



New Script Consultation Response
to
Paul Frew MLA's Private Member's Bill
on a Statutory Duty of Candour

October 2025

www.nlb.ie/campaigns/mental-health For further information please contact Jemma Blacklaw, Research and Policy Officer, PPR, jemma@pprproject.org

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, mother of William, aged 19

We hoped following our son Conall's death that lessons would be learnt and 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, mother of Conall, aged 21

New Script for Mental Health is grassroots, activist-led movement campaigning for a rights-based, trauma-informed approach to mental health. Accountability is central to realizing the right to health, and a core focus of our work is holding government responsible for respecting, protecting, and fulfilling people's right to quality healthcare, including mental health.

Our accountability work addresses interconnected issues such as failures in oversight and regulation, gaps in mental health data, and the inability of the Mental Health and Suicide Prevention Strategies to deliver real improvements. By combining peoples' lived experiences with rigorous analysis, we expose systemic failings and advocate for rights-based solutions.

New Script for Mental Health is pleased to have the opportunity to respond to Paul Frew's MLA's public consultation on his proposed Private Members Bill. This bill proposes the introduction of a statutory individual duty of candour in healthcare settings, including a duty to be open and transparent, a duty to always tell the truth and to make it a criminal offence to obstruct an inquiry by a member of the public or investigation by authorities and to falsify records.

Statutory Duty of Candour to apply to individuals and organisations.

The starting point for our response is to reiterate our support for 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 individuals and organisations¹.

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.

As detailed in [our response to the Being Open Framework Consultation](#)², legislation on a statutory duty of candour must extend to individuals and organisations, accompanied by regulation of management and HSC leadership, robust oversight

¹ [Report of the Inquiry into Hyponatraemia related Deaths](#)

² [PPR Library | New Script Response to Department of Health Consultation on Being Open Framework for the HSC](#)

mechanisms, and equal inclusion of impacted families in investigations and monitoring. It should also extend to private contractors who are publicly contracted by statutory health bodies to provide public health services. In England currently, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the statutory duty of candour applies to all health and social care providers registered with the Care Quality Commission (CQC). This includes private contractors delivering NHS services, such as independent clinics, private hospitals, and other subcontracted providers. These organisations are required to be open and transparent with patients when things go wrong, particularly in cases of 'notifiable safety incidents.

We note with concern that this Private Member's Bill relates strictly to an Individual Duty of Candour and make the following recommendations:

Recommendations

- 1. Introduce a statutory individual and organisational Duty of Candour.**
- 2. Regulate health services leaders and managers.**
- 3. Establish independent oversight, ensuring harmed families have a significant role.**
- 4. Ensure non-discrimination and proceed with investigations in ways that recognise and seek to reduce social inequalities.**

The outcomes sought from these recommendations are as follows:

- To ensure honesty, transparency, and accountability from healthcare professionals, providers, and HSC leadership.
- To prevent reoccurrence of failings and future harm by learning from mistakes.
- For those impacted to know the truth of what happened.
- To prevent compounded harm being caused to families.

The Department of Health's consultation on the Being Open Framework, referenced above, which closed in March 2025³ included questions on a statutory duty of candour, Minister for Health Mike Nesbitt MLA stated that a detailed summary of responses would be published in June and that the Regional Being Open Framework

³ <https://www.health-ni.gov.uk/consultations/being-open-framework-consultation>

would launch in September 2025. To date, nothing has been published.⁴ The Department must urgently explain the delay and provide a clear plan with next steps.

Criminal Offence to Obstruct an Inquiry

The consultation document proposes making it a criminal offence to obstruct an inquiry by a member of the public or investigation by authorities and to falsify records.

In our view, a duty of candour is not about punishment, rather its purpose is to expose misconduct, negligence, and unsafe practice. The main purpose of a statutory Duty of Candour is to strengthen accountability, ensure learnings from failings, and systems improvement. However, in cases where harm is knowingly caused, such as wilful neglect, and then covered up, we agree that criminal sanctions should apply.

The consultation document does not address deep institutional failures regarding investigations, the widely reported flaws in the Serious Adverse Incident Review (SAI) process and the systemic failure to implement recommendations. 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.

Research conducted by Ramsey (2022) into improving implementation of recommendations from Serious Adverse Incidents (SAIs) of patient deaths by suicide⁵ highlighted that the plethora of research reports continue to repeat key recommendations, suggesting ineffective implementation. It recommended more work on how recommendations are communicated, accepted, and translated into practice.

A 2021 RQIA review of the systems and processes for learning from SAIs⁶ found the current policy to be inadequate and needing reform. 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.

⁴ aims.niassembly.gov.uk/questions/printquestionssummary.aspx?docid=442225

⁵ Ramsey, C. (2022) Improving implementation of recommendations from Serious Adverse Incidents of patient deaths by suicide: A qualitative analysis. Queens University Belfast. [Improving implementation of recommendations from Serious Adverse Incident \(SAI\) reviews of patient deaths by suicide - Queen's University Belfast](#)

⁶ <https://www.rqia.org.uk/RQIA/files/24/24765aab-014c-42bb-ba0b-9aa85e739704.pdf>

It should be noted that since the Department of Health's consultation on the introduction of a new Regional Framework for Learning and Improvement from Patient Safety Incidents to replace the current SAI process closed in June 2025⁷ there has been no information published on next steps, something the Department of Health should urgently address.

Compounded Harm

The issue of compounded harm because of organisational responses to patient safety incidents is also not acknowledged or addressed in the consultation document. In addition to the harms caused by initial service failures, families experience 'compounded harm' because of power imbalances, inequality in respect of access to information, legal support, and expertise, as well as exclusion and silencing during investigations, with lesser or no credibility being given to their testimonies.

A UK study into compounded harm, which involved families from NI, made recommendations for policy and practice which included fostering honest and transparent regulatory and organisational cultures to reduce the likelihood of patients and families feeling manipulated⁸.

Prohibition of Discrimination

As with rights-based approaches to legislation on mental health services, prohibition of all forms of discrimination should cover all interactions with the health system, including access to information and access to justice⁹. Discrimination, in all its forms, has no place in our healthcare services, policy, or politics. It is essential to make the process of reporting and investigations fair for everyone, to ensure equality of arms, and to recognise and seek to reduce social inequalities.

⁷ <https://www.health-ni.gov.uk/consultations/framework-learning-and-improvement-patient-safety-incidents-consultation>

⁸ [Humanising processes after harm part 2: compounded harm experienced by patients and their families after safety incidents - PMC](#)

⁹ UN Special Rapporteur on the Right to Health <https://documents.un.org/doc/undoc/gen/g17/076/04/pdf/g1707604.pdf> and World Health Organisation <https://iris.who.int/server/api/core/bitstreams/23e2eb5c-a043-4d6e-b38b-fed350da6fe7/content>

Whistleblowing Legislation

This consultation seeks public opinion on the Department of Health's current whistleblowing legislation¹⁰, about the protection and support of staff or individuals reporting an issue. 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 take steps to prevent reoccurrence. However, when things go wrong, front line staff are often blamed and made to carry the responsibility. This engenders fear, silencing, and a prevailing culture of deceit, cover ups, negligence, and deliberate obstruction in response to harm caused by the HSC. While professional staff such as doctors and nurses are regulated, non-clinical managers and directors are not subject to similar regulation.

To sufficiently protect and support whistleblowers and healthcare staff reporting issues, New Script is calling for a statutory duty of candour to extend to both individuals and organisations and regulation of HSC leaders and managers to be introduced.

In New Script's response to the 2022 consultation by the Department of Health on the HSC's Whistleblowing Framework and Model Policy, our recommendations emphasised the urgent need for stronger oversight, accountability, and transparency in mental health services, alongside the introduction of the Duty of Candour. A fully independent regulator should oversee policy implementation, monitor compliance, and publish regular data. The policy language must be clear and consistent, with explicit protections against retaliation for those raising concerns, and should support all workers and members of the public, including non-contractual staff. A standardised, region-wide policy is needed, with clear distinctions between whistleblowing, complaints, and safeguarding. The term 'whistleblower' should be reconsidered to reduce stigma, with suggestions made including 'reporter of wrongdoing' or 'truthteller,' and regular updates and trade union involvement should be built into the process to ensure fairness and trust.

¹⁰ [Raising-a-Concern-in-the-Public-Interest-Whistleblowing-Framework-and-Model-Policy.pdf](#)

Patient safety and organisational accountability processes must work together.

It is vitally important that all these safety and accountability processes are sufficiently robust and work effectively together to protect both patients and staff. When a Serious Adverse Incident occurs there needs to be an SAI process that involves reporting, investigation, and crucially, learning. The existence of a Duty of Candour would mean that staff have a legal duty to inform patients and families, to be honest, to apologise where necessary and to explain what the next steps would be, including sanctions, reparation, and learning. In situations where the SAI process is not followed or learning is ignored, staff should feel sufficiently confident, supported and protected to use the Whistleblowing policy to raise their concerns.

Independent Oversight Mechanism

Regarding reporting to public bodies, it is critical that a robust and verifiably independent oversight mechanism is attached to a statutory Duty of Candour. Serious failures by the RQIA in performing its legal 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). Families who have been harmed by health service failures do not have confidence in the RQIA, or indeed other existing health regulatory bodies, to hold Health Trusts or other bodies to account. 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.

Conclusion

In conclusion, New Script for Mental Health recommends an individual and organisational statutory duty of candour for healthcare professionals and providers, including non-clinical management, HSC leadership and contracted private providers, to prevent compounded harm to patients and impacted families and ensure protections for whistleblowers and staff by avoiding 'cover-ups' and to foster a rights-based culture of openness and learning within the health services. This legislative protection will be vital in shifting from a culture of fear and silencing in our mental health services to one rooted in empathy, person centred care, and the active involvement of families.

Recommendations

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- 4. Ensure non-discrimination and proceed with investigations in ways that recognise and seek to reduce social inequalities.**