Witness Statement Ref. No. 361/1	361/1

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: Brian Grzymek

Title: Mr

Present position and institution:

Deputy Director Reducing Offending, Department of Justice

Previous position(s) and institution(s):
[in 1995, 1996, 2000, 2001, and 2003 respectively]

Director Secondary Care and Performance Review, DHSS (1995-1999)
Director Secondary Care, DHSSPS (December 1999 – October 2002)
Deputy Director Criminal Justice Services, NIO (November 2002 – May 2010)

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since 1995]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all of those since 1995]

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, QUALIFICATIONS AND EXPERIENCE

(1) From organisation charts provided to the Inquiry by the Department of Health, Social Services and Public Safety ("the Department"), **[Ref: 323-027e-013 , 323-027f-040 and 323-027h-017]**, it appears that you were head of the Secondary Care Directorate of the Department for a period before August 2001 until after July 2002. Arising from that:

(a) State the dates on which:

(i) You became head of the Secondary Care Directorate

2 December 1999.

(ii) You ceased to hold that post.

1 November 2002.

(b) Provide your job description and detail the duties and responsibilities of that post. If the duties/responsibilities changed when you were in the post, please give details of the changes and when they occurred.

I have no personal record of the job description related to that post, and DHSSPS has been unable to locate a copy. My main duties were to provide strategic and policy input into the development and maintenance of the hospital service in Northern Ireland. I led work on the drafting of Northern Ireland's acute hospital strategy 'Delivering Better Services' led a number of major reviews and promoted specific regional initiatives relating to specialist services. I also led work on some resolving some cross-Trust issues – ensuring that the hospital service acted as a system rather than as a group of separate providers. I had no direct accountability functions relating to hospitals or hospital Trusts and was not engaged directly in clinical matters.

(c) Explain to what extent was your Directorate responsible for any of the following policies, or implementation or oversight of:

(i) quality of care in hospitals

(ii) patient safety in hospitals

(iii) clinical audit in hospitals

(iv) clinical complaints in hospitals

(v) clinical adverse incident reporting in hospitals

(vi) clinical governance in hospitals.

The strategic aspects of my Directorate's work related to the refocusing of acute hospital services into a smaller number of acute hospitals with Consultant delivered services. To that extent its aim was to make a significant contribution to (i) and (ii) both of which were adversely affected by the dispersed hospital model which Northern Ireland had maintained since the establishment of the NHS. However, my Directorate had no direct responsibility for (i) or (ii). My Directorate had no responsibilities for (iii) – (vi).

(d) Explain to what extent was your Directorate responsible for holding Trusts to account for any of the matters listed above.

My Directorate held no responsibility for holding Trusts to account on any of the matters listed above

(e) If your Directorate was responsible for any of the matters listed above, please give details of the actions taken by you personally, and your Directorate, in carrying out that responsibility.

N/A.

(f) Identify to whom were you accountable in carrying out the duties of the post.

To my Grade 3, Paul Simpson, the Permanent Secretary, Clive Gowdy, and to the Minister, Bairbre de Brun.

(2) The organisation chart at **Ref: 323-027f-040** identifies two units within your Directorate, *"Regional Policy"* and *"Services Development"*. Within the *"Service Delivery"* heading are included the following functions:

"Service Delivery

Hospital Prescribing

CREST Reports

SAC Liaison

Paediatric Services

Intensive Care..."

Arising from this please answer the following:

(a) Describe the objectives, duties responsibilities and activities of your Directorate for each of the matters listed above.

The 'Service Delivery' aspect of my Directorate's work covered a wide range of areas where the Branch in question sought to keep informed regarding national and regional developments and to determine whether there was a need to commission a policy review to cover that area. It would have received a number of SAC reports on that basis. Issues such as paediatric services and intensive care also fed into wider strategic work on an acute hospital strategy. The areas of interest listed tended to change fairly regularly as different national initiatives came and went.

(b) Who was responsible within your Directorate for these matters?

As Director I had overall responsibility with Branch responsibility falling to whoever was the Branch head at that time.

(3) Describe your career history prior to becoming head of the Secondary Care Directorate. In particular:

(a) Give full details of the duties, responsibilities, and accountability of any posts held by you in the Department from 1995.

From 1995 until December 1999 I was Director of the Secondary Care and Performance Review Directorate. As such I had strategic responsibility for acute hospital policy and led work in addressing a number of regional issues such as the management of waiting lists, winter pressures and the development of regional cancer services. In this post I was accountable to my Grade 3, Paul Simpson, the Permanent Secretary, Alan Elliott (and then Clive Gowdy) and a succession of Direct Rule Health Ministers

(4) Describe your career history since you ceased to hold the post of head of the Planning and Performance Management Directorate, stating the posts held and the dates between which the posts were held.

From 3 November 2002 to 11 May 2010 I was Deputy Director Criminal Justice Services in the Northern Ireland Office. From 12 May 2010 to the present I have been Deputy Director Reducing Offending in the Department of Justice.

(5) State any relevant qualifications which you hold and the date(s) on which you obtained them.

I have an MSc in Applied Social Research, gained in 1984

KNOWLEDGE OF THE DEATHS OF THE CHILDREN

(6) State when and how you became aware of the deaths of:

(a) Adam Strain

(b) Claire Roberts

(c) Lucy Crawford

(d) Raychel Ferguson.

I only became aware of the names of the deceased on receipt of the correspondence related to this witness statement.

State what action, if any, you took when you became aware of each death

None. I only became aware of Hyponatraemia and the fact that there were deaths some time after transferring to the NIO and no action was appropriate.

(7) Would you have expected, as head of the Secondary Care Directorate, to be made aware of serious adverse incidents such as the deaths of these children?

Serious adverse incidents were not reported to my Directorate. I would have expected them to have been raised with professional colleagues for investigation and action if a clear pattern was established.

(8) What would you have done if you had been made aware of any of the deaths as a serious adverse incident?

I would have alerted professional colleagues who would have investigated the circumstances of such serious adverse incidents.

(9) Would you have expected, in the period 1995-2003 that serious adverse incidents, such as the deaths of these children would be reported to the Department?

Yes

(a) If so, to whom in the Department?

To Medical and Allied Services

(b) If so, what action if any would you have expected the Department to take?

It would depend on what they found. If the deaths were caused by some breakdown in a procedure, I would have expected them to get to the bottom of the problem and to issue urgent guidance: to alert clinical staff and to offer advice.

(10) 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].** If so`

(a) What action would you have expected the Department to take?

Yes and, if received, **I** would have expected this to have been promulgated to other hospitals probably by Medical and Allied Services.

(11) Were you aware of the establishment of the Hyponatraemia Working Group?

Not until some time after leaving DHSSPS.

(a) If so, please give details of when, how and for what purpose you became aware.

(b) Please state what you considered to be the purpose of the establishment of the Working Group.

To get to the bottom of any systems failures relating to these deaths and their subsequent reporting and to establish why a pattern of deaths was not detected and acted upon.

MONITORING AND ACCOUNTABILITY ARRANGEMENTS IN THE HPSS

(12) Describe the accountability arrangements in the HPSS in the period between 1995 and 2003. In particular, describe your role and functions, if any, in those arrangements.

Accountability arrangements were focused on two areas: Trust accountability, mainly focused on their effective use of resources; and clinical governance, a developing area which related to professional accountability. I had no direct accountability responsibilities but would advise the relevant colleague if I came across any issues or concerns in my dealings with hospitals and Trust senior management.

(13) Were you personally or your Directorate, involved in monitoring the performance of the Royal Group of Hospitals Trust and /or holding the Trust to account? If so:

No.

(a) Describe your/your Directorate's involvement in monitoring the performance of the Trust or holding the Trust to account.

(b) Were issues concerning patient safety, clinical care or the quality of care raised by or with the Trust in the course of monitoring the performance of the Trust or holding the Trust to account? If so:

(i) Please provide details and examples.

(ii) What action was taken by the Department?

(c) Were issues concerning the deaths of any of the children who are the subject of this Inquiry raised by or with the Trust in the course of monitoring the performance of the Trust or holding the Trust to account? If so:

(i) Please provide details and examples.

(ii) What action was taken by the Department?

(14) Were you personally or your Directorate involved in monitoring the performance of the Altnagelvin Hospital Trust or holding the Trust to account? If so:#

No.

(a) Describe your/your Directorate's involvement in monitoring and holding the Trust to account.

(b) Were issues concerning patient safety, clinical care or the quality of care raised by or with the Trust in the course of holding the Trust to account or monitoring the Trust's performance? If so:

(i) Please provide details and examples.

(ii) What action was taken by the Department?

(c) Were issues concerning the death of Raychel ever raised by or with the Trust in the course of holding the Trust to account? If so:

(i) Please provide details and examples.

(ii) What action was taken by the Department?

(15) Were you personally or your Directorate involved in monitoring the performance of the Sperrin Lakeland Trust? If so:

No.

(a) Describe your/your Directorate's involvement.

(b) Describe the specific arrangements by which the performance of the Sperrin Lakeland trust were monitored by the Department and by which the Department held the Trust accountable for the discharge of its functions.

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

(d) Where did those meetings take place?

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

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

(g) Were the meetings minuted?

(h) 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.

(i) Were issues concerning clinical care or patient safety ever raised by the Trust or discussed with the Trust either within or outside the formal accountability meetings? If so:

(i) Please provide details and examples.

(ii) What action did the Department take?

(j) 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) Lucy Crawford's death.

(ii) 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]**

(iii) 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]**

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

(v) 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]**

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

(k) 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 above? Please give reasons for your answer.

(16) Describe what arrangements were in place in the period between 1995 and 2003 to enable you personally and/or the Department to know what was going on in HPSS hospitals and of issues affecting HPSS hospitals.

A number of senior staff in the Department engaged regularly with the hospitals and hospital Trusts. I understand that there were accountability meetings with the Trusts on a regular basis. As the official with responsibility for the acute hospital strategy I would visit hospitals on a regular basis and discuss areas of concern such as winter pressures, waiting lists, the sustaining of acute services in small hospitals – talking to senior administrators and consultants. I also met the four Health and Social Care Councils on a regular basis and took receipt of patient/family concerns and issues where these were reported.

(17) Paragraph 18 of METL 2/93 **[Ref: 323-001a-007]** under the heading *"Ground Rules For Intervention"* states, so far as relevant, as follows:

"Intervention by the ME in the affairs of a trust should be exceptional, in line with the principles of maximum delegation. It may be judged necessary in certain circumstances eg-

Items of concern relating to patient safety or client care;..."(a number of other examples of circumstances in which intervention may be judged necessary is also provided)

Arising from this:

(a) What arrangements did the Department have to become aware of *"items of concern relating to patient safety or client care"* in the period 1995 -2003?

Accountability arrangements, where a major issue was involved, and otherwise SAC and other meetings with Medical and Allied; meetings between Trust staff and senior DHSS officials; correspondence; and direct feedback from patients and the Health and Social; Care Councils.

(b) How did the Department expect to become aware of *"items of concern relating to patient safety"* in the period 1995-2003?

As above.

CLINICAL GOVERNANCE/QUALITY OF CARE

(18) Detail the actions taken by the Department between 1995 and 2003:

(a) To encourage or require trusts-

(i) To manage and improve the quality of care which they provided.

(ii) To implement and improve clinical governance.

(iii) To implement and improve clinical audit

(iv) To implement and improve systems for dealing with complaints

Where system failures were identified the Department developed and ensured the implementation of policy to manage the problem and resolve it. In areas such as winter pressures, waiting lists reduction, cancer services and 'trolley waits' the DHSS's role in identifying regional problems and finding solutions contributed to managing and improving patient care. I was not involved in implementing and improving services relating to (iii) – (iv).

(b) To satisfy itself as to the steps taken by trusts to progress the matters at (a).

As above.

(19) Departmental Circular PRSC (PR) 2/99 beginning at **Ref: WS-066/1 page 105,** issued under cover of a letter signed by you **[WS-066/1 page 106]** states at paragraph 6.1 **[Ref: WS-066/1 page 119]**;

"Promoting Quality: a Framework for the HPSS" which is due to be issued in the autumn of 1999 will provide a framework for improving the quality of health and social services. The framework will emphasise that ensuring high quality services is everyone's business. It will build on existing good practice and set out the action to be taken the action to be taken throughout the HPSS to help fulfil the Government's objective that everyone has fair access to effective prompt high quality health and social services." Arising from this please answer the following:

(a) Was *"Promoting Quality: a Framework for the HPSS"* issued in autumn 1999 or at all?

I don't know. My recollection is that this was a Northern Ireland version of a national initiative which was under development in 1999. However, with the start of devolution, the Assembly Minister was keen to promote local solutions and a number of national initiatives were set aside. Responsibility for that part of my previous Directorate was reassigned at devolution and I have no recollection of ever seeing a published Quality Framework.

(b) If it was not issued, what were the reasons for that?

See above.

(c) Can you provide a copy of this document, or any drafts thereof to the Inquiry.

No.

(d) What steps did the Department take to emphasise that *"high quality services is everyone's business?*

This was implicit in everything that we did in that period.

(e) What did the *"existing good practice"* refer to?

Those practices currently operating in Northern Ireland which had demonstrated their quality, effectiveness and value.

(f) When did the Government in Northern Ireland first set the objective that *"everyone has fair access to effective prompt high quality health and social services"?*

I think that this was a read across from national government objectives at that time.

(20) Were there communications between you and your Directorate and the Chief Medical Officer and her team, or the Chief Nursing Officer and her team about the performance of trusts in any of the following matters:

(a) Patient safety and care;

(b) Quality of care;

(c) Clinical governance;

(d) Patient complaints;

(e) Clinical audit.

I do not recall communicating with the CMO, CNO, or their respective teams, on Trust performance relating to any of these matters. I would, of course, have discussed regional aspects of (a) and (b) in working with professional colleagues on the development of the new hospital strategy and in progressing some regional acute hospital initiatives.

(21) If there were communications of the kind mentioned:

N/A.

(a) Please give examples of the matters which were the subject of the communications.

(b) Were there established systems/forums in the Department for such communications.

ADDITIONAL QUERIES

(22) Between 1995 and 2003, what policies were there for the dissemination of guidelines / protocols from the Department down to Boards / Trusts?

The Department issued Circulars, Circular Letters, 'Dear Doctor' letters and very occasional Directions. I was not directly involved in the dissemination policy.

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

My recollection was that this was undertaken by the issuing authority with the degree of monitoring etc. dependant on the type of guidance and other factors.

(24) 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?

See above.

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

See above.

(26) What do you consider to have been the main impetus behind the creation of a formal adverse incident reporting system from 2002?

I am not aware of this system and any answer would be speculative.

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

I assume it was because the existing arrangements were considered adequate at the time.

(28) 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 Trusts/hospitals to have put patient safety first and raised matters with the Department where a system or practice failure was identified at any stage which could recur elsewhere to the detriment of patients.

(29) Mr. Clive Gowdy, former Permanent Secretary, DHSSPS, stated in his Inquiry Witness Statement **[Ref: WS-062/1, page 4]** as follows:

"In December 1998, the Department commissioned Healthcare Risk Resources International consultants to undertake a survey of risk management in all HPSS organisations. The terms of reference for the survey were to determine the level of application of risk management methods and the implementation of best risk management practices within these organisations. Incident reporting was one of the items included in the survey. [...] There was a general perception that there might have been a significant level of under-reporting of adverse incidents."

(a) Were you aware of this report and its findings? Please provide a copy of the report if you are able to do so.

No. I do not recall ever hearing of this report and have never seen a copy.

(b) What was done as a result of the report's finding that *"there might have been a significant level of under-reporting of adverse incidents"*?

I am unclear as to the precise context of this quote or the source and accuracy of this 'general perception'. I am not aware of the report being disseminated or of any action relating to this finding.

(30) Provide any further points and comments that you wish to make, together with any relevant documents.

This was a very sad series of deaths, the pattern of which appears not to have been appreciated at the time. I have no further comments or documents which could helpmteh Inquiry in its work.

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

Signed: Brian Gygnek, **Dated: 30 September 2013**