COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Dental Issues in the Belfast Health and Social Care Trust

10 February 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Dental Issues in the Belfast Health and Social Care Trust

---

10 February 2011

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O’Neill (Deputy Chairperson)
Mr Mickey Brady
Mr Pól Callaghan
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Professor Donald Burden	)	
Mr Colm Donaghy	)	Belfast Health and Social Care Trust
Dr Tony Stevens	)	
Dr Andrew McCormick	)	Department of Health, Social Services and Public Safety
Mr Donncha O’Carolan	)	

The Chairperson (Mr Wells):
I welcome the witnesses, who are well known to most members. With us, we have Dr Andrew McCormick, who is the permanent secretary; Mr Donncha O'Carolan, the Department's Chief Dental Officer; Colm Donaghy, who is well known to many members as the chief executive of the Belfast Health and Social Care Trust; Dr Tony Stevens, director of medicine at the Belfast Health and Social Care Trust; and Professor Donald Burden, who is clinical director of dentistry at the Belfast Trust.

Donald may not have been here as often as the rest of you, who have been here many times. I suggest that you make an opening 10-minute presentation, after which members have quite a few questions to ask.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
Thanks, Chairman, and thanks for the opportunity to have this discussion. I will make some opening comments, and I am sure that Colm will want to add to those.

The first thing to say is that we are profoundly sorry for what has happened in this case: for the delays that people have experienced in accessing treatment; and for the anxiety, inconvenience and stress that has arisen for those who had to be recalled as a result of this exercise. Our first concern throughout all of this has to be the interests of the patients affected, and that has governed all that the trust and everybody else has been doing over this past year. The first consideration is to find what is in the best interests of patients, so that we act with that as the first criterion. That affects all the handling of the discussions and interaction, every aspect of which is governed by what is the best that we can do in that context.

The Minister made his statement on Monday 7 February 2011. I do not need to repeat all the facts. However, I will recap briefly the main points on the timeline. An issue arose in November 2009, when it emerged that a small number of people who had been referred following a diagnosis of oral cancer could, potentially, have been referred at an earlier stage. At that stage, it was very much just a possible issue. The trust's action, which was absolutely correct, was to take a measured and appropriate response and to establish the facts. It is always right to do that in that type of situation.

I want to affirm total confidence in what the trust did at that time. It acted correctly. It

organised the right steps to establish the facts and to undertake a look-back exercise, which was very time-consuming and very complex. As others will explain much more fully than I can, it is a highly complex area of medicine. There are few black-and-white issues. There are many shades of grey and a lot of room for scientific differences of opinion. It is important to get a handle on that fact because we are talking about complex diagnoses. That is why it depends on only one such specialist in Northern Ireland. It is a highly specialised area of medicine.

What we are doing as a society is placing responsibility for making those judgements on a small number of people, and we depend on them. I return to what I said to the Committee previously: it is right that the Department focuses on setting standards and ensuring that the right people are in the right places. There is an inherent risk in all that we do. Risk is inherent in the management of health and social care. The right response is not to seek scapegoats or carry out witch-hunts on individuals. The correct response from an organisational and public policy point of view is to set standards; to ensure that the right people are in the right places; and to ensure that there is effective, proper, balanced regulation that provides for fair accountability and is fair to all parties and fulfils all our responsibilities under the statutory duty of quality that applies to all health and social care organisations. We must also adhere to a lot of legislation that relates to human resources practice. It is important to emphasise those points at the outset.

During the look-back exercise, some major concerns came to light. I want to make it clear that action was taken appropriately and immediately to respond to the individuals. As it turns out, all of the individuals for whom a major concern was identified were already receiving appropriate attention. Therefore, it was not that people were found to have cancer and had to be recalled; they were already being treated. Again, that was absolutely the right response.

As the look-back exercise progressed during the past year, the trust acted, checked and ensured that appropriate action was being taken, which it was in relation to the people who were most directly affected. What happened then was that the look-back exercise identified a further number of people about whom there was what is called "intermediate concern". Hence the recall, which we hope is, as much as possible, precautionary, but it is absolutely the right thing to do. If there is a doubt or suspicion about their care, it is right that it is checked out speedily. The trust has put immense effort into identifying carefully the right people to recall and organising the process so that they are being cared for in the best possible way now.

We recognise that there will be many questions. We also recognise that there are always lessons to be learned. All of us here now and the other organisation affected are covered by the terms of reference of the independent inquiry that the Minister announced. We want to be careful in all that we do this afternoon not to prejudge or pre-empt anything. We will give evidence on the facts as we see them. If you hear us, from time to time, express doubt or hesitation, that is because we need to leave room for the inquiry to investigate us and to establish its independent view of what has happened. That is proper process, and it is important to emphasise that.

I also want to make the point that we are not in a position to answer any questions on the individual concerned. It is right to be clear about that upfront. We simply cannot answer any such questions because the inquiry will investigate those issues, and there is also the possibility of legal action. We need to be very careful, but we will obviously do everything that we possibly can to answer your questions as fully as we can.

I go back to what I was saying about how we manage risk: it is important to see this as a fundamental aspect of the system. The system that the Assembly approved in the reform legislation a couple of years ago is designed to ensure effective governance and management of highly risky services. That is what we are for as a set of organisations. The constitutions of the governing bodies of the trusts, for example, make it a statutory requirement that there are medical, nursing and social representatives as directors and executive directors on trusts. That is part of the way to ensure that there is the right balance of input to decision-making and effective accountability for a range of very risky services.

We placed those responsibilities in these organisations, and it is very important that we have the right procedures to allow each organisation to fulfil them. That is what I mean by saying that we need to have the right people in the right places in governance, management and in the deployment of professional staff at all levels throughout the service. That is what all of us depend on for care and for proper governance and management of those systems. It is important, therefore, that the issues are handled in a way that allows those procedures to take their course to fulfil public accountability.

Ultimately, public accountability lies here, with the Minister in the first instance, with this Committee and with the wider Assembly. In everything we do, it is ultimately for you to judge what is done, and we recognise and accept that. We are subject to political direction; that is the

nature of public services. We also recognise that there has been a lot of concern about issues that have gone into the public domain.

One positive, which I hope that we can develop — or maybe it is just normalisation — is that the Minister has agreed that, from time to time, there can be confidential briefing on emerging issues for the Chairperson and Deputy Chairperson of this Committee. That is something that I was pressed on last time, and it is important to acknowledge that. As I said, it is probably just normalisation, but it is the right thing to do. As issues emerge, we undertake that we will give a briefing where that is appropriate.

I ask you to recognise that there will be times when there is a tension between disclosure and the interests of the patient. That goes directly to this issue. The last time I was here, I was asked whether there was anything else, anything that I was not saying. Having read Hansard, my answer was inelegant. Also, I would, given more time, want to withdraw a couple of the remarks that appeared in Hansard and change my answers.

The point remains that we do not hide anything inappropriately and that we are very sensitive to unmanaged risk. As soon as anyone becomes aware of unmanaged risk, it has to be acted on immediately. That is very clear throughout the service, and everyone is aware of it. It is, at times, very difficult to draw the line between what is a managed risk and what is not a managed risk. There are services in Northern Ireland that are vulnerable, and part of what we need to do as a service is make sure that we deploy resources and ensure that the staffing rotas, and so on, are the best that they can possibly be.

However, there will also be a range of services in Northern Ireland that is stretched and stressed. That is management of risk, not irresponsibility. It may not be ideal, and there will be issues of judgement as to whether those are concerns that should be escalated. That is a judgement call, but specifically in relation to this issue, Colm was aware of it the last time that he was here. I know that, and I want to affirm my confidence that Colm did the right thing last time round. Had I been aware of the issue at that time, it would not have been appropriate for me to have talked about it, because we were not ready. Had the issue been disclosed prematurely, anxiety could have been caused to many more people than the 117 who are being recalled. An uncontrolled announcement about an issue with the service could have caused concern to many thousands of people. That would not have been in the public interest. My judgement is that, had

I known, I would not have said anything and for Colm to have done so would not have been appropriate.

I return to the point about normalisation: what should now be possible through informal contact, confidentially, to the Chairperson and Deputy Chairperson, is that there is an issue. We could do that now, but we were not in a position to do that the last time. That is just a matter of fact. We are now in a better position, and I hope that that helps everybody concerned.

I commend the trust for the speedy action that it took from that moment onwards to organise the work, identify the numbers and ensure that things were done properly. Over recent weeks and the whole of last year, the trust has managed a very difficult and complex issue with patients' interests at the heart of everything that it has been doing. I want to express my full confidence in what the trust has done. That is all that I need to say at the moment.

Mr Colm Donaghy (Belfast Health and Social Care Trust):
Chairman, are you happy for me to give you some further context and background?

The Chairperson:
We are very keen to hear from you, Colm.

Mr Donaghy:
I start by apologising on behalf of the trust to anyone who was caused any concern and anxiety by the recall announcement that the trust made Friday week ago. It was not our intention to cause distress or anxiety. In fact, that was the opposite of what we intended. We wanted to ensure an orderly recall of patients. We put patient safety and patient interests foremost in those considerations. I hope, Chairman, in today's session, that you will be assured that patient safety was always paramount in our minds.

I want to touch on the point that Andrew made. Last time round, when you asked the question of Andrew, I was aware of the issue.

The Chairperson:
You were at that meeting.

Mr Donaghy:

Forty thousand people attend the dental hospital each year. The difficulty for me, Chairman, as Andrew indicated, was that to have said publicly in the meeting that there was an issue with the dental hospital would, in my view, have caused undue public concern, particularly given the context, of which I was aware, that we did not have our telephone helpline or other arrangements for clinics quite ready at that point. Therefore, at the previous meeting of the Health Committee on 27 January, to have said that would have caused more concern.

If you are happy, Chairman, I will give you an update on the recall and on the patients who have contacted us and booked appointments. I would also like Dr Stevens and Professor Burden to give you a chronology of how the issue has been managed from December 2009 to date, which will, I believe, help the discussion. I am aware that the public are saying that 13 months was too long to manage the issue, and we need to address that in today's discussion. It would be helpful, in addressing that, if Dr Stevens gave you that chronology.

First, I will give the Committee an update on the 117 patients, if you are content for me to do that, Chairman.

The Chairperson:

Yes, because many of those folk have been in contact with individual MLAs.

Mr Donaghy:

The current position of the 117 patients is: 104 patients have now booked appointments, 59 of whom have attended clinics; 45 are scheduled to attend; and 13 patients still have no appointment booked. Of those 13 people, five patients have given different reasons for that, which I will not go into, but we are in constant discussion with those five people, some of whom have personal reasons affecting their attendance. We are finding it very difficult to contact eight patients.

I reassure the Committee that, since the second day after we sent the letter, Tuesday, we have been proactively contacting people who have not contacted us. We did not send the letter and then wait. We sent the letter, and those who have contacted us have been booked for appointments and a number of those have attended the clinics. Now, we are proactively going out to make contact with the others who have not yet contacted us. We are having difficulty contacting eight of those people. However, I assure the Committee that we will continue to make

every effort to contact them.

Chairman, if you are content, I will ask Dr Stevens to take us through the chronology and timeline.

The Chairperson:
Sorry, you have not told us what the outcome was for the 59 people who attended clinics. That is absolutely crucial.

Mr Donaghy:
That is quite right. However, I am not in a position to give you that information. For those who required a biopsy, it takes seven days for the results of a biopsy to be returned. The first clinics were on Monday and, therefore, we do not yet have the results of those biopsies. We will begin to get those results next week, and I am happy to share that information with you. However, I am not in a position to give you those outcomes, because I do not know at this point what they are.

Dr Tony Stevens (Belfast Health and Social Care Trust):
From my perspective, this started in November 2009, when I was advised of potential concerns regarding delays in treatment amongst patients who had previously attended the oral medicine service at the school of dentistry. That concern was raised by a surgeon from another hospital who treats patients with oral cancer. He talked to Donald, amongst others, and those concerns were brought to me. That is an example of openness, because it was a difficult thing for one consultant to do, and he would have had to have been absolutely certain about what he was doing. He had identified six patients about whom he had concerns, and perhaps later Donald will be able to provide you with a little more detail on that.

As Dr McCormick said, I asked for the facts to be established. In any situation in which I have two doctors who may genuinely have different views on the care of treatment, I need to establish some facts. At that point, it was a difference in medical opinion and, therefore, I had to treat it as nothing other than that. Departmental guidance on this, 'Maintaining High Professional Standards' allows for and expects me to establish the facts. The guidance calls that an informal stage. We did that fairly promptly, and the initial view was that there was a legitimate concern. This was more than just a difference in medical opinion; there was legitimate concern.

In December, I asked to establish a formal investigation under 'Maintaining High Professional Standards'. That investigation deals specifically with an individual. As we have said, I am a little uncomfortable about talking in great detail about an individual. I am conscious of the potential implications of doing that in a public forum. However, the investigation was initiated.

At the same time, conscious that this was a concern about delayed treatment for patients with cancer, I asked Professor Burden to identify the resource that we would need to carry out a review of the oral medicine service and other patients in the system. We had to handle two things at once. We had to handle what was more than a possibility that one of our very senior consultants was in difficulty, and we had to identify and manage any patients who may have been, at the same time, at risk as a consequence of that. Professor Burden identified two very recently retired senior clinicians to undertake the review of patients. That review pretty much started in December.

The job of the clinicians was to review patients attending the service and to report back to Professor Burden and me on any concerns that they saw. They were also given a very explicit instruction that, if they identified problems as they went along, they were not to hold those back until the end of the review, but to make sure that those patients were being managed as much as possible. Again, Professor Burden can give you detail on that. At the same time as the formal investigation started, we notified the General Medical Council (GMC) and, unusually, the General Dental Council (GDC), because, again, this is specific to one individual who was dually qualified.

One of the very senior experts asked to undertake the review was also asked to supervise that senior consultant's practice. That started in January. The first meeting between the supervising consultant and the other specialist was on 5 January. That was set up, and things were then moving. In February, I received the 'Maintaining High Professional Standards' formal report, which indicated to me that we needed to continue a process. The National Clinical Assessment Service was enjoined in that process. We are required to notify that body of any doctor on whom restrictions are being placed or whom we are managing through 'Maintaining High Professional Standards'. It was enjoined in advising us on how we would deal with the situation, particularly from the individual practitioner's perspective.

In March, we received notification from the General Medical Council that its interim orders

panel, which does a relatively quick review of a referral, indicated that it wished to place some conditions on the individual's practice, which included a requirement for supervision. We had already put in place supervision, so we predicted and put in place, ahead of a requirement from the first of the regulatory bodies, a requirement to put in place supervision. We were meeting the requirement that was laid down by the regulatory body.

In April, Professor Burden and I met the experts. There was a constant dialogue going on all the time, but we formally met in April to review our position. At that stage, I received an assurance that the review was making good progress and that the supervision was sufficient. I was given an assurance that the measures that we had put in place were suitable and satisfactory at that point and with that knowledge to protect patients.

In June 2010, the General Dental Council provided us with its opinion on the situation at that point. It was very similar to the General Medical Council's position, so that did not change the level of supervision required. I wrote to both bodies to clarify that point. During the period of the late spring and summer, when we might have expected the report to conclude, the situation was quite complicated and difficult because of the number of patients who were being reviewed and the complexity of the cases. Professor Burden and I were assured that any problems that had been identified were being dealt with but that the review would be completed a little later.

In November, we received notification from the General Medical Council —

The Chairperson:
Sorry, Tony. You forgot about 9 July. What happened on 9 July?

Dr Stevens:
You are obviously going to tell me.

The Chairperson:
The GDC report.

Mr Donncha O'Carolan (Department of Health, Social Services and Public Safety):
Chair, perhaps I could clarify that. As Tony has mentioned, the interim orders panel considered it in June and then made its ruling on 9 July.

The Chairperson:

So, you are referring to the same report in June and July?

Mr O'Carolan:

One is the consideration stage and the other is the report from that consideration.

The Chairperson:

When were the six recommendations made known to you?

Dr Stevens:

I knew about those in June.

Mr O'Carolan:

They were made public on the website on 9 July. It is the exact same issue, just two different dates.

Dr Stevens:

The critical thing for you to be aware of is that the General Medical Council and the General Dental Council based their judgement on the information that we were able to provide, which included information on the original six patients about whom there were concerns. At that point, the General Medical Council, based on the information, felt that, in November, it could withdraw the restriction. It had reached a view on the situation at that point. Interestingly, that month, Professor Burden and I were in a position to meet the two experts and to receive their opinion on the review of the situation. At that time, it became clear to Professor Burden and me that there was, in our view, a substantial issue with the oral medicine service. I chose, at that time, to notify the GMC of my continuing concerns, and I can tell the Committee — things are moving at a fairly fast pace on this — that the GMC is reviewing the case again. That gives members an indication of just how complex this is and also how, in managing it, we have been subject to potential variances in professional opinion on the seriousness of individual cases or, indeed, the seriousness of the overall situation. That, I hope, will give the Committee a little bit of context as to just how difficult this has been to deal with.

In November, having been advised of the situation and of concerns about a number of specific

patients, Professor Burden and I were given an assurance that those patients about whom there had been major concerns had been properly dealt with. We were not waiting until November to find out that there were problems and only then making sure that those patients were looked after. They had been in the system and were being cared for during the year and, in fact, quite early on in many or most cases.

However, Professor Burden and I asked the two experts whether we should do anything else about the 18 cases where they had major concerns and about the other cases about which they had interim concerns. In particular, I asked them, at that stage, whether any of those patients who were out of the system needed to come back into it. They asked for a short period to review all their case notes, which were extensive. After they did that, they came back with a list of 117 patients about whom they had lesser concerns. Those were not the 18 patients to whom we referred earlier. However, on reflection, they felt that it would be wise for those patients to be brought back into the system and reviewed. That, in a way, is where we are.

The only other thing to advise the Committee is that, having been advised by the two experts of their view of the situation, we notified the Health and Social Care Board at that time and, in December, we notified the Department that we had reached a conclusion on our position. At that time in December, we felt for a number of reasons that it was best that the individual who has inevitably been drawn into the centre of this did not see patients, and we made that decision. In December, we went substantially further than either the GMC or the GDC required us to go, but we made that decision on the basis that we felt that we had an absolute priority for patients at that time, and we also wanted to put every resource that we had, including those two experts, into dealing with patients. Since that time, Professor Burden and I have been preoccupied with and engaged in preparing for the recall of the 117 patients. Members are familiar with what has happened subsequently. I hope that that is of some help.

The Chairperson:

Thank you. Colm, we will deal with the issue of how the Committee has been treated and then get down to the problems that have arisen. Colm and Dr McCormick, you were here on 27 January. At the very end of that meeting — I think that it is important to read into the record exactly what was said that day — I said:

"That leads me to ask a difficult question of you, Andrew and Colm. You are expecting me to ask this: is there anything out there of which we are not aware, such as a major investigation, report or in-depth review of any description? Is there anything that, if it were to enter the public domain courtesy of some local newspaper, could catch us on the hop or ambush us

and leave you saying that you should have let us know about it? What is out there that we do not know about?"

I distinctly remember, Colm, that you were sitting over there and Andrew was in his usual seat. He is here weekly, as you know. I remember thinking specifically about the Belfast Trust when I asked that question. Andrew's answer to me was:

"Nothing out there matches the words that you used."

Dr McCormick told us that he did not know on that day about the school of dentistry issue. However, you were aware of it, and you have now explained why you did not tell us about it. The problem is that that fundamentally undermines the relationship between the Department, the Belfast Trust and the Committee. Although you may have had good reasons for not telling us, we have to ask ourselves whether there are other issues — I am coming to that question at the end of this hearing, folks — about which we have asked the same question and, for "pure motives", you decided not to tell us.

You had the option of taking me, the Deputy Chairperson and the Committee Clerk into a room to tell us what was going on, but that you and Andrew could not reveal it, because of its sensitive nature. At least the Committee would then have been reassured that there had been no attempt to cover the issue up. Had it subsequently emerged, I could then have said that there was nothing to worry about. I could have explained that the trust, for very good reasons, could not tell us about it and that we had been fully briefed but could not release the information. We could have said that it was all above board. However, what happened? We walked out that door and, 10 days later, while standing at a fishing harbour, I received a phone call from the Minister to tell me that there was, indeed, a major issue out there that we should have been told about and were not. I am speechless as to why an option was not taken to let us know somehow, so that we did not, quite frankly, look foolish, having asked that specific question.

Dr McCormick:

I recognise and understand entirely your concern and that of every member of the Committee about what happened. As you know, the Minister is concerned that he had not been informed. That is one reason that he initiated the inquiry, and we need to let that be the way in which that is addressed.

We recognise that there are learning points from what happened in this case. We recognise that the sequence was not right. We need to learn, move on and find ways forward. We all recognise that, and we recognise that part of the right way forward is, as you said, to have

confidential briefings on any such issue. That is our commitment, and we will fulfil that. However, when it comes to investigating the whys and wherefores, the Minister has asked the inquiry to look into that issue. We have explained why Colm took the position that he did on 27 January, and I think that he had a very legitimate reason for acting as he did. We will all be able to do better in the future. We put our hands up in that sense. You have our commitment on that and our apology that things were not as they should have been. We will definitely find a better way forward. I hope that that is helpful.

The Chairperson:
If it happens again, it will totally undermine the confidence of this Committee in the Department.

The other option was to say to me, or any other member, that an issue was out there but that, because of its sensitive nature, you could not tell us about it at that moment. That was an option. Mr Donaghy could have intervened and said that, but that did not happen.

Dr McCormick:
I think that that would not have been helpful. Colm was concerned with avoiding anxiety for 40,000 people. To have followed your suggestion would have created unlimited anxiety. Everybody knows that health and social care is an area of high risk. To simply have made a statement such as that would have begged so many questions. Given the extent of media coverage and irresponsible journalism at this time, for us to have done that would have been irresponsible. I would regard creating anxiety on that scale as unacceptable behaviour on my part or anybody else's. I do not agree with you, Chairman.

Mr Donaghy:
I will try to provide clarity. I made a judgement on that day. If I had answered in the way that you suggested and said that an issue was out there, Committee members would, quite rightly, have been concerned to know what that issue was and would have pressed me further to say what the issue was. I believed that it would not have been in the public interest to give details or to say that that was an issue, given that we were not ready as a trust to deal with all the concern that would have been expressed.

As I said, 40,000 people attend the dental hospital. That would have been the level of the concern caused. Even in the current context in which, as you know, we have recalled 117

patients and given reassurances, we are still receiving hundreds of calls from other concerned people. We deal with those as we receive them. If we had said in the public domain that we had an issue, up to 40,000 people or more would have expressed concern, given that that is the number of people who attend the hospital each year.

The Chairperson:

The general view in the public is that there was a problem. We accept that it emerged gradually. Perhaps, there was no definite point in time when you could say that action had to be taken. However, people do not understand why it took 13 months to deal with a problem of that nature.

Let us look at what happens in the real world. Say, someone works for Shorts or NIE. For how long would that person be put under supervision? For how long would there be case reviews? The fact is that, in most cases, the person would not be there long enough for there to be any review. If the person was at senior management level, he or she would be out.

The system seems to make it extraordinarily difficult for the Belfast Trust, or any trust in Northern Ireland, to take effective action if a consultant's standard of work seems to be declining. It seems that the system is stacked against the manager, the boss or the employer in that situation. Are you telling me that, out there in the real world, that sort of time span is required before action can be taken?

Mr Donaghy:

No. It depends on the situation, Chairman. It depends on how that situation evolves. The standard is not to take 13 months. In any of those issues, we maintained high professional standards in the medical workforce. It takes time to work through the processes. Judgements that are made in the process are on the basis of patient safety and risk. That is how we judge the decisions that are made as we move forward. Therefore, as Dr Stevens indicated, even though the GMC, which is the regulatory body, and the GDC imposed restrictions, we went further than that at that point in time. I assure the Committee that patient safety was always paramount in how we dealt with the issue.

As Andrew said, there is an independent review. We want to learn the lessons that need to be learned from that situation through the independent review. If the independent review indicates to us that we should have moved more quickly in the context of this process, we will learn lessons

from that and we will put them in place for our organisation. We are open, and we will co-operate fully with the independent inquiry.

The Chairperson:
You reviewed 3,000 sets of case notes. Well into that process, it must have become apparent whether things were OK or had declined. It seems to me that you left it till the end of that process to make a decision when, somewhere along the line, alarm bells should have started to ring. Ring they did because, at the end of the process, you decided to take action to ask the clinician to step aside from clinical duties. Why did it take so long when you had been alerted, you were looking at the problem and all sorts of alarm bells were ringing, such as the GDC referral and the fact that 25 patients had to be recalled? Why did you not decide much earlier to take precipitave action?

Mr Donaghy:
Perhaps, Chairman, it might be useful to ask Professor Burden to provide greater clarity on the management of the process and on the number of patients concerned — those for whom we were most concerned and the 117 that were recalled. I do not want to give the impression that we waited until the very end of the process before we started to treat patients, particularly those for whom we were most concerned. That is not the case. We were managing those patients as the process was ongoing. Again, I say to you that we put patients' interests first in that regard. I will ask Professor Burden to give you a quick rundown, for clarity, of the numbers and statistics involved.

Professor Burden (Belfast Health and Social Care Trust):
As a practising clinician, I would like to say at the outset that these are numbers, but there are real people behind them, and I would like to apologise unreservedly for the distress caused to our patients and their families.

Initially, six cases were reported to us by a colleague. He had concerns about the management of those patients while they were within our oral medicine service. At that stage, those patients were in another service and being managed and appropriately cared for. We then undertook a review of our oral medicine service for the 12 months of 2009. We assigned two experts to that review, and —

The Chairperson:

Was that in 2009 or 2010?

Professor Burden:

They reviewed the patients during the 2009 calendar year. The practitioner was —

Mr Donaghy:

Sorry, perhaps I could clarify that the review was of patients seen during 2009. The review took place in 2010, but the patients were seen —

The Chairperson:

Yes. Did you know about the issue at the start of 2009?

Professor Burden:

No, not at all. As Dr Stevens said, we did not become aware of it until December 2009.

During the review of the patients seen in 2009, our experts found 16 additional patients about whom they had questions in relation to the management of their care while in our oral medical service. They were reassured to find that those patients were being cared for by the appropriate clinicians. Also during the review, they identified 117 patients about whom they had no immediate concerns. They categorised those as intermediate, and those are the 117 cases currently being recalled.

The Chairperson:

Yes, but you knew about those 117 cases long before last Saturday.

Professor Burden:

Yes. As they came to light, our clinicians were looking carefully and diligently at their clinical records, and they reassured themselves that there were no immediate concerns about those patients while they were reviewing the case notes.

The Chairperson:

Right, so you send out a courier on Saturday morning to deliver a personal letter to every one of them telling them to come in on Monday or as soon as they can for a review. That strikes me as

being somewhat at odds with not being awfully concerned about the 177 cases that you have known about for a while.. Suddenly, there is a knock at the door at 7.30 on Saturday morning.

Mr Donaghy:

In any of the 117 cases, if there was any doubt, missing information or anything at all that gave us any cause for concern, we recalled people. We recognise that that caused anxiety to the individuals, but we feel that it was the right thing to do in the interest of patient safety when we had any doubt. In some cases, it may be that we had insufficient information to make a determination, but in such cases we still called or recalled the individual, because we felt that it was better and in the interest of patient safety.

Dr McCormick:

We have talked specifically about the urgency of getting letters out and even about what the letters said. Some of those points were themselves a consequence of the media's handling of the issue. Had there not been an urgency dictated by a leak to the media, the trust would have been able to handle the issue more smoothly and in a more low-key way. The recall would still have been necessary, but it would not have been necessary to have courier letters or to put very special arrangements in place. Last Friday, I had a discussion with Colm, as well as with John Compton and the board, to establish what we could do to ensure that each and every individual who was going to be recalled would personally receive information personally as close as possible to the time when this story hit the press. That is part of our duty of care to patients. That is part of putting patients first. That has been our practice in previous recall or look-back exercises. There have been several such exercises. They happen, but the point always is to make sure that, at the point in time when the issue goes public, it is possible to say "If you haven't received direct communication from the trust, you don't have anything to worry about." That was consistent with our objective, and it was necessary to do that only because there was a leak. The effect of the media coverage accentuated the anxiety. We apologise for that. That is unfortunate, but it was not entirely down to us. There were issues about how the issue was handled before it came in.

To handle things in an orderly, sensible, responsible way, confidentiality matters, and it is important for staff in our organisations to have regard for the patient's interest in all that they do and say. What is overheard and what is passed on inadvertently will sometimes mean that information that causes anxiety is disclosed, and we have a responsibility to do all that we can to

avoid that. That is why that happened, Chairman. It is important to understand that it was not a knee-jerk response. There was a plan in place, but that plan was disrupted by media handling.

The Chairperson:
As quite a few members want to come in, I will ask my final question. It is on a relatively minor issue, but it has to be asked. The 'Belfast Telegraph' revealed that, from 2001 until the present, the individual concerned was paid a bonus of £56,000 a year. That is a performance bonus for clinical excellence. Given this litany of investigations, supervisions, referrals to the GDC and patients being called back for further analysis, how on earth can you justify continuing to pay that £56,000 throughout? For most people in the Province, £56,000 is double their salary. It is a lot of money to most people in the Province. How can you justify that as a performance bonus? Why on earth was the decision not made, or why is there not a general policy in place that, if some person's clinical performance is under review, his or her bonus stops immediately?

Dr McCormick:
I will not make any comment, as I said, on the individual issue, but let me state some points of principle, which, I hope, will answer your question. Decisions on clinical excellence awards are a matter for the Northern Ireland clinical excellence awards committee. It is an independent committee that takes decisions on the higher level merit awards. Lower level merit awards are a matter for individual employers, but the higher level awards are a matter for that committee.

That committee has procedures for the review and reconsideration of awards, if there is a reason to do so, through a careful procedure based on evidence from the employer and the individual concerned. Just as the employer has responsibilities, the individual has rights. In that context, we ensure that the proper procedures, which are in place, are followed to ensure that this is scrutinised independently. It is not a decision for the Department or the trust; it is a decision for the committee that has been established to take responsibility on the basis of evidence. We always proceed on the basis of the evidence and fair process, and I assure the Committee that that will be followed.

The Chairperson:
Out of interest, did the trust send the Committee the GDC ruling that was published on 9 July?

Dr Stevens:

No. The procedure for higher awards is a five-yearly review, at which we would normally provide evidence. As I said, we are not in a position to talk about this individual case, but that is our normal procedure.

The Chairperson:

So it does not matter how steeply performance declines within the five years, it continues automatically —

Dr McCormick:

Let me answer that not based on the individual case but on normal procedure. There is a procedure by which concerns can be drawn to the attention of the committee at any point. That is possible.

The Chairperson:

It was not done in this case.

Dr McCormick:

Sorry, I am not saying anything. I am not answering any questions on the individual case. Nothing that goes on the record from us in this hearing can make reference to that individual case. OK?

Mr Easton:

I want to discuss who knew what and why the information was not passed up the chain of command. I am still slightly confused, and I am conscious, Colm, that you were not the chief executive throughout most of this.

How far back did your recall of patients go? Was it just a couple of years or did it go right back?

Tony, you became aware of the issue in 2009, when a consultant approached you about the situation, and you initiated some sort of investigation in and around Christmas 2009, I believe. Who did you report that to? At the time, would you have reported that to the former chief executive?

Dr Stevens:

The documented actions that I took at that time were to trigger the 'Maintaining High Professional Standards' process, which involves the director of the service and the director of HR being aware. In this case, because of the concerns, we notified the Department of our concerns and, in February, because of the nature of the concerns, we asked the Department to issue an alert letter. We also notified our chairman because, once we have gone into the process of a formal investigation, I am required to obtain the support of what is called a nominated board officer. By "board", I mean our own board of directors. So, one member of our board of directors was nominated by the chairman to oversee the process, and, at that time, the chief executive, obviously, would have been aware as well. So, at the time, I complied with all my requirements under 'Maintaining High Professional Standards'.

Mr Easton:

People developed cancer and have, sadly, passed away, and so forth. When did the chief executive of the trust know the total when it became apparent how serious the issue was?

Dr Stevens:

I could not really give a straight answer to that question. It was an evolving and iterative process that involved a situation in which people were —

Mr Easton:

But the chief executive knew? He was told?

Dr Stevens:

The chief executive and two members of the board of directors were informed and were aware of the process that was ongoing.

Mr Easton:

Would that have then been passed on to the board or the Department?

Dr Stevens:

We managed the process through 'Maintaining High Professional Standards', and, at an early stage, I chose to inform the board, and, as I say, because we felt that an alert letter should go out,

I went back to the board again in February about that.

Mr Easton:

So Mr Compton, as the chief executive of the board, would have known then? Would he have been aware of that?

Dr Stevens:

I did not report this directly to the chief executive of the Health and Social Care Board.

Mr Easton:

Who in the board would you have told?

Dr Stevens:

I did not directly report this to the board until I had the outcome of the review. I reported it to the director of dental services — I think that Professor Donaldson did — in November 2010.

Mr Easton:

Would that have been passed on to Mr Compton then?

Dr Stevens:

That would be a question for the board.

Mr Donaghy:

Maybe I should not speak on behalf of John, but John has indicated that he was aware in November because —

Mr Easton:

2010?

Mr Donaghy:

Yes, November 2010. When his Chief Dental Officer was informed, he, in turn, informed John.

Mr Easton:

OK. We now know that the board knew and that the trust passed it on to the board. Andrew, you

did not seem to know too much about this until a couple of weeks ago. Was there a failing in communication between the board and you or the trust and you? It is quite serious that you and the Minister did not seem to know. Are we looking at a breakdown somewhere from the board level up to the Department?

Dr McCormick:

The inquiry will look into exactly what happened. I want to qualify what I said by reference to that. I cannot give a definitive answer because anything that I say, however clear it might be to me, remains subject to that inquiry. So it is very important to have total respect for that process. However, as far as I am concerned, my factual position is that I was not made aware of the specifics of the issue. Sorry, there was an initial briefing in December 2009. That was through Donncha to me and the Minister at the initial stage of the issue. It did not come back to my attention until just after late January this year at my level. That is, obviously, a cause for concern, hence the inquiry. However, I have underlying confidence that the trust was taking the main important corrective steps in the intervening period. So Donncha would have been aware. The Department was aware from early December of the conclusions of the look-back exercise, and it was then in touch with the trust about the follow-up action.

So yes, there is a concern about the fact that the Minister was not aware at a certain point — that is the reason for the inquiry — but it is important to stress that the most important things to do right were being done by the trust in the intervening period. The Committee can have confidence that the system was working. There was definitely a problem in relation to the escalation of information or the reporting of information, and we will see what the inquiry concludes about that.

Mr Easton:

My next important question is about the fact that, obviously, some people have passed away from cancer. Are we able to say that the failure to diagnose or call back those patients contributed to that? That is a huge concern out there, and we need to reassure the public. I ask again, as I did at the beginning, how far do we have to go back to make sure that everything is OK?

Dr Stevens:

I will pick up on the question about patients who have died and pass on to Donald to talk about the other issue.

The Chairperson:

Could we expand that slightly to those who died whose health had been compromised or whose condition deteriorated as an apparent result of this issue?

Dr Stevens:

I am happy to deal with that.

Obviously, we have a list of patients about whom we have concerns — I have to be very careful how I put this — and expert opinion that there has been, potentially, a delay in diagnosis and, therefore, potentially a delay in treatment. Of those patients with oral cancer, three have since died. We have to be exceedingly careful here, because the evidence on this is still potentially disputed, and expert opinion may be brought to bear on all of these cases. We find ourselves in a very difficult position. However, we have made a decision, because we have to, to make sure that all these patients are aware of our concerns. A proportion of them are already aware, because the treating clinician, and in particular the clinician who raised the concerns with us, has advised those patients that he treated that there was, potentially, a delay.

We have brought in a further expert. I now have access to a very experienced expert in head and neck cancer who still works within the Belfast Trust and has a lot of experience in dealing with medical legal issues. He is going to support the clinicians who currently look after these patients to have conversations with the patients and give them the information that we have and our views and concerns. We will do exactly the same with the families of the three patients who unfortunately died.

That, I think, summarises the situation, Alex. It is a very difficult area. We are very conscious of the need to let these patients and their families know exactly where we think we are. We are taking it very carefully, because I have to be extremely careful in the context of this matter. When it comes down to individual cases, there will be differences of view. That is illustrated even by the position of the regulators, the General Dental Council and the General Medical Council. They have details of the original six cases and are taking a great deal of care and trouble to consider their position on those.

However, we recognise that we have to be open now with these patients. This is in the public

domain, and we will give them as honest a view as we possibly can. As I said, we have brought in another expert from outside the dental school to help and support that process. We will also use experts with good counselling skills to support those patients. We will not just go in, give them the information and run. We will make sure that these patients are properly and fully supported as we move forward. They remain patients. That would maybe be going too far. A number of them will remain patients, and, therefore, we have a continuing duty of care to them. So we are trying to deal with this as sensitively as we can within the context of this review.

Mr Donaghy:

I will ask Professor Burden to address your question, Alex, as to why 2009 was the year in which the look-back exercise took place.

Professor Burden:

We took the opinions of three local experts in this field in Northern Ireland, and we also sought the view of an internationally recognised expert from Great Britain. Their collective view was that the natural progression of the disease is such that if someone had this disease, oral cancer, prior to 2009, those individuals would be in our health system and evident to us. Their collective view is that the review, or look-back exercise, should concentrate on the 2009 calendar year.

The Chairperson:

And? What is hanging there is that you have dealt at great length and very technically with the people who have died, but I do not detect a view as to the large number of people who have not died on whether their conditions have deteriorated as a result of the delay in diagnosis or delay in further treatment. Can we pinpoint people who are less healthy now than they would have been had this issue not arisen?

Professor Burden:

The review of cases in 2009 concentrated on — that is what we are dealing with now — looking immediately at anyone whom our experts considered to be in a high risk area. They have gone through the cases, and they are confident that anyone who was in the high risk area in that period is in our care system and being cared for. There is a supplementary, or intermediate, group that I referred to earlier of 117 cases that we are presently calling back. We want to assure ourselves and our patients that their care has been optimal, and that is what we are currently doing.

The Chairperson:

And has anybody shown up so far to be suboptimal?

Dr Stevens:

At this time, in terms of the cases that we are reviewing, as Colm said, we are carrying out tests on the patients that we are calling back, and we will know within seven days.

Mr McCallister:

To follow on from Alex and the Chairperson's point, I am somewhat concerned. Professor, is there any evidence of a peak from, say, 2006 or 2007? You said that you did not go back further than 2009 patients, but is there any evidence to suggest that this has been a problem for us or that there has been an increase in, for example, oral cancer?

Professor Burden:

No. We have no evidence of that nature.

Mr McCallister:

That is reassuring. As the Chairperson said, that question seemed to be hanging there. I agree with your point that it is important that the individual involved is not named, or certainly this is not the place for putting anyone on trial in that regard. We want to see what the situation is. I was concerned, Colm, that the permanent secretary and the Minister did not seem to know, and, certainly, going by the tone of the Minister's statement on Monday, he seemed somewhat concerned that he did not know.

Overall on the dentistry issue — this is probably for the Chief Dental Officer — is the school of dentistry receiving enough funding? Has this been an ongoing problem? Are there recommendations from the review of dentistry, and will they be implemented? What I am hearing is that the school of dentistry is possibly being run down somewhat. They are not getting the training. They are not getting the resources that they perhaps should for this area of medicine. I know that the Department puts in money and that some money comes from Queen's. Is the school of dentistry getting a fair share of the resources?

Mr O'Carolan:

There is the dental school and the dental hospital; they are two distinct functions. The dental

hospital treats the patients, which is the Health Service side, and its other function is to train consultants of the future — specialist registrars. On the university side, the school of dentistry trains undergraduates, teaches them and undertakes research. Most dental schools across the UK have teams of Health Service consultants and teams of clinical academics on the university side, all of whom are housed in one building.

Belfast is unique. Belfast has the smallest dental school in the UK, and, because of its size, we are not able to run that model of having a team of NHS consultants and a team of university consultants. Therefore, the model in Belfast has what are called joint consultants. The same people who do the Health Service work also do the teaching and research. That means that two streams of funding that go into it. There is funding through the Department for Employment and Learning (DEL), through the Queen's University side. There is also funding from two sources on the Department of Health side, one of which is the pure Health Service side for treating patients. However, we also have the supplement for undergraduate medical and dental education (SUMDE) money, which may have come up before at the Health Committee. That SUMDE money is from the Department of Health, Social Services and Public Safety to help with the cost of teaching the students, because the students on the university side are taught in lecture theatres, and the university pays for that. However, most of their training, from second year onwards, takes place in clinics. That means that Health Service consultants in the clinics may be slowed up as a result, so the Department has to put in money to supplement the Health Service side for having to take on the teaching.

Have we enough money on the SUMDE side? I think that the answer to that is yes. Have we enough money on the university side? I think that the answer to that is yes. Have we enough money to refurbish the dental school? Well, the dental school badly needs to be refurbished. I am pleased to say that the Minister has made it a priority to earmark capital for the dental hospital, so that will be completely refurbished. So where is the problem? The problem is in staff numbers. There were 20 consultants in the dental hospital/school 10 years ago, and they performed both functions. There are now fewer than 10.

You are right, John. There was a university-led review, which was carried out in December. As the Health Service is a large stakeholder, I sat on that review. That draft report has not yet been signed off by the university. I know that people are aware of it but it has not been officially issued. My take on the situation is that, when the School of Medicine, Dentistry and

Biochemistry was restructured in 2008, the dental school lost out. That restructuring did not suit the dental school. As a result, there has been no recruitment by the university into the dental school. You may ask why we do not just recruit on the Health Service side. As they are all joint appointments, if we do not recruit on the university side, there is automatically no recruitment on the Health Service side. We are acutely aware of that problem.

The ironic thing, John, is that, despite the current economic climate, the funding is there, but there has been a delay in recruitment. The university stance on that is that we want to make sure that we have a strategy in place to take the dentist school forward before we start recruiting. We do not want to recruit willy-nilly. We want to recruit the right people. My argument is that we do not have the time to do that. To the university's credit, it undertook that review in December. Although the report is still in draft form, that review has thrown up some very serious concerns, both on the teaching side and on the service delivery side. It boils down to the fact that we do not have enough dental staff in there. The money is there. I will say so to the university, and I will speak to it over the next couple of days. This draft report arrived on my desk only on, I think, 24 January, so it is that current, John.

The board and the trust want to have their say on the final draft, but the gist is that there are not enough staff in there to deliver Health Service work and teach. So I think that the university needs to get on and do its bit by starting to recruit, and very quickly; ditto on the Health Service side. We need to do both. Funding is complex because of the various streams, but it is ironic that funding is not the problem. The problem is the university and the trust getting together and getting their acts together to bring this forward.

Mr McCallister:

Based on those figures that you gave, in 10 years' time that trend would leave us with no consultants.

Mr O'Carolan:

Although it is a draft report, it leaked out. I have verbally briefed the Minister, but, to be fair to him, he has not seen the detail of it. We have already started very seriously looking at that issue. I have spoken to Andrew about what we need to do on the Health Service side. I will be speaking to Professor Paddy Johnston within the next 24 hours. He has been trying to contact me this week, but I have been very busy, as you can imagine, with this issue. The last time that I chatted

to the vice-chancellor, Peter Gregson, he gave me a very strong commitment that he wanted to invest in that dental school and make it successful. I am sure that he will honour his commitment.

Also, on the Health Service side, it is a role for the board to make sure that it has sufficient service. That dental school serves the whole of Northern Ireland. It is the only specialist centre for the whole of Northern Ireland, so the board has to have a say in that. I know that it is very keen to do that. John, a rescue package is coming. The detail is not firmed up just yet, but I am confident that, with close working between the trust and the university, we will be able to turn that manpower issue around and get the service side and the university side back on their feet.

Mr McCallister:
I am not sure whether anything was a contributory factor, but would it be fair to say that if it is not turned round, the chances of something like this happening again in the future could —

Mr O'Carolan:
Dentistry delivers a spectrum of services. Most of it is at the low-risk end. This, unfortunately, was at the very high-risk end. Oral cancer is the most serious bit of dentistry. The vast majority of dentistry is fillings, crown work, gum treatment, dentures — low-risk stuff. The threat to patient safety is low. Nonetheless, the service needs to be delivered. Where there is a small, highly specialised service, be it oral medicine or any other service, there is always a risk like that. The trust is acutely aware of that. It will have measures in place to address that. If it is an individual, a single person service, it will know that and have it on its risk radar and will manage that situation should it come across it. It would be wrong to say, John, that we are going to have anything as serious as that. You can never say never, but the vast majority of dentistry, when compared with cardiac treatments, orthopaedics and all the more complex stuff, would be lower risk. In answer to your question, it is unlikely, but you can never say never.

Mr McCallister:
I accept that point, but if you kept going at this pace and running it down, we would be at serious risk of having any of that sort of expertise that the professor spoke about even to review some of these cases.

Mr O'Carolan:
There is no complacency on the Department's side. We are acutely aware that there is a problem

with the dental hospital/school. I will let Colm and Tony speak from their end about what they think from the trust side, because they will be aware of it, and they may have a slightly different perspective on it than I do, but, overall, I think that we agree that manpower in the dental hospital/school is an issue.

Ms S Ramsey:

Do no women work there?

Mr O'Carolan:

You will be glad to hear, Sue, that 80% of the graduates going to Queen's are now female, so it is becoming a very female profession.

Mr Donaghy:

I will give a one sentence response and allow Tony to give the detail. John, we are very keen that we get a proper service model in place in relation to delivering the service and working very closely with Queen's, which wants to do that. We will also work very closely with the Health and Social Care Board on the commissioning specification that it would like us to deliver from the dental hospital. That will take in the resource that we have in Northern Ireland, not just in Belfast. I will let Tony —

The Chairperson:

Tony, we have quite a few questions still to come, and this is a more general issue about funding for the dentistry service rather than the —

Mr McCallister:

It was from the Chief Dental Officer.

The Chairperson:

Anyhow, it was good to have the Minister's views through John McCallister.

Mr Gallagher:

The next Minister's views.

Dr Stevens:

In reflecting on what Donncha has said, which is that there are challenges in the dental school for us, it is a very important educational institution to Northern Ireland because it helps to ensure that we have sufficient dentists to provide care for patients. It is also a very important centre as it delivers specialist care and a range of specialist treatments, but size presents challenges to us.

We have very small specialties, and oral medicine is an example of a single specialty. That will be seen, by a single specialist in an area, as a mitigating factor and, no doubt, by the individual. We are working very hard with Queen's and engaging very actively with the Health and Social Care Board to think about how we would staff the dental school of the future. It will be a different model, and this episode, very unfortunate as it is, is not the sole catalyst for this, although I think that it will add impetus. I probably will not say any more than that.

Ms S Ramsey:

Thank you for your presentation. I know that that this is a live issue. We are talking about human beings and families who have suffered bereavement. At the outset, I want to say that I was a patient at the school of dentistry a number of years ago, and it is important to say that it provides great care and treatment for a lot of people. So I am quite sympathetic to the staff who have been caught up in this. Rightly or wrongly, they have all been caught up in this madness and brought into this crisis. It is important to acknowledge the fact that we have been brought up with a "doctor knows best" attitude. I now know that that is not true, but we have that in this society. We need to commend a consultant for challenging another consultant. That would not have happened a number of years ago. It is the start of the process, and we need to recognise that.

I am concerned with the comments that Andrew made about the media stuff. The reason why I am concerned about that is, although you have accepted that things have not happened as well with providing information to the Committee, I have no doubt that, unless the media had run with that — whether you believe that it is right or wrong — we would not be discussing this or getting any information. So I think that the media had a part to play. The Committee has a part to play, and it is important that we are all singing off the same hymn sheet and all playing our part.

I have a number of questions. Is this deemed a serious adverse incident? I am glad that Donncha cleared up the point that it was not a funding issue. If student fees increase, we might not get the doctors, the GPs and the dentists that we need. John can take that point back. There is

an issue about the board level. I know that the inquiry will cover that. I am concerned that nearly four years have passed, and the Department, at whatever level, has realised and recognised the responsibility and role of this Committee. That is four years too long. However, we are there now, and we need to work on that. I also think that the Minister — he is not my party colleague — was left quite vulnerable in all this. The review will look at how information goes up and down, and Andrew said that we are accountable to the public. We are. So it is important that we get all the information because we were left looking quite stupid, and people were asking what was happening and, given that it was in the media, why we did not know about it. We cannot do our job unless we get the information.

I have some specific questions. Has anyone resigned, left or even taken early retirement in the Belfast Trust because of this or any associated incidents? I want to thank Tony for giving that outline. That was helpful because, in any employment law or contractual law, it is important to go through that. If it is not done properly, we could end up with other issues. That is important. It is important that, in their roles, the Chairperson and the Deputy Chairperson — the wise people that they are — should have been told of that. We can deal with things off the record. It is important that we get that information out there. Are we going to punish families further by closing ranks if there are any legal cases?

Mr Donaghy:
I will deal with that. You asked specific questions about the SAI, whether anyone has resigned, left or taken early retirement and how the litigation might affect how we deal with families. Those are the three specific questions as I have seen.

This is now reported as a serious adverse incident to the board.

Ms S Ramsey:
It is or it is not?

Mr Donaghy:
It is. It is now reported as a serious adverse incident to the board. Over the course of 2010, it was dealt with by the trust under the Maintaining High Professional Standards process, which Tony outlined earlier. I am not aware of anyone who has resigned, left or taken early retirement as a result of this.

Dr Stevens:

Given the earlier conversations about openness, I would have liked notice of a question like that.

Ms S Ramsey:

I did not think that I would ask it until the conversation came up. If you do not want to go into that in detail, I am content for you to send the information to the Chairperson.

The Chairperson:

Information is sent to both the Chairperson and Deputy Chairperson on all occasions. That is only right for fairness and to provide a bit of balance.

Mr Donaghy:

We will do that.

Dr Stevens:

I will deal with the media issue, Sue. I can only look you straight in the eye and tell you that we would have issued a press statement on this before we went out with a look-back exercise. That was already planned. We were bounced by the leak. The leak did not help us. In fact, it was our worst nightmare that we had to pull out all the stops on a Friday and bring in teams of staff to work the entire weekend to ensure that this happened. We wanted this to be orderly. I can give you only my complete word that we would have issued a press statement. That was the intention and the plan. I hope that you will take that word.

The legal cases are very important. We obviously have to do follow due process and take legal advice. Where there is a clear agreement that we are at fault, we try to settle as quickly as possible. That is the process now, and the directorate of legal services functions on that basis. However, we have to follow proper due diligence because, ultimately, it is public money. Our first priority is to be as open as we can with families and patients. I give you that undertaking today. We, in the trust, within the constraints, have to be careful about due process. Within the constraints, I am also very well aware that the individual practitioner concerned here will be independently represented, and his advisers may well take a separate view. We will be open and honest with people within our ability. We will ensure that these people are properly supported. I also give you that complete undertaking, and Professor Burden and I are already dealing with it.

Mr Gallagher:

Good afternoon. Donncha, you spoke about the school of dentistry, which is obviously part of the inquiry. From what you said, there are two parts to the investigation: the university and the Royal Victoria Hospital. Will both parts be involved in the inquiry?

Mr O'Carolan:

Tommy, I am not quite sure that the inquiry will cover the function of the school and the hospital. You will have received the terms of reference. My understanding is that this specific incident is being looked at in respect of the regional oral medicine service; quality of care for patients in that regional oral medicine service; communications within the trust; communications between the trust and the board; and the communications between the trust, the board and the Department. I understand that those are the terms of reference. It is not a review of the dental school.

Mr Gallagher:

OK. Thanks for that. Was any aspect of the case referred to the ombudsman?

Dr Stevens:

Again, I would have preferred notice of that question. Each individual patient in this case is being dealt with in a slightly different way. As we are dealing with such few numbers of patients, it would be difficult for me to give you an answer on that. Obviously, all patients have the right to go to the ombudsman. I probably want to reserve my position on that.

Mr Gallagher:

Would it be possible to provide an answer to the Committee?

Mr Donaghy:

Yes. Confidentially.

Ms S Ramsey:

We are working together now.

Mr Gallagher:

I took some notes on what you said, and I want to make sure that I picked you up correctly on the

sequence as you see it. Was the first GMC report in March?

Dr Stevens:
The interim orders were in March.

Mr Gallagher:
Were restrictions placed on Dr Lamey, the individual at the centre of all this, at that stage? I think that that is what you said.

Dr Stevens:
Can I be clear: I had rather hoped that we were not going to be so personal in this. I am rather thrown by that, Chairperson.

The Chairperson:
The member is within his rights. I purposefully have not but, within the privilege of this Room, Tommy can actually say that if he wishes to. Some have decided not to, and Tommy has decided that he wishes to do that.

Mr Gallagher:
OK; I will put it to you this way. Was an individual placed under restrictions following that GMC report?

Dr Stevens:
No. The GMC placed conditions rather than restrictions. We had already put in place supervisory arrangements —

Mr Gallagher:
The trust?

Dr Stevens:
Yes. We had already put in place appropriate measures that predicted what the regulators would require.

Mr Gallagher:

OK. The General Dental Council issued its report in June. I understand that that report was similar to the report of the GMC?

Dr Stevens:

That is correct.

Mr Gallagher:

Then the restrictions were withdrawn in November.

Dr Stevens:

Can I be clear —

Mr Gallagher:

You used a different terminology, but —

Dr Stevens:

The General Medical Council withdrew its conditions on the basis of the original six cases, which was the information that it had available to it at that time. I have subsequently made the council aware of the additional information that I and the Committee now have, and it is reviewing the case.

Mr Gallagher:

That is correct. When did the GMC decide to review the case?

Dr Stevens:

Relatively recently. It made that decision in the past few weeks, based on the fact that we have provided more information.

Mr Gallagher:

I thought that you said that someone made the decision in December that the doctor concerned was not to see patients again.

Dr Stevens:

Again, can I be very clear: that was a decision made by me in consultation with Professor Burden.

Mr Gallagher:

Was that on behalf of the trust?

Dr Stevens:

In making that decision, I was acting in my role as an executive director in the trust.

Mr Gallagher:

Can you tell us why?

Dr Stevens:

On the basis of patient safety.

Mr Gallagher:

Thank you. The issue has arrived at this place. What have you to say about the issue of public confidence in the school of dentistry?

Dr Stevens:

We are very aware that incidents such as this will have an impact on public confidence. I would be very sensitive to the fact that public confidence in our Health Service is probably being buffeted on a daily basis. I can really talk only as a doctor. We are acutely aware of our responsibility to offer the highest quality of safe care as possible and to allow the public to believe in their Health Service.

This case began on — it is hard to say a positive note, so let me find a different way of putting it. It started when one doctor felt confident enough to come forward with concerns about another doctor, and that is a reassuring feature of the case.

As regards public confidence, I am genuinely very concerned that the media's attention and approach to the case could, potentially, make doctors very nervous in the future. Not only do I have to provide you and the public with reassurance about the quality of care that is being

provided, but I have to provide assurance to medical and other professional staff in the Health Service that they will be treated fairly. I am trying to walk that very fine line at present.

Mr Donaghy:

Although it might sound ironic, the fact that we are having this conversation should reassure the public that we have in place processes and risk management to identify where we believe that there is poor practice and that we will take action on it. Therefore, if there is confidence that we can give to the public, it is that in the service that we deliver, we will always put the patient first. We will actually ensure that that service delivers safe care of patients.

Dr McCormick:

I just want to relate that point to the statutory obligations on the service. Since 2004, there has been a statutory obligation on every health and social care organisation to provide services that are high quality and safe. The obligation on the Department, the board and the agency as commissioners and on trusts as providers is to have systems in place that do all that is reasonably possible to secure patient safety and high-quality services, and to manage risk effectively. That is the assurance. The basis for confidence is that we have a system and statutory obligation in place.

We also have to ensure that the culture is right. What I mean by that is that the culture has to be one in which every professional has the power and responsibility to act on the basis of patient safety. That is what clinical governance is all about. I am sure that Tony and Donald can speak much more eloquently on clinical governance than I can. It empowers every member of the team to have and to fulfil a responsibility for patient safety. That fundamentally important assurance exists. It is backed up by clear procedures for regulation, both professional regulation with regard to each and every staff member and organisational accountability through a strong independent regulator.

The role of the Regulation and Quality Improvement Authority (RQIA) as an assurance mechanism is very important. As part of how we operate, we ensure that the RQIA is strong and able to investigate and can provide a planned programme of inspections to ensure that there is confidence in accountability back to the Department and the Minister and, hence, to the Assembly that we are fulfilling those obligations. Therefore, the right response to anxiety about standards is to ensure that they are in place, good, scrutinised and updated. We have professional staff who

update and review standards that are set for each and every aspect of health and social care. That matters strongly in a publicly accountable system.

It is about setting standards and ensuring that the right staff are in place. I am clear that professional staff throughout health and social care earn their money. They are tasked with highly responsible jobs on which our lives depend. I am personally very conscious of that given my experience during the past couple of years. We depend on those individuals to manage risk on our behalf. It is important to build confidence and to ensure that there are effective procedures, governance and regulation in place to ensure that we continually review and improve those things so that the public can have full confidence that everything possible is being done to manage risk. There are risks around. That is the nature of what we do. It is important that that is recognised and understood. As a set of organisations, we accept that it is our responsibility to do everything that we can to manage risk and to ensure that there are grounds for confidence. We want to ensure that that is fulfilled in every possible way.

Mr Callaghan:

First, it is not a declaration of interest by any means, but given that we are beating on about transparency, I just want to put on record that in a former life, when I worked for the trust, Tony was my line manager's line manager, briefly, for about three months. We met at one stage, long before any of this happened. Sue knows that I have been elsewhere before.

I want to perhaps pick up on some of the things from the debate on Monday to do with numbers. We started off with six people being identified by the surgeon. That was in November 2009. Correct me if I am wrong on any of this, because a lot of information and data is being thrown around. The look-back exercise flagged up 18 cases in which there were serious concerns. That is 24 people about whom we can say that there were serious concerns. Is that correct?

Mr Donaghy:

Not quite, Pól.

Mr Callaghan:

The Minister's statement said that there were 22 people.

Mr Donaghy:

There is an overlap in the six people and the 18 people. Perhaps Professor Burden can outline that.

Professor Burden:

The best way to explain it is that six cases were initially flagged up, and the review of cases in 2009 identified a further 16 cases. That is the 22 figure.

Mr Callaghan:

Thank you for that.

If Andrew has read the Hansard report from Monday, he will have had previous notice of this. I asked the Minister whether there was information on the breakdown by trust of patients who have been affected. Are you in a position to provide us with that information today?

Mr O'Carolan:

The answer is no, we cannot provide that information. An Assembly question has also come in on that. I am not a statistician, but the guidance under which they work is such that, if individuals could be identified by breaking information down by constituency, that information cannot be disclosed. I had a conversation with a statistician in the Department, and it appears that that is the case. The numbers are so small when broken down to that level that individuals could be identified. Therefore, that information cannot be disclosed. That is my best information at this stage, Pól.

Mr Callaghan:

There are lies, damn lies and statistics, as they say. I am not for one second accusing you of lying, Donncha, not by any manner of means. However, we are always cautious of statistics. Are you talking about the 117 recall patients? What about by trust? Presumably those numbers would be significantly higher than by constituency.

Mr O'Carolan:

Again, I would need to take advice if that question was asked. I would have to speak with our statisticians.

Mr Callaghan:

We can park it for today.

The Chairperson:

I do not know how saying that there are 22 people in the Western Trust or 16 people in the South Eastern Trust identifies anybody. I cannot follow that logic.

Mr O'Carolan:

The original question was by constituency.

Mr Callaghan:

By trust.

Mr Donaghy:

We also have that query and are looking to see what those statistics look like.

Mr Callaghan:

The answer as of today is that the information is not available to you. It is a separate question as to whether or not we are going to have that information made available to us.

In his statement, the Minister said:

"As regards the six people identified initially, I have been informed that they have all had the opportunity to discuss their condition with their clinician and are aware of the potential delays in treatment."

That is the original six people, who all know of the potential delay.

"At this stage, I understand that not every patient will have been told that there was a potential delay in their diagnosis."

Does that refer to the further 16 people? Have they been made aware of the potential issues around delayed diagnosis since the Minister's statement on Monday?

Professor Burden:

We are actively pursuing that process now. We hope to have that completed within the next week or two.

Mr Callaghan:

Can you give us a figure as to how many of those further 16 people have or have not been notified?

Professor Burden:

I would prefer not to do that. We can come back to you with that detail.

Mr Donaghy:

We could come back to you.

Mr Callaghan:

I think that it was Colm who gave us the statistics about how many people had appointments, were booked in, were not booked in and were not currently contactable. The figure that you gave for people who had been seen was 59. The Chairperson asked about the state of play for those people, and you said that the biopsy results were not back yet. That is a different question from asking whether or not those people have been referred for biopsy. Can you tell us whether any case has been deemed not significant enough that a biopsy is required to probe the matter further?

Mr Donaghy:

Again, Chairperson, unless either Professor Burden or Tony has any of those statistics to hand, I can come back and give you a breakdown of the number of cases where a biopsy was taken, and the number of cases where a biopsy was deemed not to be appropriate. I do not have that breakdown with me.

Professor Burden:

We can provide that.

Mr Callaghan:

When the Minister's statement, the Department and the system — which I use as a generic term for everybody else — uses the phrase "serious concerns", and then uses the phrase "intermediate concerns", I would find it helpful, and I imagine other members may do as well, to know what exactly you mean by that. Donald mentioned earlier an "immediate concern" relating to "serious concerns". What does that actually mean about the potential scope and seriousness of the conditions that we are talking about?

Dr Stevens:

I will start answering that and then hand over to Donald. The two experts who carried out the

review used the terms “major concerns” and “intermediate concerns”. They were talking about concerns about the quality of the care as much as about the severity of any illness. You are absolutely right in that there is the potential for confusion or a little uncertainty about exactly what we are talking about.

For example, in some cases where they thought there major concerns about the quality of the treatment, those patients are actually fine. Unfortunately, there are others in that group with cancer about whose treatments we have concerns, but there are others in that group for whom, even though major concerns were raised, there has actually been no detriment.

The intermediate concerns related more to their feelings about the quality of care. That is why we then asked our two experts to go away and refine very carefully, from that and their experience of the whole review, exactly who they would call back. I will hand over to Donald to explain that group to give you a sense of those 117 people whom we chose to call back.

Professor Burden:
The experts involved in carrying out the review, as Tony said, designated the two groupings into one of major concerns, about whom they immediately took action to reassure the patients and themselves that they were being cared for, and the second group of patients, which they termed intermediate concerns. In those cases, they indicated that there was no immediate problem that they could see with those patients, but to reassure ourselves, we decided in our meeting when we looked at the completed review that we felt it appropriate to call those patients back.

Mr Callaghan:
I want to return to something that Tommy raised earlier, and I think that Donncha was responding at that point, about the terms of reference of the review. I have just seen those terms of reference this afternoon, as, I think, most Committee members have. The review makes two specific references to the **school** that I can see. It makes one in the first paragraph, but that is a general one. Paragraph 2(a) states that the purpose of the inquiry will be to:

“Evaluate the general quality of care provided by the School of Dentistry”

and the trust. Paragraph 2(b) continues that it will be to:

“evaluate the systemic nature, extent, timeliness and effectiveness of communications between and within each of “

the school, the trust, and so on.

First, on the matter of the school, I do not profess to speak for Tommy, but if I were to rephrase what I think he may have been getting at: in light of what you can see in those terms of reference, is there any potential concern that the fact that some people are employed by two different bodies or serve two different purposes could impact on the fulfilment of the inquiry? I think that the Committee would be interested in knowing about that.

Mr O'Carolan:
I think, Pól, in answer to that question, we have to accept the model that Queen's was designed on. It was designed on a joint appointment model, and you are not going to turn that around overnight. Tony Stevens has alluded to the fact that is not the model for the future. I think that both the trust and the university accept that. That is what came out of the draft report that people are talking about but which cannot be in the public domain yet because it has not been signed off.

There is no doubt that that model is starting to fail, and we need a new model for the future. As a result of the review, we have an idea in our heads of what that model might look like but that has not been signed off yet. So I do not think that that model is going to impact on this inquiry.

Mr Callaghan:
You have no grounds for believing that anyway.

Mr O'Carolan:
Ten years ago, for example, there were roughly 20 joint appointment consultants. One reason why the dental hospital and school have experienced this is the sheer manpower issue. Since that review in 2008 when the school was restructured, there has been no recruitment to the dental school in the interim period. We needed the review in December to address that problem, because it could not continue any longer.

Mr Callaghan:
I have no reason for disagreeing with anything that you are saying. One of the things that you learn in Committee is that if you do not ask questions, you do not find out answers. Unfortunately, sometimes when you ask questions, you do not get answers. However, that is another thing that we will come back to. The Committee obviously wants to be assured that an inquiry initiated by one Minister will not in any way be adversely affected, compromised or limited purposefully or otherwise by the fact that servants of another Department are also

involved, directly or otherwise, even if they are wearing two hats at the same time.

Mr O'Carolan:

I cannot comment on the inquiry, because I am subject to it. I would not want to pre-empt the findings or say anything that would influence it. I have to be careful, as it looks at the staff in the Department, the trust and the board. We are all subject to the inquiry, and I have got to respect the process.

Mr Callaghan:

Let me ask it in a different way. In day-to-day activities in the school — I do not know about all of the ins and outs of how it is internally administered and organised — presumably the fact that someone fulfils two functions, an academic function and a clinical function, does not ordinarily — this is a leading question — mean that they will say, "Well, I am not doing something that is a Health Service function, because I am actually an academic at the minute." Is it effectively joint and several compulsion?

Mr O'Carolan:

Probably the best thing to do would be to refer that question to Professor Burden, because interestingly he is the head of the school on the university side and the clinical director on the hospital side. What I would say from my experience of having trained and worked at the school is that the boundaries are blurred. The two functions overlap, because you are treating patients in a clinic and teaching students at the same time. There is no clear divide between the two. However, I think that Donald could maybe give you a clearer answer than that. That is as good an answer as I can give. I sit at a desk in Stormont; I am not in the dental school. That is my overall synopsis.

Professor Burden:

I will summarise my view on this. The challenge that we in the school of dentistry face is that we have to serve two functions for the people of Northern Ireland. We have to provide specialist care and be responsible for training the next generation of dental surgeons. Most dental surgeons are trained in a clinical environment. They are best trained by competent skilled practitioners treating patients at the chair side. As part of their training, they also have to treat patients under supervision, again, from competent skilled supervisors who make sure at all times that the health and well-being of patients is foremost. It is a challenge for our dental school and for every dental

school to meet both requirements.

Mr Callaghan:

I have one final point. What is the name the committee that Andrew mentioned earlier that evaluates higher level clinical excellence?

Dr McCormick:

The Northern Ireland clinical excellence awards committee.

Mr Callaghan:

I am at a bit of a loss as to why disclosing a matter of fact to that committee at a given point in time about something — a determination from the GDC — that was in the public domain anyway, as I think that Hansard will show, could in any way compromise an independent inquiry, especially one that is determined to be robust. I understand that the Department can at least argue that where it is being asked to evaluate something under the terms of reference of the inquiry there could be a difficulty with that being disclosed. Whether or not we agree is a matter for the Committee to deliberate on. However, I simply cannot get my head around the refusal to share that information with the Committee today. It was a straightforward question about what was done and when it was done.

Dr McCormick:

I will deal with that point in the confidential session.

The Chairperson:

The difficulty is that I cannot understand it either. Pól has made a valid point. If you share that information with me and the Deputy Chairperson, we cannot share it with the Committee. I see this as a point of fact. The GDC ruling is on the Web for all to see. I cannot see how it prejudices your inquiry if you simply confirm or deny that that has been referred to this Committee.

Dr McCormick:

I am not only concerned about the implications for the inquiry. I need to recognise the responsibility to put patient safety first and to fulfil proper HR practice. We are trying to walk a line here. I hope that you will accept that we are acting in good faith in seeking to fulfil a full

range of responsibilities and to follow proper procedure faithfully. I am happy to take that matter further, but I would rather not do it in public session.

The Chairperson:

Maybe I could come at it in a different way. Does the trust have a protocol to deal with the situation? What is the normal pattern of events? If this had never happened, what would you have done in a situation in which there was a problem with a totally different person's performance?

Mr Donaghy:

And that person had been given an excellence award?

The Chairperson:

Yes.

Dr McCormick:

I have answered that already. I said that the procedures governing the clinical excellence committee include provision for referral of issues to the committee as they arise. Those procedures exist, and our obligation is to make sure that they are followed in all cases. That is my undertaking.

The Chairperson:

You should be a politician, Andrew.

Mr Callaghan:

I am not entirely sure whether permanent secretaries should take a smaller "p". Can the Department share those procedures with the Committee?

Dr McCormick:

Yes.

Mr Callaghan:

Can you tell us a bit more? The Committee has dealt with the issue of clinical excellence awards on a number of occasions. What is the clinical excellence committee? Is it appointed by the

Department or is it an external organisation? Who are those people?

Dr McCormick:

It is a committee appointed by the Department — by the Minister.

The Chairperson:

Am I right in thinking that some of its members are consultants?

Dr McCormick:

Is that not entirely appropriate?

The Chairperson:

Is it not likely that a body full of consultants is going to grant performance awards to other consultants?

Dr McCormick:

I will get back to you with the details of the membership of the committee. It is properly accountable and is designed to provide an evidence-based assessment. Yes, there is a need for expert advice. How could such a committee operate without people who understand exactly what it means to be a consultant and who know how to judge excellence? It needs expertise and also a lay contribution. There is confidence that the committee is balanced and effective. The model in Northern Ireland is the same as those used in the other jurisdictions in the UK.

Mr Callaghan:

On behalf of my party and my colleague, I would like to put on record our admiration for the individual who came forward to raise concerns. Whether or not, in the fullness of time, concerns are held up is another issue, but we commend that person's bravery and interest in patient safety in so doing. We also commend the diligence and determination of other people who, it would appear, are working daily under various pressures. As with other recent matters, such as swine flu or X-rays at Altnagelvin, this Committee, in my opinion anyway, is not in the business of hunting down staff. We are in the business of making sure that there is good performance and proper accountability.

I have one final question on the issue of the clinical excellence committee. In the terms of

reference, paragraph 2(b) refers to:

> "evaluating the systemic nature, extent, timeliness and effectiveness of communications between and within each of"

and it names a number of entities including the Department. Can the permanent secretary tell us, implicitly or otherwise, if it is his understanding that this clinical excellence committee is included as one of the bodies if it is appointed by the Department? In other words, whether or not any determination by a body such as the GDC or the GMC in a case such as this, and whether what took place in this case was or was not referred to them.

Dr McCormick:

As Donncha said, we ourselves are subject to these terms of reference. They have been approved by the Minister. It is the Minister's inquiry, so we are subject to them. My reading of paragraph 2(b) does not explicitly bring in the committee that you mentioned or the regulators because the focus on communications is communications in the context of the actual substantive communication of the issue and, hence, ultimately telling patients and the wider public that there was an issue. I do not see any impediment if the inquiry wanted to secure evidence in relation to the:

> "extent, timeliness and effectiveness of communications"

with the clinical excellence committee or the regulatory bodies. I am sure that that could be done. It is not explicitly there, but I do not see any impediment. However, it is not my inquiry: it is the Minister's inquiry, and that will need to be judged. If the Committee wants to write to suggest that, I am sure that the Minister will consider it.

The Chairperson:

We may well follow up that idea. I have a couple of final questions, one is routine and the other is the one that you are expecting. The routine question is: does any of what has happened affect the ability of a clinician in that position, though not specifically this one, to continue private practice?

Dr McCormick:

Again, speaking generally, the right thing that happens in a context such as that is that when a concern is raised, all employers or potential employers are alerted to the concern. That is the right procedure to follow so that there is an awareness of issues. That is the first step. The second step is to ensure that there is effective regulation of all such bodies, and most of our regulations are already in place and fully effective. Donncha will explain the issue that is

outstanding following actions last year.

Mr O’Carolan:

I am glad that you raised that question, Chairperson. You may remember that the last time that I was at the Committee, on 2 December, that very issue was raised. You had the BDA on the one hand saying that we need only to regulate purely private practices. I said to you at that stage that we needed to regulate the mixed economy. Again, we cannot name individuals, but let us take a theoretical example: somebody in a similar position could go and work privately. I am glad that the Minister brought forward the regulations, which came before the Committee and which it supported, and they will come into effect on 1 April 2011.

The answer to your question is yes: an individual in that situation could continue to practise privately. However, the conditions set by the regulators would apply. For example, they could not go in unsupervised. All the other conditions are listed on the GDC website. From 1 April 2011, the RQIA can, without any difficulty, regulate such practice. It may even be able to do so under the existing legislation. The existing legislation lists dental treatment under anaesthesia and sedation, but dentistry is wider than that. For example, something like orthodontics does not involve sedation and it does not involve anaesthesia, but it could be problematic. Therefore, it is watertight from 1 April 2011, but even under the existing regulations, the RQIA may still be able to act should such an opening occur. You are absolutely right: someone in that circumstance could work privately.

The Chairperson:

So there is nothing to stop one practising to 1 April in that situation?

Mr O’Carolan:

Someone who has restrictions placed on them cannot practise without those restrictions. They must notify the GDC where they are practising and that someone is supervising their work. If they did not follow that, the GDC would act straight away.

The Chairperson:

Even if they did that, they could still practise.

Mr O'Carolan:

Yes, as long as they met the terms that the GDC sets out.

The Chairperson:

If someone had sat down at Christmas and tried to devise a series of steps to undermine public confidence in the National Health Service in Northern Ireland and had written down what has happened since Christmas, the script would have been rejected by the publishers as the events were so unimaginably weird and outlandish that they could never have happened. Since Christmas, we have had a constant stream of things that have come out and — quite frankly — bitten us.

Is there anything else out there that should be in the public domain, which we, as a Committee, should have known about and which we have not been told about? Do you wish to tell us about it now? Colm outlined that there may be issues that, for good reasons, you cannot go into. Every other issue that we have dealt should have been out there — the Western Trust, the children's hospital and swine flu, and so on. Are there any issues that you wish to tell us about that are coming up that we should have known about but do not know about?

Dr McCormick:

We will have a further meeting next week following discussions with the Minister on that topic, and we will be happy to explore that more fully. I want to try to deal with the issue of public confidence, because the first concerns for the Department are patient safety and public confidence. Let us just take issues that might be a cause for concern from first principles.

Two broad categories are important from the point of view of patients. The first of those are situations in which patients have received care in the past, and there is evidence that it might have been substandard. That is the territory that we have been in today, but there is no regional or major-scale issue with that. There will always be cases that need to be followed up and reviewed. We set very high standards, and all aspects of health and social care are subject to those very high standards. However, the Health Service depends on human beings, and we need to have failsafe mechanisms and ways to ensure that people are protected. The way in which we do that is to ensure that proper governance is in place. There will, of course, be individual cases in which people receive substandard care, but those are caught, followed up and pursued through normal procedures. There are no further imminent look-back or recall exercises that the Committee has

not heard about. I am not aware of any such case.

The second area that may cause worry is when there is a risk that a patient might receive substandard care now or in the future. Some services are vulnerable, and it is difficult to always secure the right standards and to have the right rotas in place. However, as I described earlier, the protection that we have comes through our statutory obligation on every provider to ensure that they are providing safe and high-quality services. That means that those providers are obliged to act on and correct any material risk of substandard care.

I come back to the main theme that we, as a community, depend on people to manage risks on our behalf. That applies to the individual front line professionals and to the organisations that have been put in place to ensure a high standard of care for the population of Northern Ireland. Several things need to be really strong to make that work. The first foundation is training, and we need people who are trained to the highest standards and receive the necessary continuous professional development. We also need strong clinical governance. As I said earlier, that means every member of every multidisciplinary team putting patient safety first and speaking up when they see issues going wrong. That is what happened in this case, and that worked. The system fundamentally works on that basis. We also need strong corporate governance. The trusts are very large organisations, and they have strong internal systems to assess and review all these governance issues. That is the way in which it works.

We also need strong, effective and credible professional regulation so that there is — the phrase I always use — fair accountability. Some people talk about needing a no-blame culture. My position is that we need fair accountability at an individual level so that individuals know that they will be held to account but that they will receive fair treatment. That is the only way to ensure the confidence of the public and confidence in that each member of staff knows that he or she can do his or her job without being hung out to dry for no good reason. We have to have confidence in both those dimensions.

We also need strong statutory regulations, so the role of the RQIA is vital in providing a further check and information base as to how things are working out and a planned inspection programme based on risk management. The final assurance is that we have an open and valid complaints process that is well thought through and provides the right checks and balances and access for individuals to redress or correction. There is also a strong body responsible for

fulfilling that role — the Patient and Client Council — to act and speak on behalf of patients.

Those are the assurances that are there to provide public confidence. Will we get everything right? Will we always notify you in time? Can I guarantee that there will not be another headline in the 'The Irish News'? I cannot do that, because the criteria are not always applied in the way in which I described them. I am speaking about how we try to fulfil our responsibilities properly and effectively. The best we can do is to set the right standards, to ensure that the right people are in place and that communication is good among the organisations. That is what we can do, but if it is judged by journalists that something that they have heard about is of regional significance, and they put it on the front page of a newspaper, that does not mean that it is of regional significance or that it is important.

The Chairperson:

Andrew, you must accept that everything that has been on the front page of the papers — not just that one, but several — since Christmas has all been of a regional significance. We are talking about swine flu, the X-rays and the children's hospital. They are all issues that clearly —

Dr McCormick:

I absolutely accept the points that you make. There was a significance, but that does not necessarily mean that they were not handled properly. Some were of regional significance, but there have been some stories that were absolutely not of regional significance that have, nevertheless, received front page attention. That is a decision by journalists and editors of newspapers.

I have a responsibility to the Committee and to the Minister to form a proper judgement as to what matters. I want to work with you through the additional dialogue that we have talked about to help to ensure that we are giving account on judging what is important. The Minister will judge what is important, and we will do our best to do that. What I am saying is that we are subject to the Minister's judgment and your judgement as to what is really important. I will certainly not accept that we are subject to the judgement of journalists as to what is important and what is not.

Mr Brady:

Thanks, Chairperson; I will be brief. I think that the point has already been addressed, but it

seems that this situation developed because one consultant expressed concern about what was happening. Obviously, when that type of concern is expressed, you have to make some sort of value judgement about how you progress. Given that medical and clinical issues are involved, time is obviously of the essence. In the chronological order, do you think that it is possible to refine the processes so that that could be dealt with in a quicker timescale? We are talking about a period of a week or two weeks from December, and those cases could be fairly important.

Professor Burden:
That is a point well made, and I certainly think that it will be something that the inquiry will look at. We are a learning organisation, and we will take on any learning points that derive from that inquiry.

Mr Brady:
It is a straightforward point, but it seemed to me that it is an important point that needs to be made, because you obviously have protocols and processes in place already, but they can always be refined. In cases such as this, they need to be refined.

Professor Burden:
You are quite right to draw attention to the fact that it was just a matter of weeks from the initial cases being brought to my attention that we had put everything in place.

Mr Brady:
However, it obviously puts you in a delicate situation, because you are dealing with fellow professionals.

Professor Burden:
Absolutely. It is a difficult balance; you are correct on that.

Mr Donaghy:
To re-emphasise what Professor Burden said: as it evolved at the time, Mickey, there were judgement calls, as you quite rightly said, made at those times. We are quite open to looking back and reviewing whether those judgement calls could have been made at an earlier stage. Hindsight is perfect, if you like, but at that time, Professor Burden and Dr Stevens were fully confident that the decisions that they made were timely.

Mr Callaghan:

Something struck me there: I asked earlier about the six and the 18, and it was clarified that there was a degree of overlap, so there were 16 in addition to the initial six about whom serious concerns were raised. When I asked about the Minister's statement that said that not everybody had been notified, Donald clarified that that still seems to be the case. When were the additional 16 known to the trust? So much was going on earlier, so this is a look-back.

Professor Burden:

They became known during the review. As Colm explained, the instructions given to our experts who carried out the review were that, if they came across anything of concern, it should be dealt with immediately and brought to our attention. When they came across anything of concern, all such cases were already in the care pathway system; they were in the hands of the appropriate specialists.

Mr Callaghan:

With respect though, Donald, that does not answer my question about the calendar of events that we are using.

Mr Donaghy:

I will try to answer that for you, Pól. The 16 were not a part of the recall. The 117 were separate, so the 16 were dealt with, I understand, early on in the process of taking forward the treatment. Those people were already in treatment, so the —

Mr Callaghan:

However, the fact that they were in treatment does not necessarily mean that they were aware of any potential impact of the failure to spot something. What I am trying to get at is that my understanding of what Donald said is that not all of them have yet been notified of that potential. It seems to me to be a fairly straightforward question: when did the trust know that there was a potential issue, given that it is now 10 February 2011? Unless I am missing something, it seems reasonable to assume from what you are saying, Donald, that, if it was in the earlier part of the inquiries, we are talking about at least a year ago. When did the look-back exercise start? To be honest, I sort of missed that because there was so much going on earlier. It was like data burst that was on children's ITV when I was a young fella. That is a reasonable point of concern to me.

Mr Donaghy:

Yes, absolutely. Let us be open and honest here, Pól. There are people whom we have known about for a while who are being treated but are not aware that there was a potential delay in their treatment, and we are informing those people now. They should have been informed earlier in the process; they were not, but we are informing them now.

Mr Callaghan:

Yes, but my question still has not been answered, Colm, with respect. When did you know that there was a potential impact from these issues, given that some patients still have not been informed? So that may apply to some or, for all we know, potentially all 16 people. We do not know if 15 or one have not been informed.

Mr Donaghy:

OK.

Mr Callaghan:

You are indicating now that, at least maybe a year ago in some of those cases, the trust knew that there were issues, and people have still not been told that issues arising from this individual's performance might have had an impact on their treatment. Whether or not they are being treated is a separate point. You can all clarify this. You are all intelligent men. We can all separate those issues in parallel tracks in our minds. When did the trust know about the 16?

Mr Donaghy:

At different times, as —

Mr Callaghan:

Within a range of when to when?

Professor Burden:

During the period of the expert review, which started in 2010, those cases emerged during the early part of the year, and then the review was completed just after the summer. Therefore, they emerged right across that whole period. I cannot give exact dates of when each emerged.

Dr Stevens:

May I give an answer to this? The experts reported back in November. At that point, I asked them for a detailed case history of each patient about whom they had significant concerns, and I received those. If you are looking for a technical answer about when the trust knew that I had a list of case histories, the answer is November. However, during the year up to November, I was not dealing with specific cases. That would not have been the purpose. I was being given an assurance that there were no unmanaged and untreated patients languishing in the system that it had identified. The technical answer is that, when I got a detailed exposé — that is an unfortunate word, I suppose — or, perhaps, a detailed precis of those cases, it was in November. However, Donald and I were receiving updates during the period of the review up to November and being given an assurance that those patients were being looked after.

Mr Callaghan:

You said earlier, Tony, that you had given an instruction, as the medical director, that any issues that were being flagged while the inquiries were being conducted should not be withheld from you until the end of the inquiry. So, presumably, issues would have been flagged up to either you or other senior people in the trust. I am not totally sure, but would people in the school have been notified? Obviously, aside from you being officially notified in November, people in the trust must have known. I notice in various papers that the wording is "the trust became aware". It seems to me that, in the mindset of the trust, that sometimes means someone at executive level in the trust who epitomises the body corporate in a corporeal body form. Obviously, the trust goes right down to people who work on the front line on a whole range of levels. When did people in the trust who are in a position to make some judgement about the effect of those issues know about their impact on those 16 people? It seems that Donald has given us a range from the start of 2010 to the end of the summer.

Dr Stevens:

The best I can say is that the key decision-making that brought us from where we were then to where to where we are now started in November when Professor Burden and I got the detailed feedback from the two experts. Up until that time, we were dealing with it at a clinical level, and as I say, I talked to Donald and got updates. However, those updates said that the issues were being managed at a clinical level. Again, let us be very clear: there were two tracks to this. Very clear corporate decision-making was going on throughout this to manage the service overall and to manage individuals on the relationship with the GMC, GDC and all that. That was an active

programme, and the timeline will demonstrate that there was a very active programme there throughout the year. The practical issue of managing individual patients was being dealt with at a clinical level in the school of dentistry, and I was being provided with an assurance that that was happening. My key decision-making was in November when I got the detailed report, and everything has flowed from there, including the request for them to identify people for the look-back exercise.

Mr Donaghy:

I was not in the trust at the time for part of this, but I will try to clarify the issue. I would be very surprised if a decision was made at any level in the trust not to tell patients about the potential delays. That is demonstrated by the fact that a number had been told. The number who primarily had been told are those who went to the oral surgeon who originally indicated that he had concerns. Some of the other people for treatment went to other clinicians who would not have been aware of the delay. We are aware now that some people would have gone to other clinicians. The clinicians who treated them were not aware that they were subject to a delay. We are now bringing those people back in and saying that their treatment may have been subject to a delay. You could argue that the trust should have done that a much earlier stage, and that will be part of the communications review. The other side of this is — Tony or Donald can bear this out — that I do not think that there was a deliberate decision made in the trust at any level not to tell people.

Mr Callaghan:

Of course, whether or not there was a deliberate decision to withhold information is not really the point. If that is the case, that is, obviously, a grave matter in itself. There is a difference between commission and omission. In some ways, what you have helpfully added, Colm, raises further questions. You have detailed how some people who happened to end up on one treatment track found out because they were on that track, whereas other people who were on a different treatment track, through no fault of their own, did not get access to the same information at an appropriate time.

I am trying to get my head around what I think is still a fairly straightforward question. Let me put it a different way: if I had been one of those people and, say, a senior practitioner in the school became aware — for whatever reason, formal or otherwise — on St Valentine's Day 2010 that I was one of the 16 for whom there were serious concerns, and I am still here, getting ready

to bring my wife out to dinner on St Valentine's Day 2011, which is news for her — maybe it does not happen every year —

Ms S Ramsey:
I hope that that is not the case. St Valentine's Day is next Monday.

Mr Callaghan:
I am getting ready.

I have still not been told. It is legitimate for people to wonder, especially by virtue of the fact that the trust itself has recognised that some people were told, which was appropriate. Why was I not told? When did those issues arise? I accept that we do not have a quantum today and that that will be provided. However, it should be disclosable when those issues became known to somebody in the trust regardless of the final precis, or whatever, that came to you, Tony, in November.

Dr Stevens:
I am conscious that I, at least, in part answered your question when I responded to questions from either Alex or Sue on how we handled that. I reiterate that the issue of delay is still a matter of medical opinion and some degree of conjecture. I would still qualify that and say that we need to be exceedingly careful. The six original patients who were seen by the surgeon who had the original concerns were told at that time. He felt able and confident enough to say that. We have to be exceedingly careful that we go out with the right message to the remaining patients. It is only as we accumulate all the evidence in the case that we will be in a position to tell people confidently what we think is the situation. I really do have to counsel caution here. It remains an issue of debate. Even some of the information that we pass on may be subject to legal challenge.

The Chairperson:
There is inconsistency, Tony, because you told some people and did not tell others. That is an argument for telling nobody or telling everybody.

Dr Stevens:
No: clinicians made a choice to tell people. I have not gone out deliberately either to tell people or not to tell people. As I said, since I knew in November, we have been action-planning for the

events that have occurred. They have occurred very quickly over the past day or two. In fact, we were just action-planning all those points, ready to move to inform patients. As I think that I said in a previous answer, we were putting together a very detailed process to inform those patients what we believe that we can say, with the appropriate support.

I think that I answered the question earlier. I am not clear whether there is still some ambiguity.

Mr Callaghan:

I have a final question. Tony, the Minister's statement — I do not think that I am taking him out of context — acknowledges that some are complex cases and that other conditions would be involved. We accept that. That is a fact of life. However, the Minister said to the House:

> "I want to assure patients and the House that the Belfast Trust will inform individuals of any potential delays."

Dr Stevens:

We are doing that. I want to be very clear that every patient who is involved in this will have a detailed and ongoing conversation. Earlier, I gave the undertaking that that would happen.

Mr Callaghan:

If it is going to happen, why has it not happened? On the one hand, I cannot really get my head around how you can say that, perhaps, it is not appropriate to tell people because those matters are complex and whatnot. Perhaps, there is no issue there. However, on the other hand, the Minister effectively said that there is an issue. Three of you said, in unison, that patients will be told.

Mr O'Carolan:

I will give you a very simple analysis because I know that these guys have been so bogged down in the detail. I will give you an example from my background in having been a general dental practitioner. In oral cancer, there are what are called potentially malignant lesions. That does not mean that they are pre-malignant; they are potentially malignant. If a patient comes in on 1 January with a potentially malignant lesion in his or her mouth; an oral medicine consultant or oral surgeon looks at that potentially malignant lesion, and the biopsy shows that it is dysplasia, which just means that the cells are irregular and so are potentially malignant; the patient is told to come back on 1 July 2010 when it will be reviewed; the patient walks in on 1 July 2010; the

surgeon biopsies it again, and this time it is cancerous; the question is whether it turned cancerous on 2 January, in which case there is a six-month delay, or on 30 June, in which case there is one day's delay. There is split medical opinion. My understanding is that some of the cases went to an oral surgeon, who was aware of the background and can inform the patient, and some would have gone to plastics and ENT surgeons, who would not have been aware that there was a delay. They are having to get a group of people together and ask whether there was a delay. There is still a grey area. I think that Andrew said that there are shades of grey where nobody can give a definitive answer.

Mr Callaghan:
The Minister talks about potential delays.

Mr O'Carolan:
Yes.

Mr Callaghan:
My understanding of the Minister's English is that, whether or not there was an actual effective delay, they ought to be told and shall be told. I do not think that it is unreasonable, therefore, to retrofit the question and ask why they were not told or from what point they could reasonably have been told.

Dr Stevens:
I would suggest some time after we were informed in November and now. Remember that we had to be very clear about the issues because we are going to have to go to a group of clinicians who are not aware of the issues yet and explain to them the context and the difficulties. Some of the issues, being a matter of challenge, will legitimately be challenged. Only since November would I have felt confident enough for us to make a very definite plan for that to happen. Donald and I would have taken the approach that, where the clinicians were dealing with it in the period from the start of the review to November, it was reasonable for them to have a conversation with a patient if they were confident at that time to do so. However, for us to take a corporate decision to inform the patients of the complexity, I felt in a position to start making decisions in November, just as we made the decision that we needed to call back those additional 117 patients. I felt in position to make that decision in November. We can argue about whether I should have been a position to make that decision earlier, but that was where we were. That decision-making

process started then, and, since then, we have been enjoined with the board and the agency in the decision-making process.

The Chairperson:

I do not think that we are going to get too far with this. There are grave doubts in my mind about this whole issue. I allowed Pól to continue because I thought that he was going down a route that we should have explored earlier. We need to read the Hansard report very carefully and see whether we have got the answer to when the 16 are going to be told. This has left me slightly doubtful, to put it mildly.

Dr McCormick:

Let us go away and think exactly how to re-express this. The Minister's commitment is clear, and our obligation is to fulfil the Minister's commitment. We will do so. I give an assurance on that basis. We will think very hard and make sure that we fulfil and address all the points that Pól and you have made, Chairman, if that is OK. We give you that undertaking.

The Chairperson:

Right, gentlemen. I think that this is even longer than the last four sessions that we have had on similar issues. Thank you for your time. We, as a Committee, will not be around on 31 May, when the report is issued. Some of us might not even be MLAs; we do not know. However, I am sure that the incoming Committee will be very interested to see the report. All I can say is that I really hope and pray for you and us that we do not have to through another Star Chamber — that is the only phrase that I can think of — again because it is taking up huge amounts of everyone's time. I am reassured by your comment that there is nothing out there. That often seems to be the starter gun for the press to go and find something.