INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

LUCY CRAWFORD

CLINICAL GOVERNANCE ISSUES

SUBMISSION
On behalf of
DR ANDERSON

1. The representatives of Dr Anderson have been invited to provide a written submission to address the evidence provided during the hearings into clinical governance issues touching upon the death of Lucy Crawford.

2. Dr Anderson is a willing witness who provided two witness statements and attended the Inquiry to give oral evidence on 11th June 2013. It is not proposed to rehearse the detail of Dr Anderson's evidence in this submission but rather to assist the Inquiry by highlighting a number of features of his candid testimony.

3. The Inquiry will undoubtedly reflect upon the imperfections of memory that can inevitably arise given the passage of time between the incidents under consideration and the hearings in 2013. It is of note that Dr Anderson was not a primary witness to any of the clinical or medical events relating directly to Lucy Crawford's death. Dr Anderson was not involved, at any stage, in the direct provision of care to Lucy.

4. Dr Anderson spent the bulk of his clinical career practicing as a consultant obstetrician and gynaecologist in South Africa. He had no direct expertise in anaesthetics or paediatrics. He returned to Northern Ireland in 1998 and was made a Clinical Director at the Erne Hospital in 1999.

5. Dr Anderson was appointed to be a coordinator of the review in the Erne. The Inquiry will note the hierarchical arrangement that applied in the Erne at that time. Mr Fee was the Director of Acute Hospital Services and Dr Kelly was the Medical Director. Both were directly accountable to Mr Mills, the Chief Executive. Dr Anderson was the Clinical Director for Women and Children's Health. He was not directly

accountable to Mr Mills but reported to Dr Kelly. He was not a member of the Senior Hospital Management Team.

6. In his evidence on 11th June 2013 he stated that he was given no training whatsoever for the role of Clinical Director and, indeed, was reluctant to take on the post. Moreover, Dr Anderson stated that he had no experience in clinical audit or in conducting a critical incident review. Dr Anderson's position was supported by the evidence given by Dr Ian Carson on 26th June, 2013. Dr Carson stated that:

> "Whenever you say it was the responsibility of a clinical director or a medical director to institute an investigation, I think that there's a real gap here. Doctors are required to give opinions and to write reports, particularly if they have got a medico-legal practice, but generally speaking doctors are no skilled in making statements, be it for the police, be it for the coroner, an investigation or an inquiry. And medical directors, certainly during my time and maybe even more recently, have had very little experience or training in how to convene an investigation."

7. Dr Carson's view was echoed by Dr McFaul when he gave evidence to the Inquiry on 27th June 2013. It is of note that Dr McFaul had been critical of Dr Anderson in his written report. However, in his oral testimony to the Inquiry he adopted a more measured view of Dr Anderson's skill set for conducting reviews. The following exchange between the Inquiry Chairman and Dr McFaul is revealing:

> "[Dr McFaul]…..And around 2000, it was an issue because medical directors were appointed often with limited training and limited support. Clinical directors very often had no training, and very little support in how to do their job, but they would find out through themselves. If you contrast the amount of training that is required and evaluation to become a consultant in a specialty with clinical responsibilities, with the amount of training and support given to a person taking up a managerial post at a clinical director level, the two are completely separate. There's a big gap there. There are courses and I think that from 2000 there has been a step, of possibly several steps, changed for the better.
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> Chairman: So when Dr Anderson effectively complained that he was put in as part of the review team in Sperrin Lakeland but he didn't have any training or any experience in doing something like this, it's not enough to say that common sense would tell you what to do because his skill set for his specialty might be rather different to the skill set which is required of somebody who is doing an investigation?
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> A. Yes, I think that is a very fair position. …

8. An objective external appraisal of Dr Anderson's role in the review would support the conclusion that he was engaged to conduct a review in an area outside his clinical specialism in circumstances where he had

been given no specific training on how to to discharge such an investigative function.

9. Further, a consistent theme of Dr Anderson's oral and written evidence to the Inquiry was that he considered his role to be subordinate to that of Mr Fee. As is noted above Mr Fee was at a senior level in the hospital management hierarchy and had access to administrative and secretarial support for the review when Dr Anderson did not.

10. Both Mr Fee and Dr Anderson recognised, properly, that neither had the specialist expertise necessary to engage with the clinical issues arising from the treatment of Lucy Crawford at the Erne. They sought and obtained authority to commission an external expert opinion from a Paediatrician outside of the Erne hospital. Dr Murray Quinn provided an opinion based on a review of the case notes that were sent to him.

11. There was a difference of approach between Mr Fee and Dr Anderson in respect of seeking information from the nurses and doctors. Mr Fee wrote to the nurses and asked them to provide an account of events and to specifically address the issue of fluid management. Dr Anderson did not put his request in written form but asked the individual doctors to provide a factual report. He did not expressly ask the doctors to address the issue of fluid management. Dr Anderson has frankly acknowledged in his evidence that he was not as engaged in the review as he might have been had he had training or experience in an exercise of this type and that he played a relatively passive role in the process.

12. Dr Anderson was not involved in providing instructions or directions to Dr Quinn in relation to the nature and content of his report. While he and Mr Fee correctly identified that there was an issue in respect of fluid management, he did not meet with Dr Quinn when his report was commissioned and he was on annual leave when Dr Quinn met with Mr Fee to discuss the case on 2nd May. There was no direct engagement between Dr Anderson and Dr Quinn in respect of the findings made by Dr Quinn. Dr Anderson's evidence to the Inquiry was that he had "no communication at all with Dr Quinn."

13. The Inquiry has noted that Dr Anderson had identified that fluid volume may have been a factor in Lucy's demise but that he deferred to Dr Quinn's expertise in the field.

14. Dr Anderson specifically adopted a statement made by Mr Fee at the conclusion of his evidence. He stated:

> "I am not now satisfied with the review we conducted or the conclusions we reached, given the findings of the inquest. On reflection, we should have involved the family at the outset. The review should have been conducted using a more systematic approach, such as root cause analysis.

> The team selected would probably have benefitted from the inclusion of a paediatrician and an experienced paediatric nurse and perhaps the medical director. We probably relied too much on the external opinion without having the expertise to examine the opinion offered. The case should probably have been jointly reviewed or investigated by the two hospitals involved in Lucy's care."

15. Dr Anderson's evidence has been robustly challenged by the Inquiry. He has conceded that there were significant shortcomings in the review process that he and Mr Fee conducted. His actions (and omissions) must, however, be viewed through the appropriate lens. The Inquiry has heard evidence from the Deputy Chief Medical Officer and from Dr McFaul that, prior to 2000, clinical directors were appointed to their posts without any formal training outside their area of clinical expertise. There was no specific guidance on matters of clinical audit, governance or the conduct of critical incident investigations. From the standpoint of 2013 the review conducted at the Erne has obvious imperfections but is must be acknowledged that since that time, as Dr McFaul has stated, there has been a "step change" in the approach to the audit and investigative role of clinical directors.

Tony McGleenan QC
1st December 2013