CHAPTER TEN

THE INDEPENDENT CASE NOTE REVIEW (ICNR)

Introduction

1. The Inquiry heard live evidence from Dr Mike Laker, who had been appointed by the Trust as lead clinician in respect of the Independent Case Note Review (ICNR) undertaken during 2009 and 2010 at the request of patients or their families. Dr Laker was a former medical director of Newcastle upon Tyne Hospitals NHS Trust, with lead responsibility for clinical governance. He had conducted independent case note reviews in Newcastle and had chaired two independent inquiries into healthcare there as well. At the time of his involvement with the Trust, he had a part time appointment as an advisor in patient safety at the North East Strategic Health Authority. He made an undated provisional statement[1] and a statement dated 18 January 2011.[2] He gave evidence on 14 February 2011 (Day 44).

2. Dr Laker told the Inquiry that in April 2009, he had been approached by Sir Stephen Moss, who had recently joined the Trust as a non-executive director. In the aftermath of the publication of the Healthcare Commission's report, the Trust had offered past patients of the Trust or their families the option of a review of case notes by an independent specialist. By April 2009, 60 such requests had been received. Dr Laker was appointed to oversee the process, which would necessarily require input from specialists in many fields.

3. Dr Laker said that he considered that the Trust should have established an independent office for dealing with the ICNR. In addition, he realised as time went on that because he had been selected by Sir Stephen Moss and appointed by the Trust, he was not perceived

[1] ML00000000001
[2] WS0000002471

as independent. He considered that he should have been appointed by either the strategic health authority or the primary care trust.[3]

4. A further problem in ensuring that the ICNR was both independent and perceived to be independent of the Trust was that the Trust, in Dr Laker's words, 'did not spread their net wide enough in their search for independent clinicians' to carry out the case reviews. Dr Laker gave the example of the appointment by the Trust of a specialist based in Stoke who knew personally the clinician involved in the complaint he was reviewing.[4]

5. When Dr Laker was lead clinician for the ICNR, the procedure for conducting a review was Dr Laker would carry out the initial interview with the patient or relatives; the Trust would appoint the clinician or nurse to carry out the review, who would then produce a report; Dr Laker would review and amend the report where necessary; and the report would be sent to the family. If the patient or their family agreed, a copy of the report would be sent to the Trust. A feedback meeting with the patient or relatives would take place if requested.

6. Dr Laker began interviewing families in May 2009, seeing approximately six per week and eventually met 120 families. Problems with the Trust's conduct of the ICNR emerged, including:

- The Trust believed that the clinician's report should be the end of the matter and was reluctant to make provision for the report's authors to give verbal, face-to-face feedback. Dr Laker disagreed with this approach but this was never resolved.
- Although the reviews were being conducted for the patients and their families, the Trust's Head of Governance had been planning to undertake a co-ordinating role that included seeing all reports before they went to the families. This was stopped after Dr Laker intervened.

[3] Mike Laker statement para 5, p2
[4] Mike Laker statement para 10, p3

- The resource allocated by the Trust to the process was inadequate and the recruitment of the reviewing clinicians was too slow.
- Requests for reviews escalated rapidly and it soon became apparent that the task of conducting them was beyond a single lead clinician. The Trust did not address this issue.
- Dr Laker's advice to the Trust arising from interviewing patients and families was not being acted upon.
- Patients and their families believed that the ICNR could not be truly independent of the Trust because of the manner of Dr Laker's appointment.

7. These problems led to the transfer of co-ordination of the ICNR from the Trust to SSPCT. Dr Laker was told by Stuart Poynor, Chief Executive of SSPCT, that this would happen in July 2009 and the PCT took over in September 2009.[5]

8. Overall, Dr Laker was impressed by the PCT's management of the ICNR process. However, he told the Inquiry that the PCT was under 'extreme political pressure' to do the whole process very quickly and conclude the reviews.[6] This was difficult, not least because each review would take approximately five to six months to complete.[7] Some decisions were taken by SSPCT in respect of the ICNR based more on expediency than the need for thoroughness.[8]

9. Dr Laker found that the Trust was remote from other organisations and insufficiently networked with other trusts. Historically, there had been a lack of leadership from the Trust Medical Director, Dr Gibson, and Director of Nursing Jan Harry.[9]

[5] Mike Laker statement paras 18-19, pp4-5
[6] Mike Laker statement para 25, p6
[7] Mike Laker statement para 23, p5
[8] Mike Laker statement para 28, p6
[9] Mike Laker statement paras 64-72, p15

10. Dr Laker was clear that the ICNR process could not identify the 'excess deaths' at the trust during the period 2005-09. During his work, which included editing 40 to 50 reports, he had come across perhaps one such death.[10]

11. In terms of the perspective that involvement in the ICNR had given him on the role of organisations external to the Trust, Dr Laker gave as an example a case in which it had taken two junior doctors 48 hours to obtain the services of the appropriate consultant for a case in the EAU. Such a lack of support for junior doctors should, he said, have been picked up by the Postgraduate Deanery.[11]

[10] Mike Laker statement para 87, p19
[11] Mike Laker statement para 75, p16

12. There is no conclusion heading for this chapter.

END CHAPTER