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# DUTY OF CANDOUR & BEING OPEN – DRAFT POLICY PROPOSALS FOR CONSULTATION

## Summary

In January 2018, Justice John O'Hara published his report on the Inquiry into Hyponatraemia-Related Deaths (IHRD). His first recommendation was that a statutory Duty of Candour should be enacted in Northern Ireland and that it should apply to Healthcare Organisations and everyone working for them. Justice O'Hara also recommended that criminal liability should attach to breach of this duty and to obstruction of another in the performance of this duty. He made further recommendations about the guidance, support and protection that should be provided for staff in order to create a more open culture.

In response, the Department of Health (DoH) established an Implementation Programme to take forward the recommendations arising from the Inquiry and the Duty of Candour Workstream, and its Being Open subgroup, have been responsible for developing the proposal options to address the recommendations on candour.

Through a co-production process, the Worksream and Subgroup have developed policy options for the statutory Duty of Candour and the policy framework for Being Open guidance, taking account of: research commissioned and evidence submitted; feedback from staff and service users; and input from other key stakeholders.

The DoH is now seeking your views on the following proposals developed by the Workstream and Subgroup:

a. Policy options for the statutory organisational Duty of Candour; and

b. Policy options for the statutory individual Duty of Candour; and

c. The policy framework for Being Open guidance.

A detailed summary of these proposals is available here on the DoH website.

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**Ways to respond**

The consultation opened on 12 April 2021 and will close on 2 August 2021. Stakeholders can respond by completing this questionnaire, or by submitting their own written response, to the policy proposals to:

**E-mail:** **IHRD.implementation@health-ni.gov.uk**

**Written:** IHRD Implementation
Department of Health
Room D1
Castle Buildings
Stormont Estate, BELFAST
BT4 3SQ

In addition, an online questionnaire is available on the Citizen Space website here, which allows stakeholders the opportunity to respond to the consultation questions online.

If, for any reason, you are unable to access the electronic versions of the documents you can request a paper copy by e-mailing IHRD.implementation@health-ni.gov.uk or by writing to the address below. The consultation documents, including the questionnaire, may also be requested in an alternative format by also contacting this address.

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**Terminology (paragraphs 2.25 – 2.27)**

1. Do you agree with the terminology and definitions adopted by the Workstream in respect of “openness” and “candour”? If yes, please provide any additional information and / or insights.

I do not agree with the use of the word 'openness' as this is not sufficiently comprehensive. It is too nebulous and carries much subjectivity. It can be applied in a manner to escape responsibility. It does not encompass the need for the 'totality of the truth' but rather an approximation of its elements.

'Candour' is a standalone term, easily understood by most parties. It adequately covers the parameters for this discourse.

2. If not, do you suggest a preferred terminology that should be used to describe this policy and the statutory duty? Please provide evidence to support any alternative proposal.

In place of 'openness', may I suggest ' a duty to total truthfulness'?

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**Statutory Organisational Duty of Candour (Section 3)**

Scope (paragraph 3.8 – 3.9)

3. Do you agree with the proposed scope of the statutory organisational Duty of Candour? If yes, please provide any additional information.

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| No. |

4. If not, do you have a preferred approach for the scope of the statutory organisational Duty of Candour? For example, should the scope be limited to regulated organisations that directly provide health and social care services? Please provide evidence to support any alternative proposal.

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| To date, sanctions imposed by 2015 legislation in England and Wales, and most recently in Scotland have had a no registerable impact on the behavior of clinicians and administrators within any NHS organizations.<br><br>Had substantial sanctions been imposed they could easily have been sustained by the large hospital trust (or other) with their apparently bottomless pockets and without impact on the senior administrative and clinical personnel. |

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Routine Requirements (paragraphs 3.10 – 3.11)

5. Do you agree with the routine requirements of the statutory organisational Duty of Candour? If yes, please provide any additional information.

I agree that a statutory duty of candour needs to be imposed on NHS organisations but, in itself, this will not be sufficient as it will rarely be invoked and easily evaded or minimised.

6. If not, do you have a preferred approach for the routine requirements of the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

It should be on the statutes but should not be considered as the main relief for the mischief in this context.

Only a statutory liability for individual errant clinicians is sufficient to act as the ultimate deterrent.

Requirements – When Care Goes Wrong (paragraphs 3.12 – 3.18)

7. Do you agree with the proposed definition for the significant harm threshold for the Duty of Candour procedure? If yes, please provide any additional information.

I agree with these definitions of

* serious harm

*moderate harm

*prolonged psychological harm

But in addition, I wish to introduce a term more often used by philosophers

* epistemic injustice

which attempts to describe the strong enduring reaction of patients or relatives to having been deliberately deprived of the truth by clinicians.

8. If not, do you have a preferred definition for the significant harm threshold for the Duty of Candour procedure? Please provide evidence to support any alternative proposal.

Most patients or relatives are willing to accept that clinicians will make mistakes from time to time and will accept that so long as such acts or omissions were accidental.

But the situation which they will not accept is when their doctor deliberately lies to them, in order to conceal information that the doctors already have in their possession, in an effort to protect their reputations. This is viewed by them as deception and can launch families on years of pursuit of the truth, at a huge financial and psychological cost to them. This inevitably draws down a large cost in time and from the clinicians and organisation administrations.

Statutory Duty of Candour Procedure (paragraphs 3.19 – 3.23)

9. Do you agree with the proposed requirements under the statutory organisational Duty of Candour when things go wrong? If yes, please provide any additional information or insights.

Inevitably, there will be events outside these parameters of a 'notifiable incident', when harm is caused and these thresholds are not triggered in such a formulaic manner.

The process should be available for such 'atypical incidents'. which are outside the above recognised categories.

10. If not, do you have a preferred approach for the requirements under the statutory organisational Duty of Candour when things go wrong? Please provide evidence to support any alternative proposal.

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| Any such process should attempt to furnish the inquiring relative or patient with the totality of information already available to the treating clinicians. Any offer of a preliminary investigation should be carried out by independent clinicians in a manner so as not to give the appearance of any conflict of interests. |

Apologies (paragraphs 3.24 – 3.26)

11. Do you agree with the proposed legislative requirement to provide an apology as part of the Duty of Candour procedure? If yes, please provide any additional information or insights.

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| An apology is a minimum requirement. Without it, contrition cannot begin. But often it is delivered in a manner that 'rings hallow' when it can do more harm than good. |

12. If not, do you have a preferred policy approach in respect of apologies in circumstances where the threshold for the Duty of Candour procedure has been met? Please provide any evidence to support any alternative proposal.

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| Clinicians have long been told by their lawyers and litigation officers that an apology does not necessarily confer liability. In a sense, they are already in the routine of delivering an apology at some stage of an inquiry. The legislators should not consider the inclusion of an apology in the statute as being ground-breaking, in any sense, but rather it is recognition of an existing practice. |

13. Do you agree with the proposals in respect of apologies under the statutory organisational Duty of Candour? If yes, please provide any additional information or insights.

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| Any statement of apology should not automatically carry some special indemnification. If the intention behind issuing an apology is a genuine act of contrition, it should contain admissions of liability at an early stage, where applicable. An apology should not be used to evade or delay the responsibility of liability. |

14. If not, do you have a preferred approach for the proposals in respect of apologies under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

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| Any statement of apology should not automatically carry some special indemnification. If the intention behind issuing an apology is a genuine act of contrition, it should contain admissions of liability at an early stage, where applicable. An apology should not be used to evade or delay the responsibility of liability. |

<u>Support and protection for staff (paragraphs 3.27 – 3.28)</u>

15. Do you agree with the proposals for support for staff under the statutory organisational Duty of Candour? If yes, please provide any additional information or insights.

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| Staff members require entirely new training that will encourage each individual clinician and administrator to present the totality of information they have available to an appropriate inquiry. Their professional Duty of Candour as set out by the General Medical Council in 'Good Medical Practice' should dictate their conscience and they should not allow themselves to be deflected from this position by advice coming from legal advisors if it conflicts. |

16. If not, do you have a preferred approach for the support for staff under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

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| So long as any putative support system is centred on truth-telling and not escaping liability or reputational harm, it will be acceptable. |

Reporting and monitoring (paragraphs 3.29 – 3.32)

17. Do you agree with the proposed reporting and monitoring requirements under the statutory organisational Duty of Candour? If yes, please provide any additional information.

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| Agreed |

18. If not, do you have a preferred approach for the reporting and monitoring requirements under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

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| n/a |

Criminal sanctions for breach (paragraphs 3.33 – 3.40)

19. Do you agree with the proposed criminal sanctions for breach of the statutory organisational Duty of Candour? If yes, please provide any additional information.

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| I agree, in so far as statutory organisations are concerned but continue to assert that this alone is insufficient. Individual liability must be explicit with any new statute. |

20. If not, do you have a preferred approach for the criminal sanctions for breach of the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

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| Criminal sanctions should be reserved for the most egregious acts or omissions perpetrated by individual clinicians. Otherwise, those rare wrong-doers escape their responsibilities. |

Obstruction offence (paragraphs 3.41 – 3.42)

21. Do you agree with the proposed obstruction offence under the statutory organisational Duty of Candour? If yes, please provide any additional information.

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| Yes but individual clinicians who have proven guilty of deliberate and serious wrong-doing must also attract penalties in rare cases. |

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22. If not, do you have a preferred approach for the obstruction offence under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

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| n/a |

Additional feedback

23. Is there any additional evidence, or observations that you wish to provide in respect of the policy proposals for the statutory organisational Duty of Candour?

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| There is no evidence that any legislation in England, Wales, and Scotland has produced the desired effect on NHS organisations within those jurisdictions.<br><br>It is clear from the very structure of this consultation document, so far, that collectively the Workstream Group are determined to push through an agenda of applying a statutory duty of candour exclusively to NHS organisations and not to propose Sir John O'Hara's explicit recommendation of a statutory duty of candour on individual clinicians. If the Workstream gets its way, another public inquiry similar to the Hyponatraemia-related Deaths in Children Inquiry (IHRD) would have the same sad outcome as happened over the fourteen years of the IHRD (2004-2018). Nothing will have changed. |

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**Statutory Individual Duty of Candour (Section 4)**

Policy Proposal – Statutory Individual Duty of Candour with criminal sanction for breach (paragraphs 4.13 – 4.22)

24. Please provide comments on the policy proposal for the statutory individual Duty of Candour.

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| Criminal sanctions on individual doctors would be reserved for the rarest and most egregious violations of their Duty of Candour. Accidental or inadvertent mistakes should not attract such sanctions. But doctors who intentionally and repeatedly fail to provide the correct information at their disposal to the relevant enquirer should not escape legal sanctions in addition to those which exist in the civil courts. The penalty should be sufficient to draw public attention to their serious deliberate wrong-doing. |

Alternative Policy Proposals (paragraphs 4.23 – 4.35)

25. Please provide comments on the alternative policy proposals for the statutory individual Duty of Candour.

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| Without statutory sanctions for individual doctors under the criminal justice system, we will be in the same position as we are currently. There will be nothing to stop a similar sham as the IHRD in which doctors, supported by their legal teams, continued to play a game of cat-and-mouse with the truth. Three years after Sir John O'Hara delivered the final report, clinicians are still appearing before investigation determining what went wrong. Seventeen years after it started, there are still large lacunae in the truth as some of the clinicians who were present during and after the deaths of the four children, fail to furnish the families with the whole truth. |

26. If you do not agree with any of the three high-level policy proposals, do you have a preferred alternative policy approach for implementation of the recommendations relating to the statutory individual Duty of Candour? Please provide evidence to support an alternative proposal.

A statutory Duty of Candour that applies to individual doctors in the most serious of cases is a public priority in order to restore trust in the medical profession.

In addition, it gives protection to junior doctors who may otherwise be pressured to conceal information about serious errors, and who may find themselves under threat of corporate reprisals or coercion by their senior colleagues.

Furthermore, as was seen in IHRD, the doctor-lawyer nexus is central to the understanding of the impedance of information to any inquiry. The presence of a clear statute would deter all but the most fool-hardy of lawyers from advising their doctor-clients on engaging in a criminal act, as that could cost a solicitor or barrister their professional career.

Scope (paragraphs 4.36 – 4.38)

27. What is your preferred policy approach in respect of the scope of the statutory individual Duty of Candour? Please outline the reasons for your preference, and provide evidence to support your reasoning.

As the doctor/clinician is at the heart of the inquiry into an incident, as a primary witness to the actual events or to the following consequences, liability should focus on him/her.

Other members of the administation or nursing staff would testify on the basis of what has been told/written by the primary attending doctor. In other words, they may be said to be acting on hearsay with the consequent evidential difficulties for any tribunal of inquiry, diverting attention away from primary wrong-doing.

Such a course could prove to be a distraction and unnecessary. It could generate another layer of concealment to investigate.

Routine Requirements & Requirements When Care Goes Wrong (paragraphs 4.39 – 4.43)

28. Do you agree with the proposals in relation to the requirements under the statutory individual Duty of Candour? If yes, please provide reasons for your agreement.

Once again, your text is not very clear in its meaning. This is badly written.

""This is to allow case(s) where a clinical or professional judgement or other legal obligations mean candour may not be appropriate at certain times.""

You have not iterated those instances where it may not be considered appropriate and I cannot envisage any such circumstances. Please provide...

No exceptions,

29. If not, do you have a preferred approach for the requirements under the statutory individual Duty of Candour? Please provide evidence to support any alternative proposal.

No to any alternative.

Exemptions (4.44)

30. Do you have any comments to make on the case for exemptions from the requirements under the statutory individual Duty of Candour? Please provide evidence to support your position.

You have not explained your 'exemptions' so it is not possible to answer in your terms.

Sufficient to say that I am against any 'exemptions.

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Additional Feedback

31. Is there any additional feedback that you wish to provide in respect of the policy proposals for the statutory individual Duty of Candour? If so, please provide evidence to support alternative proposals, if possible.

It seems clear to me that by the way that your Workstream Group has set out their laborious text that they are unintentionally exposing their prejudice in favour of limiting a statutory Duty of Candour to organisations and not to be applied to individual doctors/clinicians. As such, your efforts lack the independence expected by the public of an agency of the Department of Health DHSS.

I have received confidential information which supports that assertion.

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**Being Open Framework (Section 5)**

Policy Proposals (paragraphs 5.1 – 5.8)

32. Do you agree with the policy proposals in respect of the Being Open Framework? If yes, please outline your reasoning.

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| yes. Self-evident as iterated. |

33. If not, do you have a preferred policy approach in respect of openness and candour in health and social care? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 1 – Service Users and Carers (paragraphs 5.9 – 5.11)

34. Do you agree with the policy proposals at Level 1 of the Being Open Framework for Service Users and Carers? If yes, please outline your reasoning.

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| Yes. it should 'hard-wire' an attitude of total openness into all exchanges of information between patients (and relatives) and their clinicians. |

35. If not, do you have a preferred policy approach in respect of Level 1 of the Being Open Framework for Service Users and Carers? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 1 – Staff (paragraphs 5.12 – 5.13)

36. Do you agree with the policy proposals at Level 1 of the Being Open Framework for Staff? If yes, please outline your reasoning.

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| I agree. Important to define such situations but also important to emphasise its global application to all situations where information is exchanged. |

37. If not, do you have a preferred policy approach in respect of Level 1 of the Being Open Framework for Staff? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 1 – Organisations (paragraphs 5.14 – 5.15)

38. Do you agree with the policy proposals at Level 1 of the Being Open Framework for Organisations? If yes, please outline your reasoning.

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| Agreed. |

39. If not, do you have a preferred policy approach in respect of Level 1 of the Being Open Framework for Organisations? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 2 – Service Users and Carers (paragraphs 5.18 – 5.19)

40. Do you agree with the policy proposals at Level 2 of the Being Open Framework for Service Users and Carers? If yes, please outline your reasoning.

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| Agreed. |

41. If not, do you have a preferred policy approach in respect of Level 2 of the Being Open Framework for Service Users and Carers? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 2 – Staff (paragraphs 5.20 – 5.21)

42. Do you agree with the policy proposals at Level 2 of the Being Open Framework for Staff? If yes, please outline your reasoning.

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| Agreed. |

43. If not, do you have a preferred policy approach in respect of Level 2 of the Being Open Framework for Staff? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 2 – Organisations (paragraphs 5.22 – 5.23)

44. Do you agree with the policy proposals at Level 2 of the Being Open Framework for Organisations? If yes, please outline your reasoning.

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| Agreed |

45. If not, do you have a preferred policy approach in respect of Level 2 of the Being Open Framework for Organisations? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 3 – Service Users and Carers (paragraphs 5.26 – 5.29)

46. Do you agree with the policy proposals at Level 3 of the Being Open Framework for Service Users and Carers? If yes, please outline your reasoning.

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| Agreed. |

47. If not, do you have a preferred policy approach in respect of Level 3 of the Being Open Framework for Service Users and Carers? Please provide evidence to support alternative policy proposals.

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| n/a |

Level 3 – Staff (paragraphs 5.30 – 5.31)

48. Do you agree with the policy proposals at Level 3 of the Being Open Framework for Staff? If yes, please outline your reasoning.

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| Agreed. |

49. If not, do you have a preferred policy approach in respect of Level 3 of the Being Open Framework for Staff? Please provide evidence to support alternative policy proposals.

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| n/a |

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Level 3 – Organisations (paragraphs 5.32 – 5.33)

50. Do you agree with the policy proposals at Level 3 of the Being Open Framework for Organisations? If yes, please outline your reasoning.

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| Agreed. |

51. If not, do you have a preferred policy approach in respect of Level 3 of the Being Open Framework for Organisations? Please provide evidence to support alternative policy proposals.

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| n/a |

Additional Feedback

52. Is there any additional feedback that you wish to provide in respect of the policy proposals for the Being Open Framework? If so, please provide evidence to support alternative proposals, if possible.

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| No |

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**Consultation & Impact Screening (Section 6)**

53. Do you have any feedback about the possible ways we could measure whether or not this policy is useful?

I must protest at the design of the consultative document. It is an almost incomprehensible mess of verbiage. When one realises that the Workstream has had at least two years to generate a response to Sir John O'Hara's unequivocal recommendations for a statutory Duty of Candour for individuals doctors, I am left with the conclusion that this confection must have been intentionally created so as to be extremely difficult to recruit participation from ordinary members of the public who are, after all, the victims of such betrayals of trust and at the heart of this proposed legislation. . The nature of this consultative document is accessible only by professionals for or on behalf of the doctors who seek to limit their legal liability. So, there is an 'inequality of arms' with a clear bias towards the status quo, or if concessions have to be seen to be given, a nominal rap on the knuckles toward an organisational duty of candour would be forthcoming.

It is a fact that the Workstream Group has failed to secure the confidence of those families at the centre of the IHRD. This must be the most damning inditement for a group purporting to search for the trust following the IHRD.

54. Do you have any feedback or suggestions about how we can engage and involve stakeholders to develop this policy and put it in place?

Your Workstream group has listened attentively to all those professional bodies that represented the doctors. Their attempts to limit individual statutory liability have been based on the self-interest of their membership. To recall the famous quote from Mandy Rice-Davies, 'They would say that, wouldn't they', Yet, your group has generously afforded them objectivity in your deliberations when they have a clear conflict of interest.

Your records will show that I had made contacts with your Workstream group, through Quintin Oliver, when it was first established. I offered to give evidence in person. I am still awaiting a reply to my offer.