Doctor Eddie Rooney
Chief Executive
Public Health Agency
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Our Ref: JOH-0443-14

Date: 3rd April 2014

Dear Dr Rooney,

I enclose for your attention copy correspondence which I have recently sent to the DHSSPS, HSC Board, RQIA and Belfast Trust. I would be grateful for any contribution you can make to the queries I have raised therein. In addition it would be helpful if you would clarify the following additional matters:

1. What is the relationship, if any, between the NI Safety Forum and the Public Health Agency (PHA)?

2. When, why and how was the NI Safety Forum established?

3. What role does the PHA have (if any) in reporting, management and investigation of SAIs?

4. Do child death review panels exist here?

5. Is there an established system of paediatric early warning scores used in clinical practice in NI?

6. What does the PHA's Safety Quality Alerts Team do?

I would be grateful for your response within 10 days.

Yours faithfully,

pp J. O'Hara

JOHN O'HARA

Mr Colm Donaghy
Chief Executive
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Our Ref: JOH-0442-14

Date: 27th March 2013

Dear Mr Donaghy,

In finalising my report to the Minister, I have considered at length the papers which were helpfully provided to the Inquiry by all of the bodies whose representatives gave evidence at the public hearings in week commencing 11 November 2013. It is apparent that a lot of important work has been and is being undertaken across the health service with a view to improving the service, learning from developments elsewhere and responding to experiences generally as well as adverse incidents.

I have a number of significant concerns about aspects of the information which I received and which were developed at oral hearings in the week of the 11th November 2013. I would like to develop these concerns in correspondence to ensure that I have not misunderstood the current arrangements or what happens in practice. Accordingly, it would be helpful for your organisation to respond to my initial points of concern to the maximum possible extent:

1. I have seen repeated references to the HSCB and the PHA working in conjunction with each other. This has led me to look at the 2009 Act and the responsibilities of these bodies. Given the duties imposed on the HSCB, I am currently struggling to understand why it is that its members appear to include no clinicians or nurses. Am I correct in understanding that its medically qualified members are restricted to two practising (or retired?) general practitioners? What is the role of Dr Caroline Harper and Ms Mary Hinds, both employees of

the Public Health Agency, in the HSC Board? Why has that structure been developed?

2. Was thought ever given to the HSCB having a medical director and/or a director of clinical governance and/or a director of quality and patient safety? If so, for what reason was no such appointment made? Is that a decision which might be reconsidered given the over-arching role of the HSCB over all Trusts?

3. The support of the PHA and associated bodies such as the Northern Ireland Safety Forum seems to be essential for the HSCB to perform its clinical governance work. Is there not a confusion in the arrangements which have resulted in the HSCB being reliant on the PHA and not having a director or directors with specific responsibilities such as those suggested in the preceding paragraph?

4. Among the documents helpfully provided to the Inquiry, was the June 2013 "Learning Report – Serious Adverse Incidents" prepared by the HSCB and the PHA. While this is undoubtedly a helpful contribution, it does not address a more fundamental and worrying point, namely, whether there is any consistency in identifying and categorising adverse incidents. It seems to me that such categorisation is fundamental to any analysis of what has been happening across Northern Ireland and what might be improved upon in the future. Let me illustrate the point in this way:-

   Under cover letter of 11th November 2013 from Mr Fergal Bradley, the Inquiry received a table which listed incidents in detail across the five Trusts for the period from 1 April 2012 to 31 March 2013 (Ref: 323-037f, copy attached). My understanding is that the Ulster Hospital falls within the South Eastern Trust while the Royal, City and Mater Hospitals fall within the Belfast Trust. Taking only these two Trusts by way of example, I see that:

- Under the heading "administration and management", the South Eastern Trust has recorded 73 incidents while the Belfast Trust recorded none – under the heading "diagnosis", the South Eastern Trust reported no incidents while the Belfast Trust reported 13 (and the Southern Trust reported 30).

- Under the heading "conveyance", the South Eastern Trust reported 127 incidents, while no other Trust reported a single one.

- Under the heading "labour or delivery" – the South Eastern Trust reported 419 incidents, more than the Belfast Trust at 410.

- Under the heading "treatment and intervention", the South Eastern Trust reported 778 incidents while no other Trust reported any.

There are various other examples in the figures, but the key point should be obvious – how reliable is the adverse incident reporting system when there are such gross variations in categorisation? To whom in the Department are such figures reported; are they capable of meaningful analysis and if not what is the Department's response to such potential adequacies? Surely this must make it infinitely more difficult to identify trends and to learn from incidents which have occurred? Therefore what is the value of the current arrangements? Who is responsible for identifying inadequacies in the SAI system and taking forward effective programmes for change? What steps are being taken to ensure uniformity of reporting and implementation of a unified system involving consistent centralised reporting across all Trusts?

5. I remain unclear about just how much input patients/families necessarily have into serious adverse incident reviews. You will realise that this was an issue in 2000 after Lucy Crawford's death when a review was conducted by Sperrin Lakeland Trust without her family knowing anything about it until after it had been completed. In 2001, some appropriate responses to Raychel Ferguson's death in Altnagelvin were withheld from her family, much to their frustration and distress when they found out about them after the event. While there are some references in the current procedures to involvement of patients/families, I do not see anything in them which makes such involvement mandatory. Is there, in fact, a clear requirement to that effect?

I am copying this letter to every HSC body who potentially has responsibility in these areas in order that I obtain a clear and complete picture. I would be grateful for your responses to the issues raised in this letter within 10 days.

Thank you for your continuing assistance with the Inquiry.

Yours faithfully,

JOHN O'HARA

CC:
Mr Glen Houston, RQIA
Dr Andrew McCormick, DHSSPS
Ms Fionnuala McAndrew, Health & Social Care Board