Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Independent Neurology Inquiry

8 October 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Mr Alex Easton
Ms Órlaithí Flynn
Mr Colin McGrath
Mr Pat Sheehan

Witnesses:

Mr Brett Lockhart QC	Independent Neurology Inquiry
Professor Hugo Mascie-Taylor	Independent Neurology Inquiry
Mr Mark Scott	Independent Neurology Inquiry

The Chairperson (Mr Gildernew): I welcome to our Committee this morning Mr Brett Lockhart and Mr Mark Scott. You are very welcome, gentlemen. We are also joined by Professor Hugo Mascie-Taylor, who is a panel member. Professor Mascie-Taylor is joining us via video link.

Professor Hugo Mascie-Taylor (Independent Neurology Inquiry): Good morning.

The Chairperson (Mr Gildernew): Good morning, professor, and good morning, gentlemen. Go ahead and brief the Committee, please.

Mr Brett Lockhart QC (Independent Neurology Inquiry): Surely. Thank you, Chair, for the opportunity to update the Committee on behalf of the Independent Neurology Inquiry. From its inception, we sought to update politicians, particularly because so many of you have been contacted by patients and others who are anxious to get questions answered. When the Assembly returned and the new Minister was appointed, we recognised that it was important that we work through those structures and, but for the COVID emergency, we would have been with you in April this year. I am joined this morning by Professor Hugo Mascie-Taylor, with whom I have worked extremely closely and who brings to our deliberations a wealth of experience in clinical governance and in working in healthcare organisations throughout the world.

At the commencement of our appointment, we were determined to ensure that, in interpreting our terms of reference, we did not miss the most important voice in the inquiry. Even though our terms of reference require us to focus on the circumstances that led to the recall of patients in May 2018 and to review the handling of concerns by the Belfast Trust, we never lost sight of the fact that our inquiry

should hear from patients. To that end, we ran a public information campaign and invited submissions from those who were affected by the recall. We received over 200 written submissions from patients and invited 32 to formally give additional evidence to the inquiry. Their evidence often led us to new lines of investigation. Even in instances where their concerns did not fall squarely within the terms of reference, we signposted them to other relevant organisations and, in some cases, intervened on their behalf. By way of example, the testimony of approximately 100 patients has been sent, with their consent, to the GMC, as regulator; the Belfast Trust, as employer; and, in some instances, the Regulation and Quality Improvement Authority (RQIA), which is carrying out specific and discrete enquiries because they may be relevant to its investigations. As far as Professor Mascie-Taylor and I are concerned, the aim of the report in identifying problems is to ensure that patient safety is enhanced and outcomes are improved.

A further concern at the commencement of our work was to ensure our independence. Although we are conducting a public and independent inquiry, it is non-statutory; that was the only option that was open to the permanent secretary in May 2018. We were promised at the beginning that we would receive full cooperation from all the health professionals and employees whom we require to give evidence. We made it clear in our early meetings with politicians that failure to cooperate would result in an individual being named in the report. That remains our position. Despite a number of challenging issues, particularly with data protection and General Data Protection Regulation (GDPR) requirements, we are pleased to report that the cooperation that was promised has been delivered, with the exception of one registrar, who is in Australia and has not responded to any correspondence, and a consultant neurologist who is not medically fit to give evidence. All other health professionals have fully cooperated. Two patients declined to attend in person but gave us access to the relevant written material.

A further precautionary step that was insisted upon by Professor Mascie-Taylor and agreed by me was that we would have the final word on all the inquiries that have taken place or that are due to take place as a result of the patient recall. You will know that there is the deceased patients review and that the regulator, the GMC, still has to carry out its investigation and hearing. That is why we agreed to deliver a preliminary report, which may be to some extent a misnomer, because we wanted to reserve the right to issue a final report at the conclusion of all other inquiries. That was insisted upon because we are anxious that other reports do not raise issues or require investigation that, because of the timing of our report, could be missed.

The interruption to the hearing of evidence because of the COVID emergency was regrettable, but we assure the Committee that restrictions on hearing evidence, which began, obviously, in April, provided a welcome opportunity to draft many sections and to plan the layout of the report. Throughout the lockdown, we met remotely as an inquiry, formally with our legal team on a weekly basis, and I liaised on a daily basis with the inquiry solicitor, Mr Scott, and Professor Mascie-Taylor. Consequently, I am confident that the time that was afforded to do that was not wasted. We fully understand the frustrations of the public and the urgency of producing our preliminary report. I am happy to take questions.

The Chairperson (Mr Gildernew): Thank you. I have a brief question. What is your assessment of the time impact of COVID on the delivery of your preliminary report?

Mr Lockhart QC: I decided at the outset that we were going to try to make use of the time, and I think that we have done that. When you are hearing evidence, you find that it is very difficult to write because you are getting a plethora of material coming in, sometimes on a daily basis. I thought that the pause enabled us to try to make up time that we otherwise would have had to use at the end. Whilst you obviously have to ensure that you continue to hear that evidence — we have about, I think, 14 to 18 witnesses left out of 200, and some of those witnesses will take a long time — you cannot draft a final paragraph or a final conclusion, but you can do a lot of writing of the evidence. You can begin to form your ideas and findings, and you can obviously test those against additional evidence.

I hope and I think that we have used the time quite productively. I will be interested to hear what Professor Mascie-Taylor says about that.

The Chairperson (Mr Gildernew): What is your understanding of the reason why the large amount of evidence that was presented to you by the Department in recent times was delayed? Has that impacted negatively?

Mr Lockhart QC: What happens, Chairman, is that we will discover something in one document and then see that as a line of inquiry. When we were looking at blood patching, we felt that it was such a serious issue that we saw that emails on it, for instance, may well have been throughout the system. That was a huge task, and we accepted that. Eventually, those 30,000 documents, which were, essentially, emails, were given to us.

The good news is that, on that alone, we have four relatively young, very eager and extremely articulate and able panel D counsel, who have been quite outstanding in their application and assiduousness. We are just reaching the end of that assessment. We have split the emails into four or five, so to speak, and have quite intensively used the last six weeks to assess them.

That is an inevitable consequence of any inquiry that seeks to go beyond the original material that it is given, because you will say, "There must be more material". That just happened to be one of the areas.

The Chairperson (Mr Gildernew): Thank you. I have met family members who have been impacted by this. The scale of it, in the first instance, and the impact on individuals and on families has been absolutely massive. That is in all our minds at this time, and, indeed, members of the Committee met family members again recently.

In that light, I will go to members now.

Mr Sheehan: Thanks, Brett, Hugo and Mark, for coming in. I think that it is a year now, or nearly a year, since I last spoke to you. We have continued to keep in contact with many of the patients during that period. I spoke to some of them as recently as yesterday. All of them have expressed a great sense of frustration that none of the reviews that are taking place have patient care or the harm that was done to patients as part of their central focus. If you read the terms of reference of all the reviews, you will see that they are not about making a judgement on patient care or the harm that was caused. I am not asking you a question about that; I am just making a statement that there is a great sense of frustration.

Patients have told us that they have three objectives. First, they want justice for the harm that was done to them. Secondly, they want accountability for the person who was responsible for harming them and for those whose job it was to provide supervision or oversight at a governance level. Thirdly, they want reassurance that nothing on this scale can ever happen again. You cannot legislate for individual doctors going rogue every now and again and doing harm to patients, but this episode lasted for a very long and protracted period. It should have been stopped before it was. Can you explain to the patients who have been harmed how you and your inquiry intend to reach those objectives, which they need in order to get closure in all this?

Mr Lockhart QC: I will ask Professor Mascie-Taylor to begin on that.

The Chairperson (Mr Gildernew): Mr Lockhart, could you speak a wee bit more directly into the mic?

Mr Lockhart QC: Oh, sorry.

The Chairperson (Mr Gildernew): We can hear you fine here, but, apparently, online it is a little bit —

Mr Lockhart QC: OK, Chair. Thank you. I will indeed. I will ask Professor Mascie-Taylor to start, and I will follow up.

Professor Mascie-Taylor: Good morning. You are breaking up occasionally, and I may be breaking up with you, so I apologise if I do not immediately pick up on a question.

Pat, it is good to see you. I have to say that, in my view, patient care past and in the future are central to the inquiry. They are what the inquiry is about. I fully understand why patients, quite rightly, want justice, accountability and reassurance that this will not happen in the future. As you pointed out, you cannot give absolute reassurance, but I am sure that we can and should do a lot better. The way that we will carry out our task, and the way that we have carried it out so far, is that, without fear or favour, we will name names, praise people where they should be praised and be critical where we need to be critical. *[Inaudible.]* That is what we can do within our remit.

On accountability, Dr Watt will be held accountable by his employer and his regulator. It is not for us to hold others to account, but it is for us to point out if there is a need to hold people to account. Perhaps the major thrust of our inquiry is on what went wrong and how can, to the greatest possible extent, patients and carers in the future be reassured. As Brett said, from the very outset, we have addressed patients head-on. We did not have to see patients, but we chose to do so. We reached out. We received large numbers of questionnaires. We have seen and been guided by patients.

Our process absolutely takes into account the wishes and needs of the patients. We are most of the way through with it. We have some very important work still to do, but, when it is produced, I think that it will contribute enormously to those three areas where patients are, rightly, concerned.

Mr Lockhart QC: It is the third limb that Pat raised that we can do something about in particular. Obviously, the regulator has the statutory responsibility to call doctors to account for harm. It is regrettable that that has not yet taken place. The COVID emergency seems to have had a significant impact on hearings in the GMC. I regret that that has happened, but, as far as we are concerned, our report is trying to proceed apace. We believe that we can continue to answer, in a broad and purposeful way, the questions that we were asked.

I accept that there is tremendous frustration out there. A lot of patients have contacted us, and we are in fairly regular contact with them. As I say, we are not just hearing evidence; we have done a lot of work on signposting, so we appreciate the frustration. We want to come out with a meaningful report, so it is very important that we follow the lines of inquiry, that we do not skip over things and that we get into the detail of systems.

We are talking about systems not only in the NHS in particular but in the private sector. Those systems can, at times, be Byzantine. That is not my word, that was in the Bengoa — it was not even in Bengoa; it was in the report before that by Liam Donaldson, and it tended to suggest that we have a Byzantine arrangement in the healthcare system. You have the Department, the Public Health Agency (PHA), the trusts and a whole series of arrangements. All those people have to be spoken to. You have so many people involved at times that you are trying to focus on how you ensure, for instance, that information is properly shared in the structures.

I do not try to downplay the challenge for us and the urgency with which we have been tasked to do this, Pat, but all that we can do is do it well and as quickly as we can.

Mr Sheehan: I understand that, Brett, but what I am asking is this: can you tell the victims in this case why your inquiry is more likely to reach those three objectives that I mentioned than a statutory inquiry, which would have powers to compel witnesses and evidence? You mentioned that there is one consultant and a registrar, who I was not aware of, who are not going to give evidence, and it is also the case, no doubt, that they will not hand over emails or other documentation to the inquiry. Why is your inquiry more likely than a statutory inquiry to bring closure?

Mr Lockhart QC: Let me be more specific. There were a very large number of registrars over a period of years. I am trying to remember the exact number, but it was certainly 20-plus. We do not believe that this particular registrar is particularly significant. The consultant is more significant, but we have, in fact, got access to all the emails involving that consultant. He was involved at a particular stage, so we have got much of the documentation. It is unfortunate that he cannot come, but that would be the case even with a public inquiry. He would not be going before a public inquiry either, according to the medical evidence that I have.

Leaving that aside, your broader question is whether a public inquiry would be better. To some extent, it is not for me to express a view on that. The situation in May 2018 was that there was no Assembly, and the permanent secretary did what he could. We are now two years on. There is only one caveat that I will lay when getting into this at all. As I say, it is not really our job to determine what sort of inquiry we are; our job is to do what we have been asked to do as quickly and as properly as we can. I am concerned that, if you transform this into a public statutory inquiry, the delay will be phenomenal. There is a whole query about how you do that. Would you have to recall witnesses and hear their evidence again? Many patients may be more reluctant in a public setting. A range of factors would influence that. We have made a decision. If we are turned into a statutory inquiry, we will, of course, go with that, but we are at a pretty critical and sensitive stage at the moment, Pat, and I am anxious to make progress.

Mr Sheehan: Finally —.

The Chairperson (Mr Gildernew): I will come back to you if time allows, Pat. I want to make sure that all members get in.

Ms Bradshaw: Thank you. It is good to see you all at the Committee.

I want to follow on from that. The first question that I put to the Health Minister when he came into post was whether he would have a public inquiry into Muckamore, and the second question was whether he would turn this into a public inquiry. The scandal around both these issues is very far-reaching for the credibility of our health service. When we met in private in closed meetings — I mean the Health spokespersons and you — we bandied about the question of whether there was a need for this to be a statutory public inquiry, and the response that I got from the Health Minister in February was that he had met you and was "assured" that there was "significant progress" — I do not want to misquote him — and that it was at a "critical stage" etc. Was it put to you whether you thought that this should be a statutory inquiry when you met the Minister when he first came in to post? I assume that that was in late January or early February.

Mr Lockhart QC: We met the Minister in February. That was not the focus of our meeting; its focus was to update him on progress. If I am being absolutely honest, I cannot recall the full extent of what was said. It may well have been mentioned in passing, but the focus of our meeting with the Minister was to assure him of the progress that we have made. I think that the conversation may have been different a year earlier. By that stage, we had nearly over 200 witnesses. My concern and fear, if you are asking me about it now, is that we would have to redo or go over evidence again. I am very satisfied that, for any evidence that we have obtained, we really have got at a lot of the issues that are and will be of concern. I accept that I am saying that now and that you do not know as yet what is going to be in the report, but it is a judgement that we have to make.

My main concern is delay. That is the problem. That meeting, of course, was a month before the lockdown. You then had the lockdown on top of that. I think that that has also been difficult for patients, who are struggling and want to see answers. You then had a six-month hiatus before there was further evidence, and we started again in September. That is my main concern.

Ms Bradshaw: OK. Moving on, part of our conversations in the past have been about the limited terms of reference. The Muckamore leadership and governance had issues with the terms of reference that were set by the RQIA board, and there was a mass resignation. In many ways, people are setting the terms of reference so narrowly that we cannot actually get to the truth. To what degree do you think that the terms of reference that were set for you, as an independent panel, have restricted your ability to identify the people who are, ultimately, accountable for this mess?

Mr Lockhart QC: I will ask Professor Mascie-Taylor to comment on that as well, but my view is that they have not restricted us. It was critical that we did two things at the outset. First, we wanted to ensure that, for anyone who refused to come, particularly someone in the health service, there were various sanctions that we could apply. This may sound a little strange, but the threat of naming someone specifically for not cooperating as a health service professional in the report is very effective. People do not want to be seen as not cooperating. That has been utilised very rarely, but it has had to be utilised on a number of occasions. We have utilised that clear indication. The second thing, which I mentioned in my opening statement, is that, where there is concern about what may or may not emerge in other inquiries, we retain the ability to have the last word. That was important, because other things may emerge, and if they do, we will want to go back before we give an absolute final report and look into them as well.

I am interested in Hugo's view, but, as far as I am concerned, the terms of reference have not inhibited us.

Professor Mascie-Taylor: I agree. I do not think that it is helpful yet to hear my view on the benefits and disbenefits of two types of public inquiry. My view is that we are where we are. We must not have more delay than we absolutely have to. That is my bottom line. Do I think that we have been inhibited? No, not at all. We have had and have taken every opportunity to question people very thoroughly. As Brett pointed out, people have come, with very few exceptions, to give evidence.

The only potential benefit of a statutory inquiry is that we could subpoena people. In practice, as Brett pointed out, that would make no difference whatsoever, because the medical evidence in the particular case would win the day. I do not think that that advantage really holds. The second potential advantage is that people would give evidence under oath. I do not have any sense that that would

help us a great deal. Whilst not pretending to be an expert on different types of public inquiry, my feeling is that we are where we are, we are making substantial progress, we have not been inhibited by the nature of the inquiry and we should proceed with as much pace as we can in order to do, as you rightly pointed out, what the public want, which is to get justice, accountability and some reassurance that this cannot happen in the future. Collectively, that is what we should all do. We should stand together on that and move with as much pace and clarity as we can.

Mr Easton: I am not an expert on inquiries, so forgive me if I ask some strange questions. You said that a registrar, who is now in Australia, and a consultant, who is retired, have not been in contact, or you have not been able to contact them.

Mr Lockhart QC: I will give you the specifics on that. The consultant went to Australia. We thought that we had obtained details.

Professor Mascie-Taylor: The registrar.

Mr Lockhart QC: The registrar, not the consultant. Thank you, Hugo. The registrar went to Australia. He is one of many registrars at a fairly junior level who worked for a limited time, potentially, with Dr Watt. The purpose was to ask them about their experience of working with Dr Watt at various times. We have had no contact whatsoever from that particular registrar.

The consultant situation is slightly different in that we received a detailed medical report, and I am confident that he would not have been permitted to attend a public inquiry. This is a public inquiry, but he would not have been permitted to give evidence under oath in a statutory inquiry either. I am satisfied with that. You can subpoena someone.

Professor Mascie-Taylor: To be clear, the registrar is very unlikely to add a great deal.

Mr Lockhart QC: Exactly.

Professor Mascie-Taylor: On the other hand, it would have been very helpful to have had the opportunity to talk to the consultant at the inquiry, but I recognise that that is not possible. However, to be candid with the Committee, I do not think that the registrar makes a great deal of difference. It is unfortunate that we have not had the opportunity to talk to the consultant.

Mr Easton: The point that I was trying to make was that if you felt that you needed to contact them, even though you say that it would not make much difference, it must have been important enough to ask for their opinion and to ask them questions. If that was the case, can you dismiss it?

Mr Lockhart QC: We do not dismiss it at all, Alex.

Mr Easton: I do feel that it is so serious that those two individuals should be pushed as far as possible. They may know nothing or very little, as you say. However, there may be something there.

Mr Lockhart QC: Let me reassure you. Hugo put it correctly. When we are talking about the registrar, we are fairly confident that that would be of limited evidential relevance to us. The consultant was someone whom we were interested in talking to, and we pursued that with some intensity, to put it mildly. We were, ultimately, given two medical reports, and we followed up on the first one. We wanted a further medical report, and that report was given to us to mitigate the effect of the consultant's not attending. We were also able to obtain access to all the relevant emails in the healthcare system that the consultant was involved with. We have a significant volume of documentation that is relevant.

In addition, under the Maxwellisation process, we are obliged to send him any criticisms, as we do for anyone who is potentially criticised. We are making no definitive judgement on that at all at the moment, but anyone who is going to be criticised will have a further opportunity to respond in writing. That individual is represented by solicitors, and we will liaise with them as well. It is important that you understand that we are not dismissing it or think that nothing can be done about it. We have taken every step that we can to ensure that as much written evidence as possible is obtained. I cannot say very much more, for obvious reasons. However, I can reassure the Committee that we took a lot of steps to ensure this person's attendance.

The Chairperson (Mr Gildernew): OK. Thank you. I will move to Gerry Carroll who is on the phone. Gerry, are you there?

Mr Carroll: Can you hear me?

The Chairperson (Mr Gildernew): Go ahead, Gerry. You are quite faint.

Mr Carroll: Can you hear me now?

The Chairperson (Mr Gildernew): Just about, Gerry. Speak up, you are still quite faint.

Mr Carroll: Thank you, Brett and Hugo. I echo Pat's points about patients feeling failed by the system and that many of them are still concerned that not enough support services are in place. Many of them have been waiting for seven months for a meeting with the Department. I just wanted to make you aware of that.

I had a few technical issues at the start, so I might have missed what you said about the inquiry's remit. Is it within your remit, Brett, to recommend sanctions, punishment, dismissal or things of that nature? There is a concern that whilst you are engaging in essential and, no doubt, very important work, perhaps no heads will roll and that you are highlighting fundamental flaws in governance for which nobody will be held to account.

I know that there was an issue with a consultant. Are you satisfied that the Department of Health and the trusts have cooperated fully with you and your team?

Mr Lockhart QC: I am not sure that I heard your second question entirely, Gerry.

The Chairperson (Mr Gildernew): Would you repeat your second question, Gerry? It is quite difficult to hear you.

Mr Carroll: I know that there was a problem in relation to cooperation from a consultant. Are you confident that the Department of Health and the trusts have cooperated fully with you?

Mr Lockhart QC: The answer to your first question harks back to a concern that we had in our early briefings with politicians that our report would not just offer blandishments or that it would somehow skirt over the issues and focus entirely on systems. Hugo and I have made it clear that we must talk about and, if necessary, criticise the individuals involved in the system. You simply have to look, Gerry, at other reports — the renewable heat incentive report in particular or the hyponatraemia report, which is relevant to the healthcare system.

There is a proper way for us to do things. We are not the regulator; therefore, we are not there to determine the competence of a particular doctor. However, our report, we know, will be read with intense scrutiny by those who have that responsibility. Our responsibility, and our duty, is to ensure that we give a clear and cogent understanding of the issues that arose, the problems that emerged, the responses that may or may not have been made and who was responsible for them. It is for others to follow up on that.

To answer your second question, I do not like to go back to the issue of the particular consultant. The consultant did not refuse to come to the inquiry. He would have wanted to come. However, he is suffering from a particular condition. We obtained as much medical evidence as we could on that, which was presented to us. There was nothing else that we could do, apart from trying to mitigate the effects of his non-attendance.

Mr Carroll: *[Inaudible.]*

The Chairperson (Mr Gildernew): Gerry, three other members want to ask questions, so I will move on for now.

Mrs Cameron: I want to thank the gentlemen for their attendance this morning. It is an incredibly important inquiry, and we understand that it is vital to establish the facts and rebuild public confidence. I have also had some technical difficulties, so I apologise if you have already covered my question.

Has the basic structure of the final report been devised? Can you give us an insight into themes likely to be in the report?

Mr Lockhart QC: It is a good question, Pam, and I will try to be as fair as I can. I have to be careful because the evidence has not finished, but, at the outset, a number of themes emerged that we are looking at. We have, for instance, looked at regulation in the independent sector and at the structure and governance arrangements even in neurology itself. There are all sorts of themes that you would expect. It will come as no surprise to anyone that we are looking at blood patching in some detail. That was the subject of a documentary. It is also something that we are carefully considering.

I am anxious not to say too much because we took evidence just yesterday from which we believe another chapter in the report will arise. It continues to evolve. Some of the themes are very obvious; others become obvious, as you hear the evidence. The patients constitute a chapter in themselves. I hope that it will be the first chapter, because we want to include significant evidence from many patients in the report.

During the COVID-19 lockdown, the idea was to work on many of the chapters and get a fair number of them completed. I am happy to say that we have done that.

The Chairperson (Mr Gildernew): As a follow-up, before I go back to Pam, has the issue of annual appraisals been included?

Mr Lockhart QC: Absolutely, of course. It is a significant question. That is one of the obvious ones, Chair.

Mrs Cameron: Thank you for your answer. I understand that it is difficult to know how long the inquiry will take, but can you give us an indicative timing as to when you expect the final report? What ongoing contact has the review had with those employees of the trust who were in governance or oversight roles at the time of Dr Watt's actions? Have many of them moved on? If so, has anything been put in place to mitigate poor practice in other areas?

Mr Lockhart QC: I will take your second question first, Pam. The vast majority of the key individuals concerned have not moved on. Some have moved to other positions in the trust. Some individuals have given evidence to us on more than three occasions. One of the benefits of a non-statutory inquiry is that, with sworn evidence and being subpoenaed, there tends to be a beginning and an end. It can be quite difficult to recall people, unless you are very discreet. We have a much lower threshold for recall. Frankly, people are often before us for many days at a time and often they come back, six months later, to go through a different part. Some individuals have been before us three or four times. I have one example of someone who has retired, but we have had full cooperation from that person.

In relation to the real question, which is when will the inquiry report come out, I can tell you that it is at an advanced and critical stage. We have used well the time that people might have thought was lost during lockdown. We have witnesses scheduled until the end of January 2021, we then have to go through the final drafting of the report, and then the process of Maxwellisation, which all public inquiries have to go through whereby anyone who may be criticised has to have the opportunity to comment on that criticism. We hope that that will not take a very long time. I want to get the report out as quickly as possible. However, it might be imprudent to give you a date only to find that other factors delay it. If we can get it out earlier, we will, absolutely.

Ms Flynn: The first wave of the COVID-19 pandemic had an impact on the inquiry and witness statements, which restarted in September. Does the inquiry team have contingency plans should there be a second wave and further lockdowns next year? Do you have a process to protect the inquiry from delays similar to those of the past few months?

Mr Lockhart QC: Órlaithí, that is a very good question. I think that we are quite pleased with the precautions and the steps that we have taken to recommence the inquiry. As Mr Scott and our secretary, Geraldine Quinn, will tell you, the truth is that huge efforts have to go in to even preparing to get a witness to attend, but we are doing it remotely. I hope that we will not be back to the situation that we were in in March and that we have ways of working around that. In extremis, we will use the time to write the report, as we did the last time. We hope that no time will be lost, essentially.

Ms Flynn: It is quoted in the terms of reference that part of the inquiry was to look at the reporting of issues regarding patient safety and that if there were any issues of immediate concern, the panel could bring them straight to the attention of the Department of Health. Have you come across any instances of that?

Mr Lockhart QC: Yes. Very early on we approached the Department with a number of matters that will feature in the preliminary and final reports. We will outline those in detail. We took a proactive approach at an early stage because we think that we identified matters that should be dealt with. A good example that I will ask Hugo to talk about is the electronic care record, as it is an example of something that we think is a straightforward fix that needs to happen very quickly.

The Chairperson (Mr Gildernew): Very briefly, please, because we want to get other members in.

Professor Mascie-Taylor: I am sorry. This link keeps failing, so I am struggling. I think that the point that was being made, Brett, was that we have acted in such a way as to try to create change during the course of the inquiry. Indeed, we have a lot of evidence that, across a number of sectors *[Inaudible]* potentially elsewhere, we have created useful change as we go along. I hope that that addresses the question.

Mr Lockhart QC: Let me follow up on that briefly, Chair. The electronic care record does not extend to the private sector. That is a patient-safety issue, because, particularly in Northern Ireland, you have people regularly going between the private sector and the NHS. Investigations happen, but the notes are not on the electronic care record, which, frankly, is one of the jewels in the crown of the Northern Ireland health service. We are well ahead of the rest of these islands on that.

Professor Mascie-Taylor: Northern Ireland is ahead of the rest of the UK in this regard, and patients can *[Inaudible]* notes *[Inaudible.]*

The Chairperson (Mr Gildernew): That is interesting. Thank you.

Mr Chambers: I get the sense that some members feel that Minister Swann should have changed the status of the inquiry, and I understand entirely where they might be coming from. However, it is clear from the evidence from Mr Lockhart and Professor Mascie-Taylor that such a change of direction mid-journey would not necessarily be in the best interests of the public and, more importantly, the patients. I am greatly reassured by this piece of clear, professional and independent evidence to the Committee this morning.

When any of us sees a consultant or a doctor in hospital, we put our life in their hands. Our relationship with a medical practitioner is built on trust, and, obviously, trust was broken in this case. Mr Lockhart, based on what you have seen so far, could what happened in the neurology department have been replicated in almost any discipline in a hospital? Hopefully, lessons will be learned, but can those lessons be applied across the board, and will they be relevant to all medical disciplines?

Mr Lockhart QC: The short answer is yes. Many of the issues that arose and the concerns that we looked at are relevant across the healthcare sector. They are not unique to neurology. Do not believe that. We have not looked with any intensity at other departments, but we are fairly confident, particularly with the benefit of having someone with Professor Mascie-Taylor's experience in clinical governance, that this is not unique to neurology at all. We believe that it applies right across. Therefore, some of our recommendations will — we believe and hope — be implemented across the NHS and the trusts in Northern Ireland.

Professor Mascie-Taylor: This extends well beyond Northern Ireland. It extends across the UK, and, in my experience, beyond the UK. The patterns of behaviour are not dissimilar across the world, so the sort of recommendations that we make will, I hope, be applicable well beyond Belfast.

Mr Carroll: I know that there was an issue with the consultant. Aside from that, is Brett confident that he was given all the cooperation that he needed from the trust and the Department of Health?

Mr Lockhart QC: I think that I do understand the question: are we confident that we got the cooperation from the trusts that we required? As I indicated in my opening remarks, that is crucial to our independence and effectiveness and is something that we take extremely seriously. The answer is yes: we are satisfied that we had that cooperation.

Mr Sheehan: You said, Brett, that the focus will not just be on systems of governance but will look at the role of individuals. There is a plethora of reviews, investigations and inquiries going on into this issue, and the RQIA was tasked with carrying out a couple of them. However, someone who was in a senior position in the Belfast Trust when a lot of this was happening has now been appointed chief executive of the RQIA. Would you not agree that there is a conflict of interest there, and that — without impugning the integrity of the individual — it is a clear case of objective bias?

Mr Lockhart QC: First of all, that is not actually correct. The person who, I understand, has been appointed interim chief executive is from the Northern Trust and has not been in the Belfast Trust for many years.

Mr Sheehan: He was the medical director in the Belfast Trust at a period when —

Mr Lockhart QC: Yes, which is certainly right.

Mr Sheehan: — Dr Watt was involved in a lot of this. We spoke earlier about annual appraisals, and responsibility for ensuring that annual appraisals are completed falls to the medical director. That individual was medical director at the time when annual appraisals were not being completed. Do you not think that there is a clear case of objective bias there, that he should now be supervising and overseeing two investigations by the RQIA?

Mr Lockhart QC: I am not going to get in —

Mr Chambers: Is that a fair question for Mr Lockhart?

The Chairperson (Mr Gildernew): Let Mr Lockhart deal with the question.

Mr Lockhart QC: Unfortunately, Pat, it is just beyond me. It is a matter for the RQIA, and the RQIA will have to address it if necessary. However, it is beyond the remit of our inquiry. Lawyers are sometimes tempted to answer questions because they are interested in the ideas behind what is being asked. However, answering that question would be an overreach for me, and I am not going to go there.

Ms Bradshaw: What cooperation did you get from the independent private sector?

Mr Lockhart QC: Perhaps, surprisingly, that ended up being a significant focus in our inquiry, and yes, again, we received full cooperation from the independent sector.

The Chairperson (Mr Gildernew): I thank the panel for their attendance this morning. Thank you, Mr Lockhart, Mark and Professor Mascie-Taylor for updating the Committee. We look forward to further engagement with you. Good luck with your work. Ádh mór leis sin agus slán go fóill.