Advice to the Inquiry into Hyponatraemia-related Deaths on the nature of the governance relationship between Sperrin Lakeland Trust and the WHSSB and DHSSPS in relation to Lucy Crawford - Raychel Ferguson (Lucy Crawford Aftermath)

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Statement of interests: I was Chief Administrative Medical Officer and Director of Public Health of the Eastern Health and Social Services Board from 1989 to 1993. I have written and spoken extensively on clinical governance and this has included speaking engagements in Northern Ireland. I was a member of the General Medical Council from 1989 to 1999.

I have been asked to advise on the nature of the governance relationship between Sperrin Lakeland Trust and the WHSSB and DHSSPS in respect of Lucy Crawford (Raychel Ferguson preliminary). I was asked to address a number of specific questions and my responses follow the queries.

(a) *Define the nature of the governance relationship which existed between the following organisations as at April 2000:*

(i) *The Sperrin Lakeland Trust and the WHSSB*

Prior to it acquiring Trust status in 1996 the Erne Hospital had been a directly managed unit of the Western Health & Social Services Board (WHSSB). Thus prior to 1996 the members of the WHSSB and its Chair were ultimately responsible for the operation of the hospital. This responsibility was exercised through the Board's General Manager/Chief Executive and Chief Officers, including the Director of Public Health. The WHSSB was in turn accountable to the Department of Health and Social Services.

It is important that this previous status is recognised, as the culture of management, some of the procedures in place, and the communication pathways appear to have persisted into the period after the creation of the Sperrin Lakeland Trust, of which the hospital was the major component.

From 1996 the Sperrin Lakeland Trust took over responsibility for the management of the Erne Hospital. Amongst the functions of the Trust listed in the order that it shall 'own and manage hospital accommodation and services provided at Erne Hospital'.[1] As a Trust there was no direct managerial accountability between the Trust and the WHSSB. This was in line

[1] The Sperrin Lakeland Health and Social Services Trust (Establishment) Order

with UK Government policy of 'purchaser - provider split' established in 1989.[2] The relationship thus became one of the WHSSB agreeing with the Trust both what services it required of the Trust and the sums of money to be passed to the Trust in respect of those services. The Trust was thus responsible to the WHSSB for its fulfilment of the commitment as laid out in that agreement.

However, it is apparent that whilst the post-1996 relationship between the trust and the WH SSB contains elements of a purchaser - provider relationship it also, on both parts, retained some elements of the previous directly managed situation. It is difficult to avoid the conclusion that officers of the Trust regarded the WHSSB as still occupying an ordinate position and that officers of the WHSSB continued to exercise authority even though that no longer derived from the possession of direct managerial control.

Confusion as a result of the 'purchaser provider split' is not unique. It was remarked upon in the Review of Health and Social Services in the Case of David and Samuel Briggs.[3] As late as 2006 in Northern Ireland it was necessary in the area of child protection to issue guidance to resolve confusion.[4] Although the Briggs case related to responsibilities for child protection there are parallels that could be drawn.

(ii) The Sperrin Lakeland Trust and the DHSSPS

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[2] Department of Health, Working for Patients, Cm 555, January 1989.

[3] Review of Health and Social Services in the Case of David and Samuel Briggs. R.J. Lewis, D. Cole, A.Williamson. (para 4.1.1) 2003. http://www.DHSSPSSni.gov.uk/lewis-briggsreport.pdf

[4] Responsibilities, accountability and authority of the Department of Health, Social Services and Public Safety, Health and Social Services Boards and Health and Social Services Trusts in the discharge of relevant personal social services functions to safeguard and promote the welfare of children. Circular: HSS (statutory functions) 1/2006 DHSSPS (NI) 2006. http://www.dhsspsni.gov.uk/oss-statutory-and-trusts-in-the-discharge-of-relevant-pss-functions-to-safeguard-and-promote-the-welfare-of-children.pdf

The accountability for the management of services in the Erne Hospital by the Trust from 1996 was to the Department of Health and Social Services, part of the Government structure for Northern Ireland. In December 1999, the Department of Health and Social Services was renamed as the Department of Health, Social Services and Public Safety. Thus, in April 2000 the Trust Board was accountable to the Department of Health, Social Services and Public Safety.

(b) *What information should the Sperrin Lakeland Trust have reported to the WHSSB in relation to the treatment and death of Lucy Crawford, pursuant to the governance relationship which existed at that time?*

The service and budget agreement in place between the WHSSB and the Sperrin Lakeland Trust in March 2000 covered the three year period 1st April 1999 to 31st March 2002. Although the agreement was covering the period from the 1st April 1999 it was not signed by the parties until July 1999.[5] It is also notable that the 'whip hand' in the agreement seems to be the WHSSB and this is reflected in the title, which makes it clear that it is, basically, the WHSSB's agreement.

The document refers to issues of quality at several places. At the very beginning of the document, 'quality' is noted in paragraph 2 as one of the seven core principles set by the DHSS via its Health and Social Services Executive. In paragraph 5 of the document, in relation to clinical governance, it states that the 'Board will be adopting a proactive approach to this initiative to ensure that a structured and coherent clinical governance program is in place within Trusts.' This commitment arises form the development of

[5] INQ-RF Preliminary WS-308/1 Page 74 (Document 4).

'clinical governance' in response to the lessons learnt from the Bristol paediatric surgery case and other serious clinical failures.[6]

The document as a whole is written in terms of 'purchaser' and 'provider' and reflects this managerial separation for the most part. The two most relevant sections of the agreement to the matters in hand are section 14 'Monitoring Arrangements' and section 15 'Quality Enhancement'. These sections however are very much concentrated on the activity levels achieved and the monitoring reports expected from the Trust are in respect of activity levels and quality initiatives (para 14.2). Information requirements are in respect of cancelled admissions, operations and clinics. The agreement does however require that the provider will ensure the provision of services of the highest quality within available resources (para 15.1). The provider is enjoined to share details of its quality framework with the purchaser (para 15.2) and, notably, also it contains the requirement that each specialty participates in clinical audit on a multidisciplinary basis (para 15.3).

The only other part of the agreement that could be possibly deemed to require the reporting of a serious untoward incident is paragraph 17.1, which states: 'The purchaser and the provider will adopt an open and constructive approach in terms of resolving any problems which may arise in relation to performance.'

Given the lack of any clear 'governance relationship' between Trust and Board there would appear to have been no formal requirement for the Trust to notify the Board of the death of Lucy Crawford following her treatment in the Trust and in RBHSC. That they did inform the Board probably reflects the continuing influence of the direct management relationship that formerly existed between the two organisations. This is the position stated explicitly in

[6] Scally, G. & Donaldson, L.J., 1998. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ British Medical Journal*, 317(7150), p.61-65.

a witness statement of Mr Hugh Mills where he states, *'I understood that there was a requirement to report untoward incidents to the WHSSB. They were our main commissioner about services and we were continuing with arrangements in place prior to becoming a Trust.'*[7] The decision to inform the Board may well also reflect the concern of the senior staff in the Trust that the quality of care provided may have contributed to the death.

(c) *Having been provided with information relating to the treatment and death of Lucy Crawford, including the provision of the Trust's review report and the report of Dr. Moira Stewart, what action should the WHSSB have taken pursuant to the governance relationship which existed at that time?*

In strict management terms the WHSSB had no role, as there does not appear to be a governance role at that time in relation to hospital services, except that arising from the Service and Budget Agreement.

However, having been informed of a serious concern about the treatment of Lucy Crawford and having a general responsibility, deriving from the senior professional and managerial status of the officers of the Board and also the role of the Board in respect of the health of the population served by the WHSSB, it could be argued that those in possession of knowledge about a potentially serious untoward incident should act to ensure the response to the possible untoward incident was appropriate.

In my professional view this would have included:

a) Advising in strong terms that the Trust should report the death to the organisation to which they were accountable, to wit, the DHSSPS.

[7] INQ-RF Preliminary WS-293/2 Page 3.

b) Advising that the appropriate coroner should be informed that there were potential concerns about the treatment provided.

c) That the Trust should do a) & b) in co-ordination with the Royal Group of Hospitals Trust (which I believe to have been the body responsible for the management of the Royal Belfast Hospital for Sick Children) it being the other hospital involved in the episode of care.

d) That the care and treatment of Lucy should be reviewed, with written terms of reference and appropriate clinical leadership of the review that was unconnected with either hospital.

e) That the terms of reference of the review should be agreed between the two Trusts involved and the DHSSPS.

f) That all documentation relating to Lucy's care in the Erne Hospital should be secured.

The precise sequence of proceeding in these matters would be the subject of discussion and agreement.

(d) Insofar as you can comment from the materials available to you, was the action taken by the WHSSB in response to Lucy's death adequate?

This question can be answered in two parts:
Firstly, in respect of purely the formal duties and obligations of the Board and its senior officers the response cannot easily be judged as less than adequate. This view is based on the complete lack of clear direction as to how serious clinical incidents of this type should be handled along with the absence of management accountability between the Trust and the Board.

Secondly, it is reasonable for the public to expect that any senior health manager or professional, if they have knowledge of action or inaction that might have seriously damaged a patient, to have acted on that knowledge in such a way as to reduce future risk. In that regard, there was certainly more that the Board could have done to press for the issues surrounding Lucy's care and treatment to be fully and properly scrutinised. The witness statement of Mr Bradley indicates that he would have asked the Trust to undertake at least some of the actions that I suggest above to have been appropriate, had he been notified of an unexpected and unexplained death.[8]

(e) *What ought to have been the role and function of a director of public health in an organisation such as the WHSSB in June 2000, when advised of an adverse incident giving rise to the death of a child such as Lucy Crawford?*

The role of Director of Public Health had undergone several changes over the previous 15 years. The post had since 1973 been titled 'Chief Administrative Medical Officer' but had changed to Director of Public Health in the late 1980s and the emphasis of the post altered. This change took place because of a review conducted by the Chief Medical Officer for England, which concluded that public health doctors were overly involved in NHS administration and needed to concentrate their efforts on the health of the population.[9]

Prior to the creation of Trusts the CAMO/DPH had substantial responsibilities for medical staffing issues including conduct and discipline. However, with the creation of Trusts that aspect of their role ceased, as employment of medical and other staff transferred from the Health and Social Services Boards to the newly formed Trusts.

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[8] INQ-RF Preliminary WS-307/1 Page 3

[9] Acheson ED. 1988. Public Health in England. Report of the Committee of Enquiry into the Future Development of the Public Health Function. London: HMSO

There was not, in my professional view, a clear and distinct role for the Director of Public Health in relation to dealing with what might be a potentially serious clinical incident affecting one patient and taking place in a hospital Trust.

There is nothing in the Director of Public Health job description attached to Dr McConnell's first witness statement that would mandate any distinct involvement in clinical matters or serious incidents.[10] It is, however, not entirely clear that the job description provided was the one that was in place in 2000. Nonetheless, the Director of Public Health in Northern Ireland was in a leadership position and as the senior clinician in the Board structure had a duty to use that position and authority to protect patients and the public whenever there was a need to do so.

(f) *From the perspective of a public health practitioner, was the action taken by Dr. William McConnell (Director of Public Health at the WHSSB) in response to Lucy's death adequate?*

There is some confusion in the documentation as to the accountability of Dr McConnell (and others) in April 2000. The brief with which I have been provided states, in paragraph 77, that at the time of Lucy's death Dr McConnell was accountable to Mr Frawley through the Director of Health Care, Mr Martin Bradley. This assumption is undoubtedly based on Dr McConnell's first witness statement, in which he states that his '*...responsibilities would mainly have included in forming the Director of Health Care and Chief Executive of the contact from Mr Mills regarding Lucy Crawford's death...*'[11] In his first witness statement Mr Mills states '*Mr Bradley was the Director of Health Care and Chief Nursing Officer at the Western HSS Board the*

[10] INQ-RF Preliminary WS-286/1, page 16/7.
[11] INQ-RF Preliminary WS-286/1, section 6, page 5.

main commissioners of services at the Erne Hospital.'[12] In contrast, Mr Bradley states that he was Chief Nursing Officer until 31st August 2000 and became Director of Health Care & Chief Nurse on 1st September 2000.

Assuming that Mr Bradley is correct, this alters the importance of some of the conversations that were being had in the period following Lucy's death. It signifies that Dr McConnell had a more senior role than originally indicated and was directly accountable to the Chief Executive, Mr Frawley.

It appears that Dr McConnell had no specific responsibility for clinical governance or standards attached to his post and in light of this, allied with the absence of formal authority in respect of the position of the Board vis-à-vis the Trust and its actions, it could be argued that his actions were adequate. Nonetheless, he was notified by the Trust of Lucy's death and he could, and probably should, have used his significant positional and sapiential authority to push the Trust and DHSSPS further in respect of proper and thorough investigation of Lucy's death. Indeed, Dr Kelly's witness statement indicates that Dr McConnell was regarded from the Trust perspective as having substantial authority in relation to clinical failure.[13]

The General Medical Council guidance 'Good Medical Practice' that was published in 1998 and was operational until 2001, was written in the aftermath of the failures in the paediatric cardiac surgery service in Bristol. It states that: 'You must protect patients when you believe that a doctor's or other colleague's health, conduct or performance is a threat to them.'[14] It is not entirely possible to discern with any certainty from the witness statements if Dr McConnell was aware at that initial stage of any broader concerns about Dr O'Donohoe's professional competence, although it becomes apparent later

[12] INQ-RF Preliminary WS-293/1, page 7 para (e).
[13] INQ-RF Preliminary WS-290/1, page 12 para (h) & (i)
[14] General Medical Council. *Good Medical Practice.* London: 1998. http://www.gmc-uk.org/good_medical_practice_july_1998.pdf_25416527.pdf

that those concerns existed. However, a single episode of significant clinical failure can sometimes be enough to warrant intervention.

It is commendable that following the death of Raychel Dr. McConnell took an active role in disseminating to other health care providers the lessons to be learnt from her death.[15] In the absence of a system-wide coordinated response to the problem his action was in keeping with his professional duty as a medical practitioner.

(g) Would you have expected officials of the WHSSB to have -

(i) Scrutinised the review exercise which had been conducted by the Sperrin Lakeland Trust to assess whether it was adequate and to determine whether Lucy's death had been adequately investigated;

Based on a strict interpretation of accountability it would not have been reasonable to have that expectation. The role of 'scruitinising' the action of the Trust should fall squarely within the remit of the DHSSPS as the body to which the Trust was formally accountable. It would however, in any event, have been reasonable for the Trust to share the conclusions of that review with the WHSSB and for the Board to have the opportunity to comment upon it. If upon consideration of the review the Board was not content with any aspect, it would have been entirely appropriate for the Board to put forward those concerns to the Trust and to the DHSSPS. Indeed, as an organisation with responsibility for the health of the population served by the Erne Hospital it would have remiss of them not to point out significant deficiencies.

[15] INQ-RF Preliminary WS-286/1, page 12.

Having made the above points based on a relatively strict interpretation of accountability it is worth noting the point that I made earlier in this document about the continuation of a culture of subordinate and ordinate organisational relationships that survived the formal creation of the Trust as a separate body from the WHSSB. In the context of that relationship the WHSSB could indeed have used its authority to 'scrutinise' the adequacy of the review and probably should have done so.

(ii) Directed or recommended the Sperrin Lakeland Trust to communicate with and seek the views of clinicians at the RBHSC in relation to the cause of Lucy's death in light of what was listed on the death certificate;

It would have been appropriate to have an external review of the totality of Lucy's care from the admission to hospital to her death, the issues surrounding cause of death and the communication of information about her treatment and death. Such a review would have of necessity included the care provided during transfer to Belfast and also the care in the RBHSC. I do not believe that it was possible for the WHSSB to direct the Trust, but they could have reasonably asked for an explanation as to how she could have died from cerebral oedema as a result of gastroenteritis and dehydration. This would however depend on the level of clinical knowledge of the officers of the Board who were considering the matter. My feeling is that it should have been judged as being appropriate to urge further work to clarify cause of death.

(iii)Provided a formal response to the Sperrin Lakeland Trust in relation to the review report which it had sent to the WHSSB;

See the answer to (g) (i) above.

(iv) Directed or recommended to the Sperrin Lakeland other action to take in order to address the cause of Lucy's death, the review report having failed to clarify the underlying cause of death;

See the answer to (g) (ii) above.

(v) Taken steps to determine whether an Inquest was definitely going to take place, or to take any steps to address the Coroner's Office in relation to Lucy's death at any time;

There is an undercurrent of concern at various points about the possibility of negligence or malpractice having a role in Lucy's death. If there was reason to believe that this was in fact the case, then one would have expected that the WHSSB would have contacted the appropriate Coroner. This expectation stemming, I believe, from coronial law rather than from the formal relationship between the WHSSB and either the Sperrin Lakeland Trust or the Royal Belfast Hospitals Trust.

(h) Would you have expected Dr. McConnell and Dr. Kelly to have specifically discussed Dr. Moira Stewart's comments about the treatment and death of Lucy (as contained in her report and in the notes of her meeting with Kelly) which Dr. Kelly sent to Dr. McConnell?

The report from Dr Stewart was afoot of concerns about competency of Dr O'Donohoe and took place the year following her death. Lucy's case was one of four considered and Dr Stewart's comments about 'delay' and 'deficiencies' are at the lower end of the scale of critical comment that might be expected in such a report. Unless there were other matters that indicated that the case of Lucy was still under scrutiny it would not be expected that Dr McConnell would pick up this specific comment. I would expect the main focus to have

been on the issue of whether intervention in relation to Dr O'Donohoe's clinical performance was justified.

(i) *Having advised the Sperrin Lakeland Trust to consider having a wider review in relation to Lucy's treatment and death, what steps would you have expected Dr. McConnell to have taken to ensure that this was carried out, and that it was carried out adequately?*

It is unclear to me whether Dr McConnell's reference to a wider review in his first witness statement refers specifically to Lucy's case or to the overall practice of Dr O'Donohoe. In any case, as explored above, Dr McConnell's position remains outside the formal line of accountability and he was in a weak position when it came to ensuring that the Trust took any particular course of action.

(j) *Would you have expected the Sperrin Lakeland Trust to have disclosed the second RCPCH report to the WHSSB pursuant to the governance relationship which existed at that time?*

Because of the formal accountability gap that existed there was no requirement to disclose the second report to the WHSSB. In the compilation of the second report the concentration was intended to be on the clinical performance of Dr O'Donohoe. The conclusion of the report does not deal with that issue at all. Given the vague nature of the conclusion there is no substantial matter in relation to the stated purpose of the report that would have indicated a requirement to inform the WHSSB. However, taking into account that it is likely that the conclusion in relation to Lucy's care would have been of interest to Dr McConnell given his previous involvement, the Trust should have drawn it to his attention.

(k) *Should the WHSSB have notified other hospitals within its area or further afield, of the death of Lucy Crawford and the circumstances in which she had died?*

The WHSSB's role was to act as a purchaser of services for its population. It did not, in my view, have a wider role in patient safety and clinical governance unless that role had been delegated to it by DHSSSP. The WHSSB could reasonably expect to rely upon the DHSSPS, as the ordinate body for hospitals in Northern Ireland, to have undertaken the process of ensuring dissemination of any necessary alerts. If they were aware of an important patient safety issue that, in their view, was not being dealt with appropriately they would be expected, through their officers, to raise that issue with the DHSSPS. If the issue was still not addressed to the Board's satisfaction then the matter should be raised by the Chair of the Board with the Minister responsible.

If however there was felt to be a serious risk to patients that was not being dealt with effectively and in a timely fashion by DHSSPS then I would not judge the WHSSB to have acted inappropriately if they had disseminated what information they possessed. This could however expose the Board to legal risk.

(l) *Should the WHSSB have notified the DHSSPS of the death of Lucy Crawford and the circumstances in which she had died?*

Either, or both, of the two Trusts involved in the care of Lucy Crawford could reasonably be expected to have notified the DHSSPS if they felt that the death was potentially due to inadequate treatment. There would not have been the same expectation of the WHSSB. However, because of the potential seriousness of the case it would not be unreasonable to expect a discussion to have been had with the Sperrin Lakeland Trust and DHSSPS to ascertain whether they had indeed made the DHSSPS aware.

(m) *Should the Sperrin Lakeland Trust have made a report to the DHSSPS to inform it that there had been an adverse incident leading to the death of Lucy Crawford, and that her death was going to be investigated?*

As it was to the DHSSPS that the Trust was accountable it would have been appropriate that the death and, in particular, concerns about her treatment should have been reported to the DHSSPS. There were procedures in place requiring Trusts to notify the DHSSPS of certain untoward events. In particular there were systems in place covering events affecting patients in the care of mental health and learning disability services.[16] It has to be noted however that there does not appear to have been a requirement for Trusts so to do in relation to potentially avoidable death or other instances of serious clinical failure in other clinical areas. The replacement of the accountability of the Erne Hospital to the WHSSB with accountability of the Sperrin Lakeland Trust to the DHSSPS does not appear to have been accompanied by the enunciation of a systematic protocol for the reporting of incidents. It is however possible to argue that there is a general duty to keep the DHSSPS informed of events that have had serious consequents and which might become the subject of media attention or public controversy.

(n) *If the DHSSPS had been so informed by the Sperrin Lakeland Trust of the death of Lucy Crawford, what action would you have expected the DHSSPS to have taken pursuant to the governance relationship which existed at that time?*

I would have expected the DHSSPS to ensure that the care and treatment of Lucy, and her subsequent death, was the subject of an effective review and investigation. The nature of the investigation that I would have expected the DHSSPS to insist on is outlined in (c) above. I would also have expected them

[16] RF Preliminary 319-0005-004

to discuss the report of that investigation with the Trust and agree appropriate action.

I would also have expected DHSSPS to explore the subtheme that is hinted at in the documentation, namely the questions surrounding the general clinical performance of Dr O'Donohoe. It is however difficult to see the vehicle for this course of action given the vague way in which, according to account of Mr Mills, accountability appears to have been exercised.[17]

Additional observations

1. There is value in exploring the role of the RBHSC in relation to Lucy's death. If there was any significant suspicion amongst the staff of the RBHSC that Lucy's death was due to inadequate treatment then the matter should have been reported within the mechanisms available within the Royal Group of Hospitals. In addition, under these circumstances, the Sperrin Lakeland Trust should also have been informed in a formal manner. My view is that this expectation arises out of a general obligation in the case of a death that may have been caused by inadequate treatment and is reinforced by the RBHSC role as a regional centre of excellence.

2. In a situation where there is seen to be a 'problem with fluid management' in a hospital one would expect that steps would have been taken in a timely fashion to establish an evidence-based protocol for future fluid management within the hospital in question. It would also be expected that it would have been proposed that the position in other hospitals would have been assessed by a clinical audit of practise in fluid management via the established mechanisms for conducting clinical audit.

[17] INQ-RF Preliminary WS-286/3

Documents issued to Gabriel Scally

Witness Statements
Mr Fee – WS-087/1
Mr Fee – WS-087/1
Dr Kelly - WS-090/1
Dr Kelly – WS-090/2
Dr McConnell – WS-286/1
Dr McConnell – WS-286/2
Mr Mills – WS-293/1
Mr Mills – WS-293/2
Mr Mills – WS-293/3
Dr Stewart – WS-298/1
Martin Bradley - WS-307/1
Tom Frawley – WS-308/1

Documents
File 27 – Raychel Ferguson Preliminary – Erne – Lucy Crawford Hospital Charts
027-010
027-012
027-017

File 29 – Raychel Ferguson Preliminary – Erne – Lucy Crawford Child Health Chart

File 32 – Raychel Ferguson Preliminary – SLT – High Mills Papers
032-089
032-090

File 33 – Raychel Ferguson Preliminary – SLT – Bridget O'Rawe Papers
033-101
033-102

File 36a – Raychel Ferguson Preliminary – SLT – Dr Kelly Medical Director
036a-009
036a-010
036a-025
036a-027
036a-028
036a-029
036a-045
036a-046
036a-047
036a-048
036a-049
036a-053a

036a-054
036a-129
036a-150

File 036b – Raychel Preliminary – SLT – Dr Kelly Medical Director
036b-002
036b-058

File 61 – Raychel Ferguson Preliminary – Royal – Lucy Crawford Contacts, Review/Enquiry Papers and Casenotes
061-018
061-019

File 115 – Raychel Ferguson Preliminary – PSNI Papers
115-041

File 116 – Raychel Ferguson Preliminary – PSNI Papers
116-043

File 314 – Claire Roberts – Adhoc Governance Documents
314-007
314-008
314-024
314-034
314-041
314-052e

File 315 – Raychel Ferguson Preliminary - Adhoc Documents
315-002
315-006

File 318 – Raychel Ferguson Preliminary - HSC Board Documents relating to Lucy Crawford
318-002
318-051

File 319 – Raychel Ferguson Preliminary – DLS Correspondence
319-005
319-010b
319-010c
319-010d
319-041
319-045a

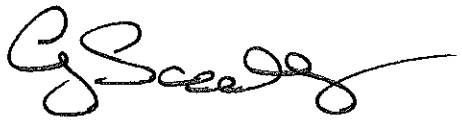
File 320 – DHSSPS – CMO Group – Medical Advisory Structures – Vols 1-3

Statement of Truth

I understand that my duty as an expert is to provide evidence for the benefit of the Inquiry and not for any individual party or parties, on the matters within my expertise. I believe that I have complied with that duty and confirm that I will continue to do so.

I confirm that I have made clear which facts and matters referred to in my report(s) are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which I refer, having studied all the relevant documents supplied to me.

I confirm that I have no conflict of interest of any kind, other than any disclosed in my report(s). I do not consider that any interest that I have disclosed affects my suitability as an expert witness on any issue on which I have given evidence. I undertake to advise the Inquiry if there is any change in circumstances that affects the above. I have no personal interest in supporting any particular point of view.

Signed:  **Date:** 25.4.13