Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Pseudomonas Outbreak: Ministerial Briefing on RQIA Final Report

31 May 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Pseudomonas Outbreak: Ministerial Briefing on RQIA Final Report

31 May 2012

Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr John McCallister
Mr Conall McDevitt

Witnesses:

Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Dr Paddy Woods	Department of Health, Social Services and Public Safety
Mr Edwin Poots	The Minister of Health, Social Services and Public Safety

The Chairperson: Minister, you are more than welcome to the Committee. I want to thank you for facilitating this meeting today. I know that there was a bit of toing and froing in trying to set the time, but I think that we would all agree that this is the best time for the meeting.

We received a copy of Professor Troop's report earlier today. Committee members have had the opportunity to read and dissect it, and we had an evidence session from Professor Troop and her team, during which a number of questions were raised.

I apologise in advance. I need to leave at 3.45 pm to do some media interviews. Mickey will take over at that point, and I will return later.

First, I think that I need to acknowledge that you accepted the recommendations of the final report and the previous report. That is welcome. It makes it easier when the recommendations are accepted, as there is not an ongoing battle.

I do not need to remind you of the issues. I know that you took a personal interest in the review, which came about as the result of the death of four babies. In her own words, Professor Troop said that she believed that there were not enough systems in place at the time. The final question that I asked her was whether, on the back of the report and based on what she had seen or heard, she believed that the buck needed to stop with someone, and, if so, who. Do you believe that the system failed and, if so, that the buck needs to stop with someone? Will you give us an idea of your next moves?

Mr Poots (The Minister of Health, Social Services and Public Safety): OK. Thank you. First, thank you for convening the meeting. I appreciate it. Pat Troop would not have been available next

week. It was important that we proceeded when the report was fresh, as opposed to it becoming stale and perhaps not being discussed in a structured way such as this.

On the question you posed, the idea behind the report was not to seek recriminations but solutions. You asked whether the system failed, and of course it did. Four children are not alive now. I do not know how many of those four children would have survived if they had not developed pseudomonas, as they were seriously ill babies. Nonetheless, their chances of survival were compromised as a result of pseudomonas.

As to whether we learned quickly enough after what happened in Altnagelvin Hospital, whether the information was translated to Belfast clearly enough and whether Belfast responded quickly enough, the report identified shortcomings in each area. I do not think that we can pinpoint one person in one trust or one part of the organisation who demonstrated gross ineptitude or who did not carry out his or her job properly. However, in every area there were small and large failings that came together in circumstances that led to this dreadful outcome. The report was commissioned to avoid those outcomes in the future.

There were calls for public inquiries at the time, but a public inquiry would not be the starting point for a number of years. The report made 32 recommendations, and we can move forward with them. I believe that the recommendations will be used widely throughout the Republic of Ireland and Great Britain to avoid those things happening right across the British Isles.

I think that it is very regrettable that we find ourselves in these circumstances. However, of course, whatever regret we have is nothing in comparison to the sense of loss of the families. We always need to recognise that.

The Chairperson: OK. Thank you. I want to move into some the points that were raised in the report. Page 33 of the report suggests that, when they received the circular of 22 December, three trusts were not aware that a baby had died from pseudomonas in Altnagelvin. Minister, are you satisfied that the circular that was issued by the Chief Medical Officer (CMO) on that date reflected the seriousness of the situation? The circular did not mention that it was urgent or did not mention the death of the baby in Altnagelvin.

Mr Poots: First, the circular was not exclusively from the CMO. It was also from one of the directors, John Cole, in the Department of Health's health estates investment group (HEIG).

The Chairperson: Apologies for that.

Mr Poots: Two people sent out that circular.

When the circular was sent out, information was not as clear as it is now. The Chief Medical Officer was keen to get a message out that there was something with which people needed to concern themselves and which they were once again highlighting — I think that the term "reinforcing" was used in the circular. When you get a message from the Chief Medical Officer, it is not a bland circular such as those telling you that your insurance is up and that you should ring the company. It is something that needs to be taken very seriously. All trusts should always take the circulars that come from the Chief Medical Officer with the utmost seriousness. Having said all of that —

The Chairperson: They did not do so, Minister.

Mr Poots: No. Had he put in that there had been an outbreak in one of the trusts, would that have caused a greater response? Belfast was aware of the outbreak, and I think that it is identified in the report that its response was no different from that of the other three trusts. One could say that it would have been better had it been in, but one could not say conclusively that, if it had been in, the outcome would have been different. That is the conundrum.

I would have probably preferred to have seen stronger words and the case made a little bit more strongly, but I do not think that we can blame the circular for the outcomes that arose in the Belfast Trust in particular.

The Chairperson: Are you disappointed at the fact that two of the trusts only knew about the pseudomonas outbreak and the death of a baby at Altnagelvin through the media, or were there

mechanisms in place that could have been used? Professor Troop highlights the communication issue throughout her report.

Mr Poots: There was a debate at some point as to whether Altnagelvin was an outbreak way back then. Perhaps, that was one of the problems. Am I disappointed about that? Yes, I am disappointed that trusts learned important information from the media. The Troop report very clearly identifies communication as an area in which we need to do better and to which we need give more cognisance and develop systems for.

In my conversation with Professor Troop, she indicated that people in Northern Ireland think that, because this is a small place and because everybody knows one another, everybody knows everything that is going on. That did not transpire to be the case. Therefore, it is important that we have the mechanisms in place so that we do not make assumptions that people know, and that we can be sure that people do know and that there is no reason for them not to know.

Am I disappointed that trusts found out things through the media? Yes, that is disappointing. Do we accept that that was a failing? Yes, we accept that that was a failing. Do we accept the recommendations of Professor Troop in this respect? Yes, we do.

The Chairperson: This is a question I put to Professor Troop and her team: Altnagelvin decided to use sterile water, which is something for which it should be commended. There seems to have been a conversation with the Public Health Agency around the issue and the use of sterile water. However, no other trust was advised to use sterile water at that time. I asked Professor Troop, during the previous session we had with her, whether she believed that there was a possibility that a child might have survived if things had been done differently.

When you talk about communication, the Public Health Agency has a regional responsibility, and you have had to face all sorts of questions and media interviews on this matter. If it was decided to use sterile water in one hospital because of an incident — sadly, the death of a baby — are you disappointed that the Public Health Agency, your Department or your senior officials did not have the wit nor the wisdom to tell other parts of the organisation to start using sterile water now?

Mr Poots: Obviously, Altnagelvin was the hospital with cases of pseudomonas at that time, and there was no evidence of there being a problem in other hospitals then. We have departments in each of our trusts that have expertise; for example, we have microbiologists in each of the trusts. They have knowledge of those types of illnesses and how to deal with them. The Public Health Agency is there to assist, to provide information, to gain further expertise, and so forth. It is a two-way process. The Public Health Agency is able to give advice. However, you are also able to ask the Public Health Agency for advice. If any trust had contacted the Public Health Agency, it would have found a very open door in providing the best-quality advice available at the time for responding to such instances.

The Chairperson: I am still a bit confused about the period when the sterile water was being used in Altnagelvin to the message going out officially that sterile water should be used. If the Belfast Trust had been told earlier to use sterile water, could the situation have been different?

Mr Poots: The Belfast Trust could have used sterile water at an earlier point. That was happening at Altnagelvin Hospital, and I think that, had the Belfast Trust used sterile water, it would have made a difference to the numbers who contracted pseudomonas. Whose responsibility was that? Was it the PHA's responsibility to advise trusts to use sterile water, or was it the Belfast Trust's responsibility to seek advice from the PHA, and how much was the PHA aware of at that time? It is not my call to judge which organisation held the most responsibility in that instance. However, communication is a two-way process. If you have a problem, you can ask for advice or you can do the thing yourself. The Belfast Trust chose not to ask for advice at that stage.

The Chairperson: Minister, can we have an update as quickly as possible on where the recommendations are sitting from the interim report and the final report? Some of them are immediate.

Mr Poots: I had a wee speech written out here, but, obviously, we went straight into questions. You have asked a particular question about the recommendations.

There were 15 recommendations in the interim report, and there are 17 recommendations in the final report. I accept all 32 recommendations. Of the recommendations in the interim report, five have

been implemented, a further six have been completed as and of today, and the work on the remaining four recommendations is under way. Implementation of those will be completed between July and December this year.

I should clarify a point about the implementation of recommendation 15 in the interim report, which concerns the development of a regional neonatal intensive care unit at the Royal Jubilee Maternity Hospital. Obviously, that will not be in place by December this year. There are two time frames in that recommendation, and the first sentence refers to the building of the new unit. I will keep as much pressure on Andrew and the Health Estates Investment Group (HEIG) as possible to ensure that we deliver as quickly as possible and at as early a point as possible. If we can implement the recommendation before December 2015, that would be very desirable.

The second part of the recommendation concerns the interim improvements that we need to make to the existing accommodation. I ask the Committee to note that the latter is the element of the recommendation for which I set today as the deadline. A solution has now been developed. Therefore, subject to business case approval, work on that is due to be completed by the end of November this year.

We received the further 17 recommendations only in the past 24 hours. In fact, we received them only in the past 12 hours.

The Chairperson: It would be remiss of me not to commend you and the Department on that. It is not that long ago that we got the first report. I would like to get a better handle on the new neonatal unit, so we can probably get that information. On the recommendations in today's report, can you give us a written update in a month's time as to where they are sitting?

Mr Poots: I think that a month is a reasonable period in which to provide that, yes.

Mr McDevitt: Thank you, Minister. I agree that there are issues of systemic failure, and it is better to be honest about that.

There are a couple of issues that I wanted to pick up on specifically. On page 45 of the report, the review team concludes:

> *"there is a gap in the current arrangements for communication of early intelligence about infectious disease events across organisations in Northern Ireland."*

Whom do you see as the person who needs to be tasked with plugging that gap? Where do you see the drive coming from to make sure that that gap is plugged and that all the recommendations that flow from it are properly implemented?

Mr Poots: Each trust spends quite a lot of money on communications, and they are sometimes publicly criticised for the amount that they spend. Communications is not purely about PR and about trusts selling how good they are to the local newspapers; rather, this is where quite a lot of the money on communications should be spent and is spent.

The communications department is a first port of call, but I think that the chief executives should be overseeing this and ensuring that they be made aware of all the relevant information, without there being an overload situation. Personally, I would prefer to see information going downwards as opposed to having someone make the decision to escalate information. In the latter instance, the person may then think whether the information is of such significance to need to be escalated. It would be a safer option to have the information go in at a higher level and for decisions then to be made to branch it out to various people to deal with.

Mr McDevitt: In that sense, do you think that it is worth revisiting the model for circulars that is currently used that seems to send a lot of information out without always particularly grading, prioritising or flagging that information in a very specific way, or do you have another approach in mind?

Mr Poots: I remain wedded to the principle that the information that is sent out in circulars from the Department and from the Chief Medical Officer's office is of a standing, in the first instance, that requires that communication to be made and that it will not contain trivial information. In fairness to the Belfast Trust, it indicated to us that it took the letter very seriously and did not see it as trivial. It

responded by having its water management unit looked at to address the issues. Unfortunately, there was not the degree of urgency that was required, and circumstances were such that the trust's response was going to be too late. Had the problem in the Belfast Trust not arisen for another month or two, it would have had its meeting by that point, and perhaps the outcome would have been different. However, those circulars should always be taken seriously by whoever receives them in the trusts, because they are not sent out as a trivial matter.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): I think that what Professor Troop recommends — that the Public Health Agency produce a weekly bulletin — is another way in which to ensure more systematic communication. I was very taken by her point. I would have inferred from what she said that, because we are a small system, people will know a lot of things, hence some of the things that we found surprising. Professor Troop's recommendations about a more systematic communication and weekly bulletins is very compelling, and we need to recognise that as a big part of moving forward.

Mr McDevitt: Finally, in section 5 of the report, the review team has captured some very powerful and poignant experiences of families, and we all pay tribute to those who co-operated and had the courage to do so. There are a lot of recommendations, from very significant stuff about confidentiality working against a family being able to get the right information at the right time through to very simple issues about how doctors conduct themselves.

What assurances can you offer families of very ill children here in our region today that that section of the report will really set a new standard for appreciating the very difficult situation that families find themselves in? The group most affected is often those whose child is ill but not critically ill.

Mr Poots: We all have something to learn from this. That is a bit of a cliché on occasion, but it may be a case of a doctor sitting down and just talking to a family and explaining things in a way in which it understands. Medical staff get used to using terminology, and ordinary people do not understand them and perhaps need what is said to be broken down into language that they do understand.

Perhaps it was the communication that took place between the trusts or between the Department, the Chief Medical Officer and the trusts. The report makes clear that the media need to learn from this incident as well. One family said that it could not place its child's death notice in the paper because it was afraid of that information being followed up by people in the media. Other families said that they felt inhibited by the presence of a TV camera when they were going in and out of the hospital. Indeed, staff said that they felt that they were being compromised in their job by the constant media presence.

We all have something to learn from this. I am being very forthcoming about the Department and the trusts. We made our mistakes and need to learn from them. Others also need to learn from the messages from the families.

Mr Dunne: Thanks, Minister and officials, for coming along again. We have raised the issue of the source of the problem on a number of occasions. A high-risk area was identified in the last couple of metres of pipework in the water system. Considerable evidence was given today of the management of the water systems being rather inconsistent across the trusts. That is disappointing.

Various circulars were sent out and returns were late. I think that some did not arrive at all until this came up. Another issue concerned flexible water supply hoses. Trusts had different attitudes to how they dealt with that. Their returns were rather inconsistent. We are very disappointed at the level of assurances given about how water systems are managed in the trusts. Are the trusts responsible for that or does that responsibility lie with the Department?

Mr Poots: The trusts are very clearly responsible for that degree of management. Indeed, from the original circular that came out in 2010, many trusts felt that they had responded. New taps were installed. In truth, the new taps were the cause of the problem in Belfast and Altnagelvin. People felt that they had responded and upgraded the system, but the upgrade turned out to be a greater problem than it was a resolution.

The responsibility for monitoring all that clearly lies with the trusts in conjunction with health estates. We need to ensure that we have the appropriate monitoring and the Troop report again makes recommendations in that area that will be helpful. Had we been operating with the benefit of those recommendations in the past, we may have had different circumstances.

Mr Dunne: Is there an argument that the circular of 22 December 2011 should have been identified clearly as a priority? I understand that 50 circulars were issued over a three-month period. We were told today that staff are under a lot of pressure. Busy staff probably prioritised those circulars themselves and scanned through them. Therefore, there was a risk with an issue such as this, which was a priority and should have been dealt with as such. Is there an argument that there should be some sort of prioritisation system in place in future for circulars?

Dr McCormick: The report brings out the systems that exist to consider, assess and distribute circulars. They are different in detail across the different organisations, but there is a fundamental system in place to assess and prioritise the circulars and ensure that they reach the particular part of the organisation that is most affected. That is part of what it has to be. There may be a significant number of circulars, but they will not all affect the same parts of the organisation. It is not a large number —

The Chairperson: Sorry for cutting across you, Andrew, but a circular went out in April 2010. Another went out in July 2011. One went out in August 2011, which followed one that went out in September 2010 about water.

Mr Dunne: They are all routine.

The Chairperson: Yes, I am putting myself in that position. If a circular comes out on 22 December 2011, is not market urgent and contains no information that a child has died from pseudomonas in Altnagelvin, based on the action plans that were in place from September 2010, the action plan in response to the circular in July 2011 and the response to the circular in August 2011, people do not respond urgently to the circular of 22 December because it does not give more information. If you are saying that there are constraints, there has to be some mechanism to say to the trusts that the circular is serious and not standard.

Mr Poots: We should remember that the circular identified that there had been outbreaks in England. It went on to say that similar circumstances prevailed in Northern Ireland. Although the circular was not wholly explicit, it was certainly at least implicit from it that there was a problem: it identified that there were outbreaks and that there were similar circumstances here in Northern Ireland. That should have sent a fairly strong signal to people that that was the case. Sometimes, we are a little careful in how we couch our terms. I am a pretty direct person, not like the Civil Service, which tends to use terminologies that may not be quite as direct as what we may use in public life. Nonetheless, people should be able to understand them. As I have just described to you, if someone says that there has been an outbreak somewhere in England, that we have similar circumstances in Northern Ireland and that the message is being reinforced, there is a degree of urgency in that regard.

Dr McCormick: The title of the circular is "Potential Infection Risk to Patients". That is in bold type. That draws attention to the issue. There is a paragraph in bold in the second page that states:

> *"It is important that teams are fully aware of the location of potential at-risk patients to allow appropriate action to be taken."*

Therefore, there is emphasis and bold type. In the culture and language that is familiar in the service, that, to me, conveyed a degree of concern. That is the way in which I would say it. I am also aware that the trusts took it seriously. I spoke to colleagues today: the circular was received and taken seriously. It is described as being treated as routine, but that is routine in the context of every trust having a system for prioritising and assessing incoming circulars. We have to put it in the context in which it was received: it was received before the worst of the outbreak in Belfast. At the initial stage, I can understand fully the way in which it was handled. There is also the sheer unfortunate circumstance that a change to the taps, which everyone would have expected to improve things and reduce risk, made the consequences worse, as the Minister explained earlier.

I am quite clear — I think that we had this conversation in April — that we always expect trusts to take every circular seriously. I believe that they do. Clearly, there were weaknesses in communication that affected the response. That is undeniable and is accepted. The recommendations on communication are very penetrating. They expose a false assumption that we have been making, which is that everyone knows everything and that people talk all the time. That is not as strong and helpful as we thought it was. Therefore, I think that Pat Troop's recommendations on more systematic and formal communication are very helpful indeed and should make a big difference.

The Chairperson: I apologise to Gordon for cutting across him.

Mr Dunne: That is OK, Madam Chair.

(The Acting Chairperson [Mr Brady] in the Chair)

Mr Dunne: I have already made the point that I have worked in organisations in which there is continual communication. When there was a priority issue, the first word on the information was "Priority" or "Urgent", or whatever. It may have made a difference in this case or it may not have done.

Andrew, is it the case that, when the Chief Medical Officer issued the circular of 22 December 2011, it was not clear in his mind where the source of the problem was? Is that a fair comment? I do not have the circular in front of me today. I had for a long time, but I do not have it today when I need it.

Dr McCormick: As the report states, the Department had only "limited information". Therefore, yes, because of the reasons for the original circulars back in September 2010, we knew that there was an association between water sources and pseudomonas. Yes, there was a general association, but there was not a detailed or analytical understanding of exactly where the source lay, even in the Altnagelvin case. An initial analysis of the water from one of the taps in Altnagelvin gave a clear suspicion that it was so. That is why the reminder and reinforcement was appropriate and general. I would just draw attention to the fact that the report itself states:

> *"the review team has also concluded that it is not possible to determine if the course of events would have been materially altered if the wording of the circular had been more explicit".*

There is certainly recognition that something stronger could have been said. There is no strong evidence, however, that it would have made any difference. The other aspects that arise are complex. Communication was not as effective as it should have been. It takes all those things to come together.

Engaging with chief executives and trusts in the management of risk is what we do all day, every day. It is what the job is all about. The range of risks is extensive. It is therefore very important that things be given the proper priority. Things have gone on here that should not have gone on. We have to acknowledge all of that, and the desperately unfortunate consequences. However, there are very important learning points in the report that we want to take on board.

Mr Dunne: You would concur with the findings —

Dr Paddy Woods (Department of Health, Social Services and Public Safety): What we have here is an example of a plan based on the precautionary principle. You apply that, very often, when information is far from complete, but you apply it because the danger of waiting for information to be complete and confirmed beyond a shadow of a doubt is that very serious adverse things can happen. The circular was issued on 22 December 2011. Issue on that date alone should have given rise to thought. None of these circulars is ever routine; they are not monthly or quarterly bulletins. They are issued because there is a concern, and that concern is expressed in the circular.

The information was not complete, and the action anticipated was that organisations throughout the system would assure themselves that they were fulfilling largely the actions prescribed by circulars at some time in the past.

Mr Dunne: OK. This is my last point. In her closing remarks, Professor Troop commented that, had stronger systems been in place, the risk would certainly have been reduced. Do you accept that, Andrew, as a fair summary?

Dr McCormick: I have to accept that as her conclusion. The detail as to how exactly that unfolded is drawn out in both the interim and final reports. We identified the different stages at which an opportunity was missed. Nobody went into this with negligence or neglect of duty. There is nothing grotesque here. These were fine judgements where opportunities were missed at each and every stage of the process. There are people whose job day and daily is to manage those risks. The teams in each of the trusts were thinking, "What is going on here? What should we be doing?" They were

seeking to find the solutions, but some opportunities were missed. Therefore, as a system, we have to say there were failings that are acknowledged and understood.

The key point, as Professor Troop brought out, is to ensure that we take a hard look at this, learn the lessons, look at ourselves very critically and ask how we can do better. There are some very positive suggestions of how to do that. As I said yesterday, I am against a punitive culture, but I am also against a no-blame culture, because that carries the wrong connation. I look for fair accountability so that there is recognition of where people are acting in good faith but making ordinary human errors and misjudgments. All of us make misjudgements from time to time — that is human nature.

The question is how to make a system as safe as possible. Safety in the health service is often modelled on the airline industry, where the objective is for someone to come to harm only if 10 things go wrong. It is about having fail-safe mechanisms at one level and another. Our objective is to design systems in which, if one thing goes wrong, something else kicks in to correct it and make it safe. That is complex and requires systems management at a high level. All the infection control teams, professional directors, management teams and the trust governance are dedicated to that work all the time.

In the very best systems across the world, there will always be avoidable deaths. It is a matter of fact that no system is perfect. What happened is very unfortunate. We have to strive to learn the lessons. We can never be satisfied. We never say, "That is just the statistics or probability." Every person is an individual, and we have to be devoted to the care of every individual patient. However, as I said, no system is perfect. The reality is that there will always be a number of avoidable deaths. We have to do everything that we can to minimise those deaths. The approach that the team has taken is extraordinarily helpful in working to ensure that we can learn lessons.

Mr Gardiner: Minister, I will raise the point with you that I raised with the Professor. Although you are taking the flak for all this, it was not your fault. You were let down by the Department and the officials in the other hospitals and trusts. I suggested that, if a thing like this ever happens again, there should be such a thing as a "red alert". You are notifying perhaps a secretary to pass it on to someone. It may be just an e-mail, a letter on ordinary headed paper or a telephone message. You have to highlight it as a "red alert" that has to be taken seriously. If someone does not take it seriously and is not capable of implementing your instructions, remove that person from that position. Babies' lives were lost as a result of this. It was not only in one unit but in other hospitals. It took them a while longer to get a handle on it.

Mr Poots: The letter that went out was headed "For action", which is fairly clear.

Mr Gardiner: In some instances, they failed and did not do it.

Mr Poots: The people whom it went to were the chief executives of the trusts, the medical directors of the trusts, the directors of nursing of the trusts and the infection prevention and control leads in the trusts, as well as the chief executives of the Blood Transfusion Service, the Public Health Agency and the Health and Social Care Board. The letter went to the appropriate people to deal with and follow up on. The letter of 22 December refers to the 2010 circular, so it was reinforcing, and followed the receipt of a number of:

> *"reports from English NHS Trusts and Public Health Wales concerning outbreaks of infection with Pseudomonads",*

The letter of 22 December continued:

> *"similar events have recently been reported in Northern Ireland."*

The right people got the letter: chief executives, directors of nursing, medical directors and those in charge of infection control. The message was that pseudomonas infections had been reported in England prior to the 2010 letter being sent out and that similar events had taken place in Northern Ireland recently. That was why that letter went out.

There is no doubt that we fell down, and Mr Gardiner is absolutely correct about that, Chairman. The messages went out, and a series of things were not responded to as well as they should have been. As Mr Gardiner also correctly pointed out, the brutally sad consequence of that was that the lives of

some babies were lost. Although we cannot say that their lives were lost as a result of that response, their battle to live was certainly compromised further.

The Acting Chairperson: Minister, that goes back to your point about top-down rather than bottom-up communication. In this case, the letter presumably went to chief executives, and, perhaps, that top-down approach did not work. I am sure that you will address that.

Mr Poots: The letter was addressed not only to chief executives but to directors of nursing, medical directors and those in charge of infection control. Many of them considered that they had acted on the advice. With the benefit of hindsight — perhaps even without it — clearly they did not act urgently enough.

The Acting Chairperson: With respect, it goes back to the point that two of the trusts found out only on 17 January through the media about the death in Altnagelvin. Either the information was not disseminated widely enough or it did not permeate in the way that it should.

Mr Poots: That goes back to what Professor Troop said earlier. We assume that people know what is going on in Northern Ireland and, therefore, we believe that do not have to make everything as explicit as we should. That assumption must be done away with, and we need to go forward with the confidence that people know everything that they need to know, rather than on the basis of that assumption.

Mr Gardiner: I think that the Department has let you down. You should crack the whip.

Ms Brown: As almost every question has been asked, my contribution is more of a comment. We welcome the report and, in particular, the acceptance of all of its recommendations. That is very good news. It was also good to hear evidence from Dr Laing. We are not health professionals, and he helpfully explained that babies need a certain amount of good bacteria. We tend to think that we have to wrap them up, protect them and keep them away from everything. However, Dr Laing explained that babies need certain amounts of different bacteria so that their immune systems can develop and their bodies can cope with whatever comes their way.

It is apparent that lessons have been and continue to be learned from this whole saga, especially on communication. I totally agree that a different mechanism of disseminating such urgent information needs to be found. In this age of technology, it is hard to believe that there is not something better in place or that what is available is not used. Everyone thought that they were acting appropriately, but something was missed somewhere.

Even had everything been done in the way that we, with hindsight, would like it to have been done, we have no idea whether any of those babies would still be here today. We have to remember that they were very vulnerable and sick children. In the same breath, we want to know that everyone is doing everything in their power to ensure that such babies are protected and to help them to survive. I am sure that you will agree that we can and must do better, especially on information sharing. I hope that there will be immediate improvements.

Mr Poots: Ms Brown made an interesting point about good bacteria, wholly sterile environments, and so forth. For patients who are immunocompromised, a sterile environment is critical. The introduction of bottled, sterile water was identified in Professor Troop's interim report as being of huge benefit. Now, however, problems have also been identified with parents who take home premature babies not continuing to use sterile water for ever. There are suggestions that, once a baby has reached 1,500 grams in weight, parents might be able to use tap water as the skin is that bit thicker — these babies have very thin and delicate skin — and that it would be appropriate for parents to be shown how to bathe them because they are very small and vulnerable in comparison with full-term babies. There are many interesting areas to consider beyond our taking these steps to have as clean and sterile an environment as possible for immunocompromised babies until they come out into a big wide world that is far from clean and sterile, no matter how well kept a person's home.

The Acting Chairperson: Minister, page 21 of the report states:

"Trusts have carried out risk assessments in relation to water systems as required under L8."

I think that L8 is to do with controlling the risk of legionella. The report continues:

"The review team found that the approach used and stage of completion was different between trusts. Plans to carry out actions to improve compliance of systems were in place but the review team was advised that additional resource would be required if full compliance was to be achieved."

Are you in a position to assure us that, if additional resources are required throughout the trusts, they will be put in place to achieve full compliance? Ultimately, the problem was with the water and taps.

Mr Poots: In most instances, the replacement of taps and sinks would cost thousands of pounds per trust. At most, it would cost in the lower tens of thousands of pounds. The smaller trusts operate with budgets of about half a billion pounds, and the Belfast Trust's budget is well over £1 billion, so those measures are all readily absorbable. Let us be frank: we will absolutely ensure that there is sufficient finance to deal with these issues, irrespective of whether it comes from the trust or the Department. Those measures will not be left undone through lack of money, because money does not buy lives.

The Acting Chairperson: That was good timing. Our Chair has just returned.

The Chairperson: Minister, my apologies for having to leave. On behalf of the Committee, thank you for the time, effort and energy that you and your senior officials have put into this matter. Thank you for also allowing the Committee to get copies of the report as quickly as possible so that members could analyse it.