Response to

‘Duty of Candour and Being Open – Policy Proposals for Consultation’

August 2021

1.0 INTRODUCTION

UNISON is the leading trade union in Northern Ireland (NI), representing over 45,000 members, and is the largest trade union in the UK with over 1.3 million members. Our membership includes public service workers in health and social care; the education and higher education services; local government; youth justice; private companies providing public services; and the community and voluntary sector. 84% of our membership in Northern Ireland are women.

UNISON represents a clear majority of healthcare workers, clinical and non-clinical, in the Health and Social Care (HSC) system. We have a duty to protect and promote their rights as workers and to act as advocates for their health, the health of their families, and public health in all dimensions of the population. All of our members are HSC users. Consequently we respond in our capacity as representatives of both service users and the health workforce. This submission is made on their behalf.

UNISON currently chairs the Health Committee of the Northern Ireland Committee of the Irish Congress of Trade Unions. We represent the Committee on the Transformation Advisory Board established to act in an advisory capacity to the Minister, and oversee the direction of reform during the programme of transformation underway in relation to health and social care.

2.0 BACKGROUND AND CONTEXT

UNISON welcomes the opportunity to respond to this public consultation on the implementation of the recommendations made by the O'Hara Inquiry report into Hyponatremia-Related Deaths (2018) (the O'Hara Inquiry).

The O'Hara Inquiry recommended the introduction of a statutory Duty of Candour for healthcare organisations and a separate Duty of Candour for all staff. Justice O'Hara also recommended that "*criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty*". Accompanying these two specific recommendations regarding the statutory duties of candour were recommendations regarding the guidance, support and protection that should be provided for staff.

UNISON, similar to other trade unions and professional bodies representing HSC staff, has significant concerns about the embedding of additional criminal liability into the organisation and delivery of health and social care services. Whilst we fully appreciate the importance of openness, transparency and accountability within health and social care, we do not believe that a duty of candour accompanied by criminal sanctions will create such a culture. We are in fact concerned that the introduction of criminal sanctions will only serve to inhibit openness and transparency, rather than creating the conditions for it to flourish. We are additionally concerned that such criminal sanctions will negatively affect workforce morale and the ability to recruit and retain staff.

In our engagement with the workstream and Departmental officials we have highlighted our concern that the introduction of an individual duty of candour with attached criminal sanctions may obscure systematic failings in the delivery of services. Workers within HSC statutory services face the daily challenge of working in services that are under-resourced and under-staffed, with thousands of vacancies across all staffing groups. These systematic frailties within our health service have gone unchecked for over a decade and have been exacerbated by the impact of the Covid-19 pandemic. This has left the workforce exhausted, overstretched and low on morale. Particular challenges are faced by those who work for private companies providing social care services, such as domiciliary care, under contractual arrangements with HSC Trusts. They work within a 'time to task' culture, where they are often expected to

deliver increasingly complex personal care within constrained periods of time, such as within 15-minute visits. In UNISON's experience the delivery of such care is under-regulated with the workforce undervalued and exploited by the system itself.

The reality faced by UNISON members working within health and social care on a daily basis emphasises why when errors occur the focus must be on system-wide learning and improvement, not a culture of blame that focuses unduly on the individual. A focus on the individual, rather than on the systematic failings that can lead to errors and mistakes in the delivery of care, will not improve outcomes in a sustained and coherent way.

The conclusions of the National Advisory Group on the Safety of Patients in England are notable in this regard. This report followed the events at Mid-Staffordshire Hospital and the Francis Inquiry and considered how patient safety could be further improved. The report states that NHS staff are not to blame and that in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems. It recommended that blame be abandoned as a tool and that there needs to be trust in the goodwill and good intentions of staff. The most important single change in the NHS it recommends would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.[1]

UNISON has made these concerns known to the Workstream and Departmental officials over the last several years as these policy proposals have been developed. In this response we will focus on specific aspects of the proposed organisational and individual duties that cause us particular concern. Notwithstanding our view that criminal sanctions should not be included within any duty of candour, we are

[1] 'A promise to learn – a commitment to act: Improving the safety of patients in England' National Advisory Group on the Safety of Patients in England, August 2013.

concerned that the proposals as currently conceived lack legal certainty in this regard and be particularly unfair on staff at all levels of health and social care services.

Rather than answer each individual question asked within the consultation document, we begin by addressing the proposals around an organisational duty of candour, including proposed duties on organisations to provide training and support for staff in implementing a duty of candour, before considering the proposals around an individual duty.

3.0 ORGANISATIONAL DUTY OF CANDOUR

UNISON is not opposed to the creation of an organisational duty of candour, but we do not support such a duty including a criminal sanction where it is adjudged to have not been properly followed. We believe that the creation of an organisational duty that does not include criminal sanctions, appropriately conceived, could support a culture of greater openness and transparency within HSC organisations, where the focus is not on blame but on learning and improvement. We do not believe such a culture will be created if such duty is accompanied by a criminal sanction. It is notable that whilst the organisational duty of candour that exists in England is accompanied by a criminal sanction for failure to notify a service user or their representative that a notifiable safety incident has occurred, Scotland and Wales do not apply a criminal sanction to their organisational duty.

UNISON entirely agrees that patients, service users and their families have a right to an apology and an explanation from an organisation providing services where things have gone wrong in the delivery of treatment or care.

It has been noted in previous Parliamentary reports into complaints and litigation within the NHS that an open culture around complaints amongst staff is essential and that attempts to improve patient safety should not focus on punishing individuals for errors, but on removing error-provoking aspects of care delivery systems. A move away from 'blame culture' where mistakes are attributed to individuals is required, as such a culture encourages covering up of incidents and a failure to learn from them.[2]

In general terms UNISON is concerned that the focus of the proposed statutory duty is punitive, rather than a focus on promoting learning and improving patient safety and experience. The need to learn and improve patient safety and experience should be at the core of a statutory duty of candour, but this cannot occur without a clear system for reporting errors or raising concerns. As we outline further below, the mechanisms by which the organisational duty of candour will operate here are underdeveloped within the consultation document, with repeated references made to how future statutory guidance will be developed.

It is further important to differentiate between mistakes and errors in the delivery of care and incidents which may amount to abuse of children and vulnerable adults, where existing and differing obligations will exist for organisations and staff around reporting such incidents and investigating them. Abuse is not limited to physical and/or sexual abuse, but can include:

- Neglect or Acts of Omission, such as withdrawing or not giving the help that a vulnerable adult needs, so causing them to suffer.
- Institutional abuse by the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use.

[2] 'Complaints and Litigation' House of Commons Health Committee Sixth Report of Session 2010 – 2012 - https://publications.parliament.uk/pa/cm201012/cmselect/cmhealth/786/786i.pdf

> Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.[3]

Where an individual working within a HSC organisation is aware of, suspects, or is concerned or worried that a person may be being abused, they should report their concerns either to the appropriate safeguarding team within their HSC Trust, the safeguarding lead within their organisation or the PSNI, with the basic advice being that if they have seen something, they should say something. In addition, some HSC staff are under professional regulatory obligations to report concerns.[4] Any such concerns must be fully and properly investigated by the organisation.

Those who are found to have caused harm due to neglect or mistreatment of children or vulnerable adults should be subject to the full range of appropriate disciplinary, civil and criminal sanctions. However we are concerned that as presently proposed, there could be some overlap between the operation of an organisational duty of candour and existing responsibilities around safeguarding which we believe could be problematic to the discharging of existing obligations.

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[3] see http://www.southerntrust.hscni.net/Safeguading.htm and http://www.setrust.hscni.net/pdf/Adult_Abuse_Guidance_for_Staff_info.pdf for further information

[4] For example, social care workers registered with NISCC are required under the Standards of Conduct and Practice for Social Care Workers to protect the rights of service users and carers, promote their interests and wellbeing and protect them as far as possible from danger or harm. The 'Raising Concerns – A Guide for Social Work and Social Care Staff on How to Raise Concerns in their Workplace' (NISCC, UNISON, NIPSA, NIASW, September 2017) states that if you do not report a concern, you may be breaking the NISCC standards, which may lead to an allegation of professional misconduct, which in turn may bring fitness to practise into question.

We have encouraged the Workstream on the duty of candour to examine any possible overlaps between the duty of candour and existing safeguarding policies and procedures across the HSC carefully. We have highlighted these issues further below.

In addition, like other organisations representing the HSC workforce we are disappointed by the lack of consideration given within the consultation document as to the effectiveness of existing processes and procedures by which concerns can be raised by staff around patient safety, such as existing 'whistleblowing' protections under the Public Interest Disclosure (Northern Ireland) Order 1998. Model policies exist across HSC Organisations in relation to whistleblowing with the aim of creating an open and just culture in which concerns can be raised and dealt with. However UNISON believes much more focused effort across HSC Trusts and all organisations providing HSC services, including across the independent sector, is required to ensure that staff are aware of when the whistleblowing protections can and cannot be deployed by them; and that they are adequately supported when raising concerns. The absence of consideration of how effective existing measures for raising concerns are and how they could be used more effectively gives the impression that the outcome of this consultation exercise is pre-determined towards implementing both an organisational and individual duty of candour.

'Unintended' or 'unexpected' incidents: In addition to what are described as ''routine'' requirements in relation to openness and transparency under a proposed organisational duty of candour, the consultation document states that in addition, there should be specific statutory requirements which would apply to organisations in circumstances ''*where an unintended or unexpected incident occurred in respect of a patient or service user during the provision of health and social care services, and significant harm has been caused.*'' These circumstances are stated to include:

(a) The unexpected or unexplained death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition; or
(b) Moderate harm, serious harm, or prolonged psychological harm to the service user.

It is unclear here why the proposals switch between stating they would apply to ''*significant harm*'' but then are widened to include ''*moderate harm*'', ''*serious harm*'' and ''*prolonged psychological harm*''. Confusingly ''*moderate harm*'' is defined to include ''*significant, but not permanent, harm*'' but ''*significant harm*'' is not defined at all. The O'Hara Inquiry recommendations used the terms ''serious harm'' and ''serious injury'', rather than ''significant harm'' or the other terms used within the proposals. Numerous differing terms have at the very least the potential to cause confusion as to what the law requires of organisations and individuals employed by them.

The duty of candour would apply here where the unintended or unexpected incident ''*has, or may have resulted in*" the harm. This is a broad scope that the consultation document states is ''*intended to bring incidents which have the potential to cause significant harm in the future within the scope of these requirements. However, "potential harm" in this context would not include near misses, which are defined as ''acts of commission or omission that could have harmed a patient but did not cause harm as a result of chance, prevention, or mitigation*.''

The potential for confusion here is also present. How will organisations assess when an incident ''may have resulted'' in harm or conversely is a ''near miss'' and who will make such an assessment, the staff involved in the incident or a third party who was not involved? If staff assess an incident as being a ''near miss'' as they reasonably believe that the unintended or unexpected incident has not and may not cause harm, but

subsequently harm occurs, will they and their organisation be held liable for breaching the duty of candour?

If harm subsequently does occur, and it is shown that the harm ''may'' have been caused either by the unintended or unexpected event, or, ''may'' have been caused by other factors such as the natural course of the patient's illness or underlying conditions, or by a combination of factors, will the duty of candour apply? If so, and organisations have not disclosed the required information, would it be fair for criminal prosecution to follow when the cause of the harm is not entirely clear?

Within the duty of candour legislation that applies in Scotland (Health (Tobacco, Nicotine etc & Care) (Scotland) Act 2016), it has been stated that the unexpected or unintended outcomes need to relate to the incident, rather than being attributable to a person's illness or condition. The decision as to whether this is the case or not should be made by a registered health professional who was not involved in the incident itself (Section 21).

In general terms, we believe that proposals around both the organisational and individual duty of candour do not recognise that the delivery of treatment or care is rarely the sole responsibility of one individual, but is rather the responsibility of a multi-disciplinary team. Where multiple individuals are involved in the treatment or care of a patient or service user, there must be clarity as to where the responsibility and authority will lie to assess whether an incident is firstly unexpected or unintended; and secondly as we have outlined above whether such an incident ''has, or may have resulted in harm''.

Notification of incident: The proposals state that if the threshold for a ''*notifiable incident*'' is met, the organization will have to comply with the duty of candour procedure. This will require them to notify the patient or a duly authorised

representative (collectively referred to as the 'relevant person') as soon as ''*reasonably practicable*'' after the organisation becomes aware that an incident, which meets the threshold for the duty of candour process, has occurred.

The consultation document states that ''*reasonably practicable*'' in other jurisdictions is defined as within 10 working days, or sooner, of the organisation becoming aware of the incident.

It appears that this notification will not need to be in writing in the first instance; the proposals state that the initial notification must be followed up with a written notification, issued by the organisation to the relevant person, which should include:

- A written summary of the full facts available to the organisation in relation to the incident at the time of the notification;
- An apology; and
- A written summary of the further action undertaken by the organisation in respect of the incident, including the outcome of any investigations or reviews.

It is not clear from the proposals whether such written notifications, if following a non-written initial notification, will be subject to the same requirement that it be transmitted within a ''*reasonably practicable*'' time.

However the consultation document does propose that any legislation drafted in respect of the duty of candour should include a provision which clarifies that an apology or other step taken in accordance with the duty of candour procedure should not, of itself, amount to an admission of negligence or a breach of a statutory duty to provide health and/or social care services. In addition, UNISON would suggest that, given the comments we make further below in relation to the interaction between the

duty of candour and any other criminal investigation and proceedings, and/or regulatory or disciplinary investigation or proceedings, this provision should be widened to state that any apology or other step taken by an organisation in accordance with the duty of candour would not be admissible in any criminal proceedings; or preferably that the duty of candour should not be applied until any criminal investigation and/or proceedings have concluded, in order to remove the risk that any statement made could prejudice an ongoing investigation.

In addition it should be provided that any such apology made under the duty of candour should not be considered as an admission for the purposes of any regulatory or disciplinary proceedings taken against an individual, given that such an apology would be required to be made by statute with an associated criminal sanction for failing to do so.

Criminal liability: In considering these proposals, both in relation to the organisational and individual duty of candour, we are concerned that it is unclear as to how any criminal liability will be established. **Whilst it is our clear view that criminal sanctions should not be attached to any organisational duty or to any individual duty that may be created, it is important that if a decision was made to take such a step there is absolute clarity for both organisations and individuals as to when criminal liability may attach, given the serious consequences that this entails.**

Whilst we understand from our engagement with the workstream that there has been some engagement with the Department of Justice (DoJ) in relation to the criminal liability and sanctions element of the duty of candour, we are concerned that the current proposals paint a confusing picture, particularly with regards to whether breach of the duty of candour will be a 'strict liability' criminal offence in relation to which no proof of fault is required; or whether at both the organisational and individual levels proof of fault will be required, through proof of either intent to commit the offence or

recklessness with regards to the commission of the offence (normally referred to within the criminal law as the *mens rea* of a criminal offence).

We note the following statements made within the consultation document that:

''*Criminal liability in this context relates to a breach of the Duty of Candour, or preventing another person from performing their Duty. It is not about penalising organisations, or people, for making mistakes; it is about holding organisations or individuals to account for their openness and honesty about a mistake when it occurs''*[5]

''Justice O'Hara recommended that the power to prosecute should apply "in cases of serial non-compliance or serious and wilful deception". Therefore, criminal prosecution for a breach of the Duty would only be pursued in the most serious cases.''[6]

This suggests that criminal prosecutions for breach of the duty of candour are only envisaged in situations where there is evidence of fault, such as the organisation or individual intentionally engaging in cases of serious and wilful deception. Alternatively, it suggests that serial non-compliance will result in prosecution, but there is no clear legal definition suggested of what would constitute such serial non-compliance. The impression that is given is that what may be considered to be more technical breaches of the duty (such as disclosing material to the relevant person shortly after the proposed 10-day period) should not result in a criminal prosecution, but no clear proposals are made as to how this will be ensured within a statutory duty of candour.

It is noteworthy that whilst the organisational duty of candour that applies in England appears to be accompanied by a strict liability offence of failing to comply with the duty, a further provision states that it is a defence to prove that all reasonable steps

[5] Para 3.33

[6] Para 3.35

and due diligence was exercised to prevent the breach of any of those regulations that has occurred (see Regulation 22(3) and (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). However, given that it appears that it is intended that prosecution for breach of the duty of candour would occur in cases of serious or wilful deception, it should be specified that breach of the duty of candour only occurs where the organisation intentionally acts in this way. This must be properly legally defined within any duty of candour legislation. This is not currently proposed which we consider to be a significant omission.[7]

Through our engagement with the workstream, we have understood that it is their intent that criminal prosecutions for breach of the duty of candour would be rare and linked to the kinds of circumstances we have outlined above. The workstream appears to have accepted that much more consideration is required in relation to how that would be articulated within any statutory duty of candour to ensure that criminal prosecutions would not follow for what would be considered technical breaches, or where reasonable steps were taken to avoid breaching the duty. **However UNISON would reiterate that we are opposed to criminal sanctions being attached to an organisational or individual duty of candour.**

Responsibility for compliance: In addition, it is further unclear where responsibility will rest within an organisation for complying with the organisational duty of candour, and how that would interact with any individual duty of candour. How will liability be established on the part of an organisation for failing to comply with the duty? Who will

[7] It is proposed that the following breaches of the statutory organisational Duty of Candour should be a criminal offence: Failure to notify the relevant person that a notifiable safety incident has occurred; Failure to provide the notification in line with the legislative requirements; Provision of a false or misleading statement to a regulator or other individual acting pursuant to the statutory Duty; or Publication of a false or misleading public statement by an organisation about its performance (para 3.36). It is noteworthy that it is not proposed in relation to any of these breaches that proof of intent to engage in a serious or wilful deception.

take responsibility within the organisation for gathering the required information and communicating this to the relevant person? Given that health and social care is frequently delivered within a multi-disciplinary team environment in order to provide the relevant information to the relevant person numerous different members of staff will need to be involved. If some members of staff involved in a notifiable incident provide the required information to their line managers or other senior staff, but others do not, or do not provide the required information within the period of what is considered reasonably practicable, can the organisation be held liable and what consequences may attach to individuals? Similarly if all relevant staff provide the necessary information, but this is not communicated to the relevant person for reasons beyond their individual control (such as administrative error or a conscious decision by the organisation to delay due to factors such as ongoing criminal investigation), what consequences would flow from that? Much greater clarity is required in relation to where responsibility for compliance with the organisational duty of candour will lie, both in terms of disseminating information and training on same to all staff, and in terms of ensuring that statutory duties are followed.

Wilful obstruction: We note that it is separately proposed that it will be an offence to wilfully obstruct another in the performance of the organizational or individual duty. It is not clear whether this offence would be applied to organisations, individuals or both. As we have highlighted above, the use of the word 'wilful' here implies that there will need to be proof that the person has intentionally engaged in conduct with the aim of obstructing another in the performance of their duty, but this is not specified within the proposals. Very little additional detail is provided here in relation to what acts would constitute wilful obstruction. As we explain further below, consideration must be given to when a delay in communicating information to the relevant person would not be seen as wilful obstruction due to other ongoing investigations into the incident.

Notification procedure and other ongoing investigations and judicial processes: It is proposed here that the organization will need to comply with the duty to notify the relevant person within 10 days of it becoming aware of the incident. This raises a number of issues that require clarification, particularly given the potential for criminal liability to attach. Firstly as we have highlighted above, an organisation may be aware of an incident, but consider it a 'near miss' as opposed to an incident that has caused, or has the potential to cause harm. Secondly, a 10 day time period from the point the organisation becomes aware of the incident may prove challenging for both organisations and individuals, particularly if any necessary investigation of an incident has not concluded.

Finally an immediate challenge that has not been sufficiently considered within these proposals is how this notification procedure will relate to those incidents which are investigated either by those responsible for safeguarding children or vulnerable adults and/or the PSNI. If an incident is being criminally investigated, but the organisation is at the same time required to follow the notification procedure (and the failure to do so could result in a criminal sanction) how will any potential conflicts or risk of prejudice to individual staff be handled?

Criminal investigations currently take precedence over regulatory investigations or a public inquiry. They also would generally take precedence over any disciplinary action by an employer. Whilst the criminal investigation is ongoing, other forms of investigation are delayed. Individuals under criminal investigation have certain rights, such as the right to be interviewed under caution and to access legal advice. Given that the essence of the police caution is that the person 'does not have to say anything' and therefore is not under an obligation to incriminate themselves, for a separate legal duty to exist that requires candour from them under the threat of criminal sanction would conflict with these fundamental rights.

Given this, UNISON would call for any duty of candour legislation to clearly provide that the duty itself and the associated notification procedure does not have to be discharged where a criminal investigation or proceedings are ongoing.

It should be noted that the DoH commissioned a 'Discussion Paper on Legal and Human Rights Issues and the Potential Impact on a Statutory Duty of Candour' (October 2018). This paper concludes that:

''*In implementing the IHRD recommendations relating to a duty of candour, particularly recommendation 1(2), the ability of HSC bodies to identify/establish all of the facts so that they can be shared with service users may be delayed or negatively affected by other legal processes and investigations, including by legal and Human Rights provisions which protect the rights of individuals who may be being investigated.*

> *• Any comments made either by a healthcare worker or the organisation which they work for, before a criminal case has been tried also have the potential to be portrayed as prejudicing investigations and/or any judicial process and may have unintended consequences.*
>
> *• It is important to understand that these types of scenario are likely to be relevant to only a minority of cases where disclosure should occur. Where these limitations do apply, they have the potential to be seen as defensive or lack of candour on the part of the HSC and individual practitioners. The workstream may wish to explore the implications of these issues in order to maximise disclosure and to ensure openness and transparency around the implications of any investigation or judicial process.*''[8]

[8] https://www.health-ni.gov.uk/sites/default/files/publications/health/duty-key-analysis-paper3.pdf

Despite these issues having been highlighted, there is very little to suggest that they have been sufficiently taken on board in developing these proposals.

Statements made to regulators or other individuals: The consultation document further proposes that provision should be made within the duty of candour legislation to require organisations to ensure that any statement made to a regulator or other individual acting pursuant to a statutory duty must be truthful and not misleading by omission; and any public statement made by an organisation about its performance must be truthful and not misleading by omission. This requirement should once again be read in light of the comments above in relation to unexpected or unintended incidents that have or may have resulted in harm. As discussed above, if it is unclear whether an incident has caused harm, may cause harm, or could instead be described as a 'near miss' there should be clarity in relation to whether an organisation and/or its staff could be held criminally liable by either failing to disclose this information if they reasonably believe that harm has not been caused and will not be caused.

Support and protection for staff: In relation to support and protection for staff when discharging the organisational duty, it is proposed that there will be a ''*statutory requirement for organisations to ensure that all employees who carry out the Duty of Candour procedure on its behalf receive: Relevant training and guidance on the Duty of Candour procedures; and Support to enable them effectively to adhere to their statutory individual Duty, and contribute to the organisation's statutory Duty of Candour requirements*.''

If a duty of candour is introduced, a detailed, resourced programme of training and awareness-raising must be in place to ensure that all staff are aware of their obligations, particularly if breach of the duty of candour will be a criminal offence. Recent experience with the implementation of the deprivation of liberty provisions within the Mental Capacity Act should be reflected upon here, with any

commencement date for the legislation following from such a programme of training being fully operational.

Responsibility for investigations and prosecutorial decisions: We note that it has been recommended that oversight of compliance with the statutory organisational duty of candour should be undertaken by the RQIA. The recommendation of the O'Hara Inquiry report included that consideration should be given to the RQIA further having the power to prosecute for breach of the duty of candour in cases of serial non-compliance or serious and wilful deception (discussed further above). It is unclear within these proposals whether such powers will be granted to RQIA, which would effectively make them responsible for both investigation and prosecution of a criminal offence, a departure from the approach adopted in relation to the vast majority of criminal offences in Northern Ireland, where the investigatory and prosecutorial functions are separated. An immediate question that arises here is where responsibility will lie for monitoring compliance and if necessary initiating investigations and prosecutions in relation to RQIA and their own compliance with the duty.[9]

4.0 INDIVIDUAL DUTY OF CANDOUR

UNISON notes that the workstream has not reached a unified position with regards to the introduction of a statutory individual duty of candour, with accompanying criminal sanctions for breach of that duty. It is stated that a significant difference of opinion remains regarding the implementation of a statutory individual duty and, in particular, the inclusion of criminal liability for breach. We note that the consultation document states:

[9] RQIA are identified as an organization the duty of candour would apply within the consultation document (p.23)

''feedback from regulated health and social care professionals and their professional bodies has highlighted that a statutory individual Duty of Candour – and in particular, the introduction of individual criminal liability for breach – could be perceived as overly harsh, given that other comparable jurisdictions have decided not to implement similar policies. They have indicated that such an approach could have unintended consequences, where fear of litigation and a culture of blame could have the opposite effect. Feedback has also suggested that this approach could have a negative impact both on the morale of existing staff and the recruitment and retention of staff, if this jurisdiction were perceived to be a less attractive location to work as a consequence.''[10]

UNISON agrees with these sentiments and would submit that they highlight why the introduction of an individual duty of candour, particularly one accompanied by criminal sanctions, is of concern. We would reiterate that many health and social care staff are under professional obligations with regards to openness and transparency and that breach of those obligations can already result in significant consequences via action taken by their professional regulatory bodies.[11]

In the absence of a unified policy position, three proposed options are put forwards with regards to an individual duty of candour. UNISON has responded to each of these in turn below. **It should be noted that many of the issues we have raised in relation to the organisational duty (such as in relation to legal certainty, interaction with other investigatory and disciplinary processes etc) apply equally with regards to the proposals in relation to the individual duty of candour.**

[10] Para.4.7

[11] For example, under the NMC Code, Nurses, Midwives and Nursing Associates must observe a professional duty of candour as part of the obligations to preserve (section 2). They must be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place. Under the NISCC Standards of Conduct and Practice for Social Care Workers, social care workers are required to be open and honest with people if things go wrong, including providing a full and prompt explanation to their employer of what has happened. The standards are binding on all registered social care workers, with a failure to comply putting their registration at risk.

Option 1 – statutory individual duty of candour with criminal sanction for breach: UNISON is opposed to a statutory individual duty of candour with a criminal sanction for breach. As we outlined throughout this submission we do not believe such a statutory duty is necessary, proportionate, or will add significantly to existing criminal, regulatory or disciplinary avenues that already exist to hold staff to account when they fail in their legal or ethical duties. Rather than creating an open and transparent culture, such a duty will only inhibit staff further.

In addition to our comments above relating to criminal liability, we are particularly concerned that these proposals display a misunderstanding of criminal law. It is stated within the consultation document that:

''*Criminal liability in this context would relate to a breach of the requirements of the statutory individual Duty of Candour and to obstruction of another in the performance of this Duty…It is important to note that, in respect of prosecution for breach of the statutory Duty of Candour, Justice O'Hara recommended that "consideration should be given to granting [the RQIA] the power to prosecute in cases of serial noncompliance or serious and wilful deception". In respect of any criminal sanction, the evidential threshold for conviction requires proof "beyond reasonable doubt" regarding the act and the intention. Criminal prosecutions for breach are likely only when investigation has found evidence of deliberate and intentional breach of the Duty.*''[12]

Whilst the standard of proof in criminal proceedings is proof beyond a reasonable doubt, it should not be assumed that a criminal offence requires proof of intention, unless that is specifically provided for within the statute that creates the offence. **Whilst it is our clear view that criminal sanctions should not be attached to any duty of candour that may be created, it is important that if a decision was made**

[12] Para 4.17 – 4.18

to take such a step there is absolute clarity for individuals as to when criminal liability may attach, given the serious consequences that this entails.

Option 2 – Statutory individual duty of candour without a criminal sanction: Whilst we note and recognise that this option would not include a criminal sanction for any breach of duty, we do note that the duty would still be subject to oversight from professional regulatory bodies and employers. We would reiterate the points made above in relation to when and how such a duty of candour would or would not apply, what it would require of staff and how it would interact with disciplinary or regulatory investigations, or any safeguarding investigation and/or criminal or civil investigations or proceedings.

In any event, we would question what such a statutory duty would add given existing obligations that exist on staff with regards to candour, openness and transparency.

Option 3 – Statutory individual duty of candour without criminal sanction for breach, and separate criminal offences for withholding information, destroying information, or providing false or misleading information: UNISON notes that it is proposed here that a criminal offence would be separately introduced which applies to staff in the health and social care sector who are proven to have wilfully, intentionally, or maliciously:

- Suppressed or concealed information;
- Distorted or otherwise altered information;
- and / or destroyed information

which would assist an inquiry or investigation that has been initiated into an incident which has resulted in serious harm being caused to, or the death of, a service user. Other behaviours which have been suggested for inclusion within the scope of this

offence include "*aiding and abetting*" another person to conceal the truth, or "*conspiring to hide the truth*".

Further detail is required in relation to the scope of any such offences. Firstly there should be clarity in relation to the form of 'inquiry' or 'investigation' that is referred to here; is it intended that such an offence would apply to safeguarding investigations carried out by employers, criminal investigations, inquests etc? Or would this apply to investigations initiated by employers or Serious Adverse Incident reviews? Secondly consideration should be given in relation to how existing criminal offences, such as perverting the course of justice, may already criminalise such behaviours in such circumstances. Finally as we have noted above such behaviours will already be contrary to the professional regulatory obligations placed on staff and so it is questionable what value they would add to creating a culture of openness and transparency. UNISON does not support the introduction of such offences in these circumstances.

Scope of individual duty: We note that it is proposed that the scope of the statutory individual duty of candour should include every employee that works for an organisation within the scope of the statutory organisational duty. Notwithstanding our view that an individual duty of candour should not be taken forwards, if such a duty is proceeded with there must be an extensive process of training and awareness raising amongst the entire HSC workforce as to the requirements of any new duty. We are also immediately concerned about the ability of all staff to discharge a statutory duty like this, particularly where they do not have sufficient knowledge, skills, training or expertise to provide patients or service users with a full and accurate account of their treatment, or to explain when things go wrong. Such conduct could be viewed as a lack of candour on their part.

In our engagement with the workstream, it was suggested to us that an individual duty of candour would empower staff such as cleaners or porters to speak up if they have

concerns on the care or treatment a patient is experiencing. In our view where such concerns exist they should absolutely be communicated in the appropriate manner, such as to those responsible for investigating safeguarding concerns. However such a process should be differentiated from a duty of candour to patients and service users themselves.

In particular we are concerned as to how an individual duty of candour for all those working for a HSC organisation will apply in relation to 'notifiable incidents'. It is proposed that legislation for a statutory individual duty of candour should include provision which requires individual members of staff to report any instances of treatment or care which would constitute a "*notifiable incident*" under the statutory organisational Duty of Candour.

This immediately appears to differ from Justice O'Hara's recommendation in this regard, which related specifically to registered clinicians and healthcare professionals, rather than all staff. In addition, as we have highlighted above, the proposals currently paint a confusing picture in relation to when a notifiable incident has occurred as opposed to an incident perceived as a 'near miss'.

Employment contracts: We note the reference in the consultation document to HSC Contracts of Employment being amended to reflect any individual duty of candour and that consequences for non-compliance for staff will be a disciplinary offence. As a trade union representing workers across all levels of the HSC system we expect full engagement and consultation in any attempt to amend the terms and conditions of HSC contracts. We would seek clarity in relation how such amendments would be expected to take place within the independent sector, where we are immediately concerned by the fact that many employers do not recognise or engage with trade unions as representatives of the workforce. The obligations placed on HSC workers

under existing contractual arrangements should be thoroughly examined to assess whether any such amendments are required.

5.0 SECTION 75 OF THE NORTHERN IRELAND ACT 1998

UNISON notes that the Department has completed an equality screening exercise for these proposals. The Department has screened these proposals out as not requiring a full Equality Impact Assessment (EQIA) at this time, but has indicated that the policy will be screened again once the consultation exercise has concluded and any amendments are made to the proposals, in order to identify and mitigate against any consequential differential equality impacts.

Noting the stated intent to rescreen the policy proposals, UNISON would urge the DoH in particular to focus on the differential adverse impact that will be experienced by the HSC workforce if any proposed duty of candour is accompanied by criminal sanctions. In our view the current screening document pays insufficient regard to the impact that introducing a duty of candour could have on the HSC workforce, as highlighted throughout this submission. **Whilst we would reiterate our opposition to criminal sanctions being attached to any organisational or individual duty of candour that may be introduced, it is vitally important that if such criminal sanctions were introduced there be absolute legal certainty in relation to when and how they could be applied, and that all workers are properly and fully trained on the requirements of such duties.**

In rescreening these policy proposals, the DoH should take it into account the following specific issues:

- The proposals will be disproportionately impact on women, given that as the current equality screening identifies, 79% of the HSC workforce are female;

- In terms of differing racial groups, the current equality screening states that the development of the policy has recognised that it will have to be sensitive to cultural differences, including language, when developing guidance materials for staff, service users, and organisations, in order to ensure the needs of persons from all backgrounds are met. However UNISON is concerned that currently our black and minority ethnic members perceive that they are particularly vulnerable to allegations of wrongdoing, with this being particularly problematic for migrant workers whose visas may be tied to their employment. We are concerned that a duty of candour with attached criminal sanctions may only leave such workers feeling even more vulnerable.

UNISON would request a copy of the revised screening document as soon as possible. In our view given the significant differential adverse impact that will be experienced by the HSC workforce if an individual duty of candour with criminal sanctions for breach of that duty is to be introduced, a full EQIA is required here and should be carried out without delay.

CONCLUSION

Given the concerns highlighted within this submission UNISON would welcome a clear commitment on the part of the Department to further engage with us and other relevant stakeholders. We anticipate a detailed response to our comments which demonstrates that they have been given proper consideration. We believe that direct engagement is the most valuable form of engagement in relation to these proposals.

For further information, please contact:

John Patrick Clayton, Policy Officer – [redacted]

Telephone – [redacted]

UNISON, Galway House, 165 York St, Belfast, BT15 1AL