability arrangements in the HPSS in the period between 1995 and 2003. In particular, describe the Department's role and functions in those arrangements.

During the period 1995-1997 (when I was the Chief Executive) the Accountability Arrangements were set out in circular MELT 2/93 (IRN 7). Para 4 of the circular describes the overall accountability arrangements for HSS Trusts, covering their relationships to the general public, purchasers and the ME – the latter as part of the Department. The circular described the primary accountability of trusts to purchasers "for the quantity, quality and efficiency of the services". This reflected the government's policy that responsibility should be decentralised. In regard to the Department's role and functions in these arrangements, HPSS Trusts were to be held accountable to the ME "for the performance of their functions, including the delivery of objectives and targets set out in the Strategic Direction and Annual Business Plans. They will also be required to meet their statutory financial obligations and conform with any other specific requirements placed upon them, including those in the Management Plan." Para 18 of the Circular went on to set ground rules for intervention in exceptional circumstances in the affairs of a trust by the ME including "items of concern relating to patient or client care". (I do not recall any such intervention during my time as Chief Executive.)

(9) Describe the specific arrangements by which the Royal Group of Hospitals HSS Trust was held accountable for the discharge of its functions in the period 1995-2003. In particular:

(a) Were you personally involved in holding the Trust to account? If so, please answer the following:

(i) Describe your involvement in holding the Trust to account.

(ii) Were issues concerning clinical care or the quality of care ever raised by or with the Trust in the course of holding the Trust to account? Please give details and examples.

Para 4.ii of Circular MELT 2/93 (IRN7) specified that the "primary accountability of trusts for the quantity, quality, and efficiency of the services they provide will be to their purchasers". I was not therefore "personally involved" in holding the Trust to account. I believe this would have been impractical given the number of Trusts. Instead, on behalf of the ME, I held the Boards as purchasers to account for the discharge of their responsibilities, including the accountability of trusts to them.

(10) 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.

I believe that Trusts had an overall responsibility for clinical care prior to the coming into operation of the statutory duty of quality in 2003. I believe that duty would have been discharged by ensuring that there were effective arrangements in place for regular monitoring of clinical care through clinical audit and professional committees. It was a systems responsibility. I do not see how a non-professional, on behalf of the Trust, could be held personally accountable for clinical care, as distinct from the professional monitoring arrangements.

(b) 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?

I consider that the primary responsibility for clinical care, at least until my departure in 1997, lay with professional committees, including clinical audit committees.

(c) 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.

I am not aware at this distance of any statute, circular or direction. I believe that it was by virtue of custom and practice, reflecting the professional nature of the care provided.

(d) 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?

I believe that trusts were responsible for ensuring appropriate arrangements were in place.

(e) 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.

I am not aware of how those responsible for clinical care discharged their responsibilities, except through professional committees.

(f) 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?

I imagine that the purpose of the duty of quality was intended to give statutory effect to custom and practice.

(11) 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.

I agree that accountability ultimately rested with the Department, led by the ME during my time as Chief Executive.

(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.

The Department held Trusts to account primarily through the purchasers.

(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 Chief Executive to enable you personally and/or the Department to know what was going on in the HPSS and of issues affecting the HPSS.

The primary mechanism for knowing what was going on in the HPSS was through the purchaser link.

(12) Please find the Management Executive's "HPSS Management Plan 1995/96 – 1997/98" attached . At page 13 states:

"Providers need to continue to focus on improvement in standards of practice. The service they provide should also continue to achieve the best possible outcomes for patients and clients within the available resources, which necessitates a strategy aimed at sustaining a process of continuing quality improvement. Specifically, units should ensure that there is a clear policy on:

- *Clinical audit as part of a programme to improve all aspects of service quality, not just clinical outcomes*
- *Support and evaluation of quality improvement programmes; and*
- *Multi-disciplinary approaches to the development of best practice in service delivery"*

(a) What was done by the Management Executive / the Department to see that the above was done? How were providers monitored or held to account?

The Management Executive relied on the purchasers to ensure that these arrangements were in place.

(b) What progress was made in the area of clinical audit?

I do not know.

ADDITIONAL QUERIES

(13) How and when did you first become aware of the deaths of:

(a) Adam Strain

(b) Claire Roberts

(c) Raychel Ferguson

(d) Lucy Crawford

I do not recall details of any of these deaths before receiving papers from the Inquiry.

(14) Were you / the Department informed of the statement produced by the RBHSC following the Inquest of Adam Strain? **[Ref: 011-014-107a]** If not, would you have expected to have been so informed?

I was not informed. I left the Department in 1997.

(15) What was the system in place in Northern Ireland at the time of Adam Strain's death in 1995 for reporting untoward deaths to the DHSSPS and disseminating information on the outcomes of Coroners' Inquests within the Health Service?

I do not know.

(16) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (11) above and in ensuring that lessons learned would be fed into teaching / training and the care of patients?

I do not know.

(17) What procedures existed in 1995 to ensure the fulfilling of roles relating to the reporting, analysing, disseminating of information from a Coroner's Inquest or untoward death and to ensure that lessons would be learned?

I do not know. However, I would expect the Department's medical staff to have ensured the appropriate dissemination of information to front line medical staff, not least in regard to lessons learned.

(18) Explain in detail the relevant Policies, Guidelines, Protocols and Codes of Practice issued by the DHSSPS from 1995 to 2001 relating to the handling of complaints within the Health Service in Northern Ireland, including those by medical or nursing staff.

I do not have access to these documents.

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

Policies etc were disseminated primarily by means of circulars. There may have also been a mechanism for disseminating professional information of various kinds through medical channels from the Department.

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

Implementation was monitored through the accountability arrangements described earlier.

(21) 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?

Formal channels of communication existed through the accountability arrangements. Informal channels also existed, including through professional contacts and medical advisory committees in the Department.

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

The Department had wide circulation lists for its communications with the HPSS.

(23) Why was a formal approach not adopted for adverse incident reporting prior to 2002?

I do not know.

(24) Prior to 2002, what would you have expected Trusts / Hospitals to have done (if anything) in regard to informing the Department when cases involving deaths due to possible medical mismanagement were involved in:

(a) Formal complaint procedures

(b) Coroner's Inquests

(c) Medical negligence actions

I would have expected the Department to be informed directly, also through the accountability arrangements and through medical channels.

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

Signed: **John Hunter** **Dated:30th September**

30th September 2013