Witness Name: William Vineall
Statement No.: 2
Exhibits: 11
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THIRLWALL INQUIRY

SECOND WITNESS STATEMENT OF WILLIAM VINEALL

I, William Vineall, Director of NHS Quality, Safety and Investigations at the Department of Health and Social Care, 39 Victoria Street, London SW1H OEH will say as follows:-

Introduction

1. I make this statement on behalf of the Department of Health and Social Care ("the Department") in response to a Rule 9 request dated 19 June 2024. I am authorised to make this statement on behalf of the Department.

2. I am Director, NHS Quality, Safety and Investigations at the Department. I have held that post since 2020. Further details of my role and employment history are set out in my first witness statement to the Inquiry dated 5 April 2024 **[INQ0015468]**.

The Guidelines and Memorandum of Understanding

3. In 2000, an expert group chaired by the then Chief Medical Officer, Sir Liam Donaldson, published 'An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer' **[INQ0107017].** This report sought to understand the scale and nature of serious incidents within the NHS and to identify the actions necessary at both the local and national level to ensure that lessons learned from adverse events in one locality were incorporated nationally. The report emphasised that an effective and consistent system of reporting was essential in identifying and learning from adverse incidents.

4. In June 2001, the Government set out its plans for implementing the recommendations of this report in 'Building a safer NHS for patients: Implementing an organisation with a memory' **[INQ0107018]**. Amongst other things, the Government committed to providing guidance to assist with standardising the processes for identifying and reporting adverse

incidents and clarifying the arrangements for handling independent investigations and inquiries into such events.

5. In February 2006, a Memorandum of Understanding ("the MoU") entitled 'Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive' **[INQ0014686]** was agreed between the Department, the Association of Chief Police Officers ("ACPO" – now the National Police Chiefs' Council), and the Health and Safety Executive ("HSE"). I referred to this MoU in my first statement **[INQ0015468_0105]**.

6. The MoU assisted those working in the NHS to identify incidents which may require referral to the police, HSE, or other agencies, and set out the roles and responsibilities of the different organisations who investigate patient safety incidents involving unexpected death or serious untoward harm. It provided a protocol to be followed to facilitate effective inter-agency working when such incidents arise, including in respect of securing, preserving, and sharing information and evidence.

7. The MoU was jointly developed by the three signatory organisations following a period of consultation (Annex 3 of the MoU lists the organisations who responded to this consultation). The design and development of the MoU was also informed by workshops run by Verita (an independent investigation and consultancy agency) which drew upon the expertise of participants including the Presidents of the Royal Colleges and healthcare professional regulators, the risk manager at the NHS Litigation Authority, the Chief Executive of the NHS Confederation, the Chairman of the National Clinical Assessment Authority, the Director of the British Medical Association, the Investigation Manager at the Commission for Health Improvement, Clinical Risk Managers from a teaching Trust and a non-teaching Trust, the Chief Executives of a Primary Care Trust, an Acute Trust and a Mental Health Trust, Medical Directors of Trusts, representatives from a Strategic Health Authority, and representatives of social services and allied health professionals.

8. The 'Guidelines for the NHS' ("the Guidelines") **[INQ0107019]** (dated November 2006) accompanied the MoU and supported its implementation. The Guidelines identify the scope of incidents covered by the MoU and provide practical advice drawing upon case studies on what to do when faced with a patient safety incident which may require investigation by the police and/or HSE.

9. The MoU and Guidelines were published and circulated to Primary Care Trust Chief Executives, NHS Trust Chief Executives, Strategic Health Authority Chief Executives, Care Trust Chief Executives, Foundation Trust Chief Executives, Medical Directors, Directors of Public Health, and Directors of Nursing.

10. Their launch was supported by a programme of training consisting of a series of regional workshops which sought to promote the MoU and foster local relationships between NHS bodies, the police, and HSE. These workshops were delivered in 2007 by Verita and included presentations by ACPO, HSE, local NHS representatives, and Verita on behalf of the MoU National Development Group.

11. As a result of the Health and Social Care Act 2012 coming into force, which introduced significant changes to the structure of the NHS in England, a number of policy documents were archived. The MOU and Guidelines refer to organisations that were abolished as part of this reorganisation including Strategic Health Authorities and Primary Care Trusts. We have therefore concluded that this is the likely reason for the MOU and Guidelines being archived with the National Archives in 2013.

12. The Department has not been able to locate any evidence of a decision at Official or Ministerial level to withdraw either the MoU or the Guidelines. However, the healthcare landscape has changed considerably since the MoU and Guidelines were introduced. As set out in my first witness statement **[INQ0015468_0040-0061]**, there have been significant developments in patient safety reporting mechanisms and new investigative bodies introduced since this time. There have also been relevant changes to the organisational structure and division of roles within the NHS: since 2012, NHS England ("NHSE") have had primary responsibility for communicating the proper processes and procedures relating to deaths and serious incidents to NHS bodies. I understand NHSE advise that staff should rely on the Patient Safety Incident Response Framework ("PSIRF") when conducting investigations regarding patient safety, however PSIRF does not replace the guidance on steps to take when investigating suspected criminal activity. I discuss PSIRF at paragraphs 136 and 137 of my first statement **[INQ0015468_0047]**. I also understand that the MoU continues to be referred to by several NHS trusts in their guidance for dealing with safety incidents (see, for example, the East London NHS Foundation Trust's Incident Policy of June 2022 (ratified in January 2024) **[INQ0107020]**.

13. These changes have not made the principles set out in the MoU redundant but there is a need to update the material. I set out below the work that is underway. In June 2018, Professor Sir Norman Williams' report 'Gross Negligence Manslaughter in Healthcare' was published following a rapid policy review **[INQ0002383]**. The report noted that, despite a relatively low rate of convictions resulting from investigations and prosecutions for gross negligence manslaughter, the frequency and lengthy nature of investigations (including in cases where there was no realistic prospect of conviction) has led to a genuine if misplaced fear amongst healthcare professionals that they will be made subject to investigation for understandable errors (see sections 6.3, 9.1, and Annex A).

14. The report emphasised a need for greater clarity in relation to such investigations and the roles of the different organisations involved. It noted (at 9.13) the lasting value of the principles set out in the MoU and recommended it be updated to facilitate this **[INQ0002383_0025]**:

> "The principles of this MoU, and the relationship that it set out between police investigations and local safety investigations, is as relevant today as it was in 2006. However, the MoU has not been renewed since the demise of ACPO in 2015. The panel believes that a similar MoU should be developed to set out the respective roles of the police, CPS, HSE and health service bodies (such as the Care Quality Commission, the Healthcare Safety Investigation Branch and healthcare professional regulators) in investigating unexpected deaths in healthcare settings in order to ensure that patient safety lessons can be understood and acted upon."

15. A working group was established by DHSC to address the recommendations of the Williams Review in 2018, which has led to the development of a draft MoU. This is currently being finalised with a view to publishing as soon as possible.

Safeguarding

16. I have been asked to identify and provide any national policy, protocol, or MoU between the police and the Department / NHS in relation to safeguarding children which subsisted during the period January 2015 to December 2017.

17. In my first statement, at paragraphs 172-175 and 211, I referred to the 'Working Together to Safeguard Children' guidance **[INQ0015468_0059-0060** and **0171]**. In January 2015 to December 2017, this guidance was contained within the 'Working Together to Safeguard Children' published in March 2013 **[INQ0107021]**.

18. At paragraph 212 of my first statement **[INQ0015468_0071]**, I referred to and exhibited NHSE's accountability and assurance framework **[INQ0012912]**. In the period January 2015 to December 2017 the equivalent document was the 'Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework issued by the NHS Commissioning Board' of July 2015 **[INQ0107022]**.

19. I would point to the 'Safeguarding children and young people: roles and competencies for health care staff' of March 2014 (third edition) **[INQ0107023]**. The document described six levels of competencies and provided model role descriptions for named and designated professionals.

20. I also refer the Inquiry to the Mental Health Crisis Care Concordat 'Improving Outcomes for People Experiencing Mental Health Crisis' **[INQ0107024]**. Although this concerns a much broader demographic, it does contain material specific to the safeguarding of children and young people. This concordat was published in February 2014 to reflect the shared commitment of the signatory bodies to working together to support local systems in improving crisis care for people, including children, with mental health issues across England. The 22 signatories included ACPO, the Association of Police and Crime Commissioners, British Transport Police, the Department, NHSE, and many other healthcare bodies and third sector and voluntary organisations.

21. I am not aware of any other policies, protocols, or MoUs relevant to the Inquiry's request.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 14 August 2024