New Script
FOR MENTAL HEALTH

New Script Response to Department of Health Consultation on

Being Open Framework for the HSC

March 2025

Nobody should have to bury their child. Nobody should have to have that feeling. These deaths are preventable. You need to listen to us. We tell our stories because we never want anyone else to go through what we've gone through. We want answers, but we also want solutions.

Kirsty Scott, who lost her son William at 19 years of age due to failures in mental health services.

We hoped following our son Conall's death that lessons would be learnt that those involved in his care would accept the failures, but unfortunately that did not happen. My hope for the future is that lessons can be learnt to improve the services that are provided, in order to protect our young ones.

Mary Gould, who lost her son Conall at 21 years of age due to failures in mental health services.

Analysis and Recommendations

1. Introduce a legal duty of candour for organisations and individuals.

Our understanding of a Duty of Candour at its simplest level is that it is about telling the truth when something goes wrong. The fundamental issue is not about staff doing something wrong or making mistakes, it is about what happens when mistakes are made. Where mistakes occur, the most important thing is that the staff member/s involved can tell the truth and engage openly and honestly to understand what went wrong, and to take steps to ensure there is no reoccurrence. However, in cases where harm is knowingly caused, such as wilful neglect, and then covered up, criminal sanctions should apply. We endorse these straightforward proposals set out by Bismark and Paterson (2005): honesty is the best policy, say sorry if you hurt someone, we can all learn from our mistakes and treat other people the way you would like to be treated.[i]

We support the 2018 recommendation by Justice O'Hara arising from his Independent Review of Hyponatraemia Related Deaths (IHRD) that a Statutory Duty of Candour should extend to both organisations and individuals[ii], for the following reasons.

Lessons are not being learnt from failures

Families involved in New Script are united in their desire to ensure that the harm and loss they experienced because of health service failures should never happen to other families. Yet the sad reality is that lessons are not being learnt. First hand experiences of families, coupled with multiple investigations, inquiries, and reviews, all point to the abject failure of the HSC leadership to learn from their mistakes and implement changes recommended.[iii]

The Serious Adverse Incident Review (SAI) process is widely acknowledged to be fundamentally flawed, with a systemic failure to implement recommendations. Research into SAIs following patient suicides, carried out by Queens University Belfast in 2022, found a lack of focus on the extent and effectiveness of the implementation of recommendations.[iv] A 2021 RQIA review of the systems and processes for learning from SAIs found the current policy to be inadequate and needing reform.[v] Key failures included an excessive focus on process over quality, unclear PPI guidance, lack of standardised training and insufficient independent advocacy and no defined competencies for investigative leads or review chairs.

Compounded Harm is Being Caused to Families

The issue of compounded harm is not acknowledged or addressed in the consultation document. Yet all too often, in addition to the harms resulting from the initial service failures, families experience 'compounded harm' which

makes the initial harms even worse for them. Research undertaken by Dr. Lauren Ramsey and colleagues, (2024)[vi], which Mary Gould, a New Script activist, contributed to, explored ways in which compounded harm is experienced by patients and their families as a result of organisational responses to patient safety incidents, and proposed how this may be reduced in practice. The six ways identified that patients and their families experienced compounded harm were: (1) powerless (2) inconsequential (3) manipulated (4) abandoned (5) dehumanised and (6) disequilibrium.

Power asymmetries between families and the health service must be addressed

The research referenced above also illuminated the asymmetries of power dynamics between patients, families, and health services. This included epistemic injustice, a form of injustice related to knowledge, which includes exclusion and silencing of families, with lesser or no credibility being given to their testimonies. The service's account of what happened is taken as 'the' account. Families are ignored, silenced, their experience diminished, not believed and gaslit. These deep inequalities and further compounded by the inequality in arms in respect of access to information, legal support, and expertise.

Three recommendations were made for policy and practice: (1) the healthcare system to recognise and address epistemic injustice and equitably support people to be equal partners throughout investigations and subsequent learning to reduce the likelihood of patients and families feeling powerless and inconsequential; (2) honest and transparent regulatory and organisational cultures to be fostered and enacted to reduce the likelihood of patients and families feeling manipulated; and (3) the healthcare system to reorient towards providing restorative responses to harm which are human centred, relational and underpinned by dignity, safety and voluntariness to reduce the likelihood of patients and families feeling abandoned, de-humanised and disoriented.

2. Regulate health services leaders and managers

The prevailing culture of deceit, cover-ups, negligence, and deliberate obstruction in response to harm caused by the HSC, is cultivated and sanctioned by those in leadership positions within it. Yet too often when things go wrong, front line staff are blamed and made to carry the responsibility. This engenders fear and a silencing and results in a 'chill factor' for staff who want to speak out against wrongdoing. While professional staff such as doctors and nurses are regulated, non-clinical managers and directors are not subject to similar regulation.

A recent whistleblower case in NHS England highlighted this toxic culture. Maxwell Mclean, former chair of Bradford Teaching Hospitals NHS Trust, claims he was forced to resign after raising concerns about patient safety, which were later confirmed by an independent inquiry. He alleges he was secretly removed by the board to cover up failures and is now pursuing a

whistleblowing claim. Mclean criticizes the CEO for resisting change and argues his treatment undermines NHS whistleblower protections.[vii]

Following a series of scandals in NHS England over the past decade or more, at Trusts including Morecambe Bay, East Kent and Shrewsbury and Telford, a public consultation has been launched on regulating managers to end the 'culture of cover-ups' in the NHS.[viii] Measures being considered include the introduction of a statutory duty of candour making NHS managers legally accountable for responding to concerns about patient safety. Regulation is being considered to close loopholes that allow poorly performing or misconduct-prone managers to continue working in the health service. Proposed options include a voluntary accreditation register, statutory barring mechanisms, and full statutory registration.

New Script is calling for similar regulation of HSC non-clinical managers and directors, including Trust Board members, to be introduced.

3. Establish independent oversight, ensuring harmed families have a central role.

It is critical that there is a robust and verifiably independent oversight mechanism attached to a statutory Duty of Candour. 'Marking their own homework' has regrettably become the modus operandi of the health service and its regulatory and oversight mechanisms. Families who have been harmed by health service failures do not have confidence in the RQIA, the health regulatory body, to hold Health Trusts or other bodies to account for failings. Instead, the RQIA itself is causing compounded harm to families, by failing to carry out its legal duties.

In 2023 a Judicial Review uncovered that the RQIA had failed to execute its legal duty to regulate community mental health services for 14 years, services accessed by approximately 42,000 across the five Health Trusts. Almost two years since that Judicial Review, families have seen no evidence that RQIA is effectively regulating community mental health services. While RQIA insists that their approach is 'intelligence led,' in 2023 not a single concern was raised by a 'service user'.

RQIA informed the Assembly's Health Committee in June 2024 that it had an Interim Inquiry Protocol in place, but to date this Protocol has not been published or made available on request by New Script. Furthermore, RQIA failed to establish two External Reference Groups, with patient and carer representation, committed to in 2009, to advise its inspection of mental health services.

Serious failures by the RQIA in carrying out its duties are not limited to the area of mental health but also occur in oversight of other areas of health and social care, including learning disability (Muckamore Inquiry) and older people's care (Dunmurry Manor Inquiry). While the Being Open consultation

document does not provide any detail as to how a new Duty of Candour would be regulated, we note with concern the proposal that RQIA be given a role in regulating proposed new Standards of Openness. It also proposes that RQIA play a role in reviewing organisational processes of assurance across the health and social care system.

The consultation document references the introduction of an Independent Speaking Up Guardian Model, following the Francis Review. In England, a network of Freedom to Speak Up (FTSU) Guardians was developed with the support of the National Guardians Office (NGO). The consultation document does not propose a similar model for NI. Instead, it points to the Your Right to Raise a Concern (Whistleblowing) HSC Framework and Model Policy, introduced in 2023. However, unless the Department of Health addresses the toxic culture of defensiveness, deceit and obstruction that exists within the health service, including through the regulation of managers as discussed above, we have no confidence that whistleblowers will be supported and protected.

The consultation document also references the role of Patient Safety Commissioner (PSC), introduced in England in 2021 and asks whether the introduction of an Independent Patient Safety Commissioner would improve openness and safety. The consultation document does not provide enough information on this role, including their role, powers, reporting and governance arrangements, to allow us to make an informed response to this question.

We recommend that oversight mechanisms attached to the Duty of Candour must include families who have experienced harm by mental health services, with equal weight being given to their role on these mechanisms as that given to HSC staff. This has been recommended by a number of independent reviews, including most recently in January 2025, in a report by the Health Services Safety Investigations Body (HSSIB) into learning from deaths in mental health inpatient services.[ix] The report recommended a shift in safety investigations and learning, away from procedural practices to a culture rooted in empathy, person-centred care, and active involvement of families.

[i] Bismark, M. and Paterson, R (2005) 'Doing the right thing after an adverse incident' in The New Zealand Medical Journal . 118 (219): U1593. Source: PubMed.
[ii] https://www.ihrdni.org/Full-Report.pdf
[iii] Inquiries include the Independent Review into Hyponatraemia Related Deaths, Muckamore Abbey Hospital Inquiry, Independent Neurology Inquiry and the Infected Blood Inquiry, with ongoing calls for an inquiry into Cervical Cancer Screening.
[iv] https://pure.qub.ac.uk/en/publications/implementing-changes-after-patient-suicides-in-mental-health-serv

[v] https://www.rqia.org.uk/RQIA/files/24/24765aab-014c-42bb-ba0b-9aa85e739704.pdf
[vi] https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473296/full
[vii] https://www.theguardian.com/society/2025/feb/10/patients-at-risk-without-better-protection-for-whistleblowers-says-ex-nhs-hospitals-chief-maxwell-mclean

[viii] https://www.theguardian.com/society/2024/nov/24/plan-to-regulate-nhs-bosses-could-see-those-who-silence-whistleblowers-barred-for-life

[ix] https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/fourth-investigation-report/