Friday, 30 August 2013

(10.00 am)

(Delay in proceedings)

(10.25 am)

THE CHAIRMAN: Good morning. Mr Stitt?

MR STITT: Mr Chairman, if I may, there is a preliminary matter which I would like to bring up, and it's to do with the litigation. I don't need to rehearse the background, I think we're all familiar with the action which has been brought by the family and the position of non-admission of liability which has existed.

I am instructed to make a statement in relation to that if you would permit me to do so, sir.

THE CHAIRMAN: I will.

MR STITT: The trust, having taken into account the evidence heard during this inquiry, including independent expert evidence and the interim comments of the Chairman, formally admits liability. The trust apologises unreservedly for Raychel's death and regrets any further hurt or distress that the delay in admitting liability has caused the family.

THE CHAIRMAN: Thank you very much, Mr Stitt. I'm delighted, thank you, and I hope that helps the family.

MR QUINN: Mr Chairman, can I just mark that moment by saying from the family that that is very welcome.

THE CHAIRMAN: Mr Stewart?

MR STEWART: Thank you, sir. Dr Ian Carson.

DR IAN CARSON (called)

Questions from MR STEWART

MR STEWART: Good morning. Since last you were with us, you have filed a further witness statement, which is WS331/1, which you dated 30 May 2013. Are you content that the inquiry should adopt it as part of your formal evidence?

A. Yes, I am.

Q. Thank you. If I might just recap to describe your roles at the time of Raychel's death in 2001. At that time you were medical director at the Royal Group of Hospitals Trust. Indeed you were deputy chief executive of the trust. You were also seconded for one day a week to work as adviser to the Chief Medical Officer at the Department.

A. Correct.

Q. Thereafter, I believe you left the Royal in July of 2002 to take up a position as deputy Chief Medical Officer --

A. Correct.

Q. -- retiring from that post eventually in 2006 and taking up a further position as chairman of the Regulation and Quality Improvement -- the RQIA.

A. Correct.

Q. And you still work in that capacity, do you?

A. Yes.

Q. Thank you.

At the time you were seconded to the CMO in 2000, 1999/2000, you were working on the consultation document Confidence in the Future --

A. Correct.

Q. -- which was work towards the appraisal of doctors and performance response.

A. Yes. There was a lot of work taking place nationally, in England in particular, both at professional regulatory level and the General Medical Council, but also in the Department of Health in England on the whole area of the subject of the recognition, prevention and management of doctors with performance difficulties, whether those were clinical performance or health performance. So I was asked, during my secondment, to chair a working group that ultimately prepared the consultation document Confidence in the Future.

Q. Part of your working party, a member of your working party in the preparation of that consultation document, was Mrs Stella Burnside, the chief executive of Altnagelvin Trust.

A. Yes, that's correct.

Q. The document Confidence in the Future, amongst other

things, stressed the importance of reporting clinical incidents.

A. Yes.

Q. At that time were you a founder member of the British Association of Medical Managers?

A. I was, yes.

Q. Did you work much with that group?

A. Well, the function of the British Association of Medical Managers was to establish a forum where doctors who were involved in clinical management across the NHS could come together to meet, to learn, to discuss issues, and to share good practice in terms of medical management. I think I have described earlier in the inquiry that this was a new area of work for many doctors, a new -- vastly new responsibilities for which, as part of their undergraduate or even their postgraduate training, at that time, there would have been little opportunity to develop those skills. So it was a forum at a national level where doctors could share and develop the necessary skills to manage their colleagues in the workplace.

Q. Yes. I mention it in passing because Jenny Simpson was the chief executive of the organisation --

A. Yes.

Q. -- and she wrote a chapter in Lugon's book, which is

a clinical governance book, which has found reference in this inquiry on a number of occasions "Making it happen" --

A. Yes.

Q. -- and she usefully includes a chapter -- or Jenny Simpson writes a chapter -- on the role of the medical director in that.

Well, to summarise many of the things she says, she says the first duty of any medical director in delivering clinical governance must be to ensure that systems to pick up quality failures are in place:

"The first duty of any medical director must be to ensure the systems to pick up quality failures are in place."

I don't think you can disagree with --

A. I wouldn't disagree with that, but what must be recognised, and would also be recognised by Jenny Simpson, is that those systems that were either in existence at the time or the effort, the energy, the resources to put those systems in place, that was not a simple or an easy task, and I think I have also referenced it to the inquiry before that Sir Liam Donaldson wrote an article in the British Medical Journal highlighting the difficulties that medical directors inevitably would encounter as they

established systems in places within their individual trusts to do that in the context of a Health Service that was under constant flux and change and also significantly constrained for resources.

Q. Yes. I think we discussed last time we had an evidence session how difficult or easy it is for communication to be made, for a medical director to be informed of an unexpected death or a clinical director to be informed of an unexpected death. You may recall that I pointed out that in neither Adam Strain's case, nor the case of Claire Roberts, was the clinical director informed of her death, nor the medical director informed of the death.

A. Correct.

Q. And I think at the time you said, "Well -- I can't quote you, but you didn't think that was that unusual but perhaps in hindsight they should have known.

A. Well, certainly they should have known, yes.

Q. In the case of Raychel, when she dies in the Royal in June 2001, as I understand it, the clinical director was not informed. As I understand it, you as medical director were not informed.

A. That's correct.

Q. Things have moved on from 1996 and 2001. Clinical governance has gathered pace, and the inquiry's been

assured that it was a different environment in 2001, but yet the information wasn't moving. How could that have happened?

A. I think that the circumstances -- I think we can have a discussion around -- in the context of Raychel Ferguson of the perception or the understanding of the clinicians who were actually involved in treating Raychel Ferguson. There, I presume, and it's an assumption I have to make, that they assumed that because the incident -- the events that led up to Raychel's tragic death took place elsewhere and that in fact she was delivered -- transferred to the Royal Belfast Hospital for Sick Children in very much a terminal condition, and it was a very short episode within the Children's Hospital to determine the outcome for Raychel. So in a sense, I can understand how that lapse, if you like, occurred.

Q. As I understand it, the death was immediately referred or brought to the attention of the coroner, but it doesn't seem to have been brought to the attention of Mr Walby, the individual within the trust who's charged with looking after cases that were referred to the coroner. How could that have been?

A. That might be something that needs to be asked of Dr Walby. But I think we have -- there has been

discussion certainly in the inquiry around the change of practice, and I think I'm on record as saying that my expectation was that that office would be informed when a case was referred to the coroner, and we had a discussion -- there has been discussion as to whether that office was there to facilitate and assist the coroner or to assist clinicians within the hospital in preparing their submissions and reports to the coroner.

I think that there was possibly -- and I know that there was a transition from the period of time when Dr Murnaghan fulfilled this function earlier -- early in the mid-90s and as a result of changes that I put in place as trust medical director by creating two associate medical directors, Dr Mulholland and Dr Walby, I think their ability to oversee absolutely everything that was taking place in relation to coroner activity in the hospital, that might have -- because Dr Walby was working part-time, it was a part-time appointment, he was also practising as a clinician, whereas during Dr Murnaghan's time, Dr Murnaghan was full-time, he was not practising as a clinician, he was director of medical administration, he was all over the hospital like a rash. The junior doctors, the senior doctors knew exactly what Dr Murnaghan's role and task was.

And I think it was maybe more difficult for Dr Walby

in the context that he had a clinical practice to undertake, he was only part-time, and he was heavily involved, I would say he was more heavily involved, I think, in managing litigation processes than possibly -- and that's my perception, I can't vouch for that, that would be an issue that Dr Walby might have to explain or clarify.

Q. Rather more to the point, the individuals concerned with Raychel should have brought it to Dr Walby's attention?

A. Sorry, I can't --

Q. The individuals concerned with the care and treatment of Raychel at the Royal should have brought the matter to the attention of Mr Walby?

A. That was certainly -- I've said to the inquiry before, that was my expectation.

Q. Yes. One of the policies that you were instrumental in introducing was the adverse incident reporting policy. We can find it at WS292/2, page 45.

This was introduced, as I understand it, in May 2000. It starts off by describing the rationale, by defining an adverse event as:

"Any unexpected or untoward event that has a detrimental effect on an individual patient, member of staff or public."

Then:

"Objectives of reporting an adverse events."

Three bullet points are outlined. The third one I draw to your attention:

"As an objective to provide formal documentation to assist in the management of complaints, claims and investigations by statutory bodies."

I draw that to your attention because, clearly, a case that is referred to the coroner is a case in which there may be an investigation by a statutory body. So I suggest to you that this policy makes it clear that this is a case in which a formal adverse incident report should have been filed.

Can you comment on that?

A. The objective was to provide formal documentation to assist the investigation in this case by the coroner. It doesn't indicate that staff had to make report --

Q. Can I just take you down further to the policy section, the second short paragraph of that:

"All staff must report adverse events as outlined in the procedure for adverse events reporting."

The 3 refers to the forms and so forth.

A. First of all, I just want to point out, I was not responsible for writing policy in the trust. The trust policy group that did this was under the aegis and leadership of the director of nursing. The policy unit

that prepared all trust policies came within her remit.

Now, obviously I was keen to ensure that such a policy in relation to an adverse incident reporting was in place, but it is recognised -- and for by what it says in the policy that does not necessarily mean that policies get implemented as effectively and as thoroughly as they should do. In fact, there is evidence, and well documented nationally, that the implementation of adverse incident reporting throughout healthcare systems can at times be very patchy.

THE CHAIRMAN: I'm sure that's right, doctor, and I'm sure that if policies were always followed life would be a lot easier and everything would flow better than it does. But I think the point of Mr Stewart's questions at this point is: do you agree that although the traumatic events occurred in Altnagelvin, that when Raychel died in the Royal, that that was an adverse incident which should have been reported within the Royal?

A. I hate using this term "with the benefit of hindsight", it's not an appropriate response at all, but the answer to that is obviously yes. I mean, would one expect in an organisation that thoroughness and adherence to policies that are approved by the trust are effectively worked through. But certainly, the evidence -- and

reference has been made in inquiry documentation to the document "An organisation with a memory", and it quite explicitly says that the work that that working party of those very eminent people, when they evaluated the effectiveness of adverse incident reporting, it was patchy throughout the NHS.

THE CHAIRMAN: Yes. Because this, in a sense, leads us into -- and I'm sorry if I'm breaking into something Mr Stewart was going to come to later. But in a sense this breaks us into the role of the Children's Hospital as the regional centre, and if the treatment of a child has come unstuck, if I put it in that awkward way, in another hospital, in an area hospital, which leads to her being sent to the Royal, can you help me with a feel for what was regarded within the Royal as its responsibility as the regional centre for trying to make sure that lessons would be learnt? Even if the lessons weren't lessons to be learnt in the Royal, there would be lessons learnt in the Altnagelvin or the Erne or wherever?

Part of the benefit of having a regional centre is there's arguably more resources, more specialties, and they can pick up lessons better to spread out.

A. I think that's a fair assessment and that should and could be the -- could easily be the case. I think

reference has been made to Professor Swainson and Dr Scally in relation to the role of the Children's Hospital as a centre of excellence.

One of the ways that the hospital and the trust would have fulfilled that obligation would be in its training. I mean, there would have not been a junior doctor training in paediatrics who had not at some stage or other worked in the Royal Belfast Hospital for Sick Children.

Surgeons work in the Royal as a teaching hospital and they observe, they learn their trade, they go through the exercises of education and development within the trust, and they carry that with them. As -- many of these junior doctors are on rotations to other hospitals such as Altnagelvin, Craigavon and Enniskillen for that matter, so they carry with them the learning and the observations they've made as part of their training.

Whether the trust has a responsibility over -- whether the trust organisationally has a responsibility over and above that, it's less easy to determine. An awful lot of this learning that takes place is conducted -- I've said this before -- down professional lines, through specialty organisations, be that the paediatric group within Northern Ireland, the

Northern Ireland Society of [inaudible], or college bodies, Association of Paediatric Anaesthetists. All of these fora are opportunities for learning to take place and for that learning to be disseminated.

Chairman, what I would say was that in the context of Northern Ireland, the Belfast teaching hospitals in particular, the Royal and the City are these centres of expertise, there is no doubt, and I think they do have a responsibility to disseminate that. But I would also say that in Northern Ireland as a small -- we have a small population, the expertise that exists here is small also in comparison to expertise that exists elsewhere within the UK.

Now, in Northern Ireland, and from the Children's Hospital and from the Royal as a whole, we would have transferred children to Great Ormond Street with complications for significant interventions for complex cases. We have transferred children -- and I know from paediatric cardiac surgery -- to Birmingham, to Newcastle, to Manchester.

Never in my experience have I received any communication from another hospital to a hospital to say, "There is learning in this that you need to put in place within your organisation". So I have never seen that sort of communication inter hospital to hospital

take place. It does happen down the professional line, but I've never seen it handled through, if you like, an administrative trust line.

That's just my experience and I don't -- even to this day, I would doubt if that happens.

THE CHAIRMAN: That's one level. The more direct level here was that there was a critical incident review in Altnagelvin. Altnagelvin did not apparently seek the input of doctors from the Royal, which seems to have been unfortunate, and for that one might say that Altnagelvin's responsible.

The other side of that coin is whether any of the doctors from the Royal, who apparently took a view about Raychel's treatment early, should have volunteered a contribution to the Altnagelvin review. If I accept your point that there is no hospital-to-hospital communication, the evidence in Raychel's case of doctor-to-doctor communication is a bit thin, and it was also pretty thin in Lucy's case.

A. I would agree with that assessment, chairman. I think -- again, I go back to some of the opening remarks that I made earlier on in the inquiry about the culture and the environment at that time when hospitals -- certainly in the early 1990s -- were in competition with each other for clinical referrals and

so on. But later, towards -- by 2000, there were certainly much more talk about clinical networks, joined up communication between trusts. That era of competition, if you like, should have moved on, and I would think that certainly now, if you take many of the specialties within the practice of medicine, the delivery of that service now is across a network.

If you take cancer services, for example, the cancer unit in Altnagelvin and the cancer centre in Belfast would be in constant dialogue, and I think if a scenario of a poorly-managed case arose now as part of a clinical network, then there would be much more opportunity and an openness for clinicians across hospitals to discuss cases. I think that was possibly lacking or we were in that cusp of moving from maybe a less open context to what is now, I trust a much more open context.

THE CHAIRMAN: Thank you.

MR STEWART: I wonder, can I bring us back from the theoretical to the actual and what happened. Professor Swainson has indicated, in his view, he would have expected a fairly full analysis of the causes of the cerebral oedema, the causes of the hyponatraemia, to be relayed to Altnagelvin at that time.

I wonder, can I bring up document 317-041-001.

This is a copy of the advice note that was issued by

the Royal. This was not sent to Altnagelvin Hospital, but in fact, as I understand it, was sent to the GP.

It simply says in respect of Raychel:

"Transferred from Altnagelvin with seizures, hyponatraemia/cerebral oedema, fixed dilated pupils. Certified as dead 10/6/01 at 1209 for coroner's PM."

That's the full sum total of the Royal Hospital's communication with Derry, and that's not to Altnagelvin.

Can I ask you to comment on whether you think that was appropriate at the time.

A. This communication was to the general practitioner; is that correct?

Q. As I understand it, yes.

A. Personally, I'm not familiar with this notation. I honestly just can't recall this notation at all. Um ...

Q. It does seem --

A. I'm not familiar with this notation at all.

Q. It is fairly uninformative, isn't it, and completely uninformative insofar as Altnagelvin --

A. It depends what the purpose of the documentation is and I'm not familiar with the purpose of the documentation.

Q. Will you agree with me it doesn't add to the understanding --

A. But it depends what the purpose of the documentation's

for.

Q. Very well. What information do you think should have been relayed back to Altnagelvin Hospital?

A. Um, I presume the clinicians who were directly involved in the management of the child in the intensive care unit -- and if I remember, a doctor from Altnagelvin, Dr Nesbitt, travelled with Raychel to the Children's Hospital --

Q. Yes.

A. -- he presumably communicated with the clinicians in the unit and returned to Altnagelvin. Subsequently, the brain tests were completed and the child, unfortunately, declared dead. I would have assumed that the clinicians who were managing the case would have at least communicated with Dr Nesbitt or, if there were other referring clinicians -- I'm not sure who referred the child, what the process of referral was of Raychel down to the Children's Hospital, but I would have expected there would have been not only -- there would have been a verbal communication and presumably the equivalent of what I would have called, using old speak, a discharge communication.

Q. Yes.

A. I'm not familiar with this particular documentation.

Q. I understand that. That communication, perhaps both

verbal and written, should have been between the referring consultant -- and I believe in this case that was Dr Nesbitt -- and the admitting consultant in the Royal; I believe that was Dr Crean. So they should have been communicating.

If Dr Crean had formed the opinion that perhaps there had been an adverse incident, mismanagement or something was not quite right with the case, should he have brought that to the attention of Altnagelvin at that time?

A. Um, that would have been certainly an opportunity for him to do that, yes.

Q. Yes. Not only an opportunity, but it's something that he should have done?

A. One could make that interpretation, yes.

Q. Yes. That's something which was good practice and had been good practice for some considerable time as at 2001.

THE CHAIRMAN: That must be the way to do it, doctor, mustn't it? Because if Dr Crean, perhaps with the benefit of additional expertise in the Royal, has identified a problem in the management of a patient, surely he should tell the referring hospital what his concerns are?

A. Yes, chairman.

THE CHAIRMAN: There might be a matter of sensitivity about how he does it or who he speaks to do it. But surely it should be done?

A. I can't -- I wouldn't disagree with that. What I can't prejudge is what Dr Crean knew at the time of the events that took place in Altnagelvin. And that's -- you know, he can -- he can relay his observations, his findings, the outcome of his management and care of the child, but I'm not in a position to evaluate what he knew and what happened in Altnagelvin.

THE CHAIRMAN: We have some evidence about what Dr Crean understood or what his take or the take in the Royal on Raychel's care was. Let's assume for the moment that the Royal had identified that there were significant failings in Raychel's care, then that should have been stated reasonably clearly --

A. Yes, I wouldn't disagree with that.

THE CHAIRMAN: -- to somebody in Altnagelvin who would take it on board and do something about it?

A. Yes, I wouldn't disagree with that.

MR STEWART: And further, should also have communicated that to the family GP?

A. Um, one could infer that as well. I'm not quite sure how the regional intensive care unit, when a referral is made to them, whether the communication -- they would

communicate directly with the GP or not. I just don't -- I can't recall.

Q. We know they did because this went to the GP.

A. Okay.

Q. Can I ask for page 305-011-578, please. This is a note of -- ah, I'm afraid the redactamaniacs have been at work again. Let's not waste any time with that.

If a doctor, let us suppose Dr Crean, had been aware that there had been mismanagement or clinical failings in Raychel's case, should he have brought that to the attention of Raychel's parents?

A. I think that's a difficult -- a more difficult judgment. I think clinicians, regardless of whether it's Dr Crean or other doctors -- and I suspect even the clinicians in Altnagelvin find it -- or found it difficult to -- and we've seen this in all -- I think all of the cases where communication between clinicians and families has not been as effective and as clear as it could have been or it should have been, and these are very difficult and stressful situations, and I think one of the problems of learning how to communicate is trying to be supportive to the family at a time of great stress on the one hand and yet conveying to them the harsh, blunt facts of circumstances of -- and the clinical condition of a child.

So clinicians have this delicate balance -- doctors and nurses -- of trying to be supportive to families and at the same time they're carrying out and fulfilling a responsibility of effectively communicating exactly the clinical condition of a patient at any moment in time.

Q. I mean, doctors are placed in profoundly difficult positions. That's understood. But they have duties to fulfil.

Can I just ask you to look at paragraph 23 of the GMC's Good Medical Practice, which appears at 314-014-012.

This is paragraph 23, the guidance to doctors:

"If a child under your care has died, you must explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility."

Now, I do appreciate that Dr Crean was at the receiving end in the Royal, but if he had formed a view and Raychel was under his care, do you believe that this applied to him and he should have explained to the Fergusons what he thought?

A. Chairman, I am fully behind -- in fact, I was involved to a degree in terms of developing the standards that are espoused by the General Medical Council. These are

absolutely fundamental standards that should be there, but what they do not say is when do you do this, under what circumstances.

Yes, you have a responsibility to do this. Do you do it in the heat and the stress of the day or do you choose the right time to do it? It must be done, and I think this is the difficulty -- the dilemma.

THE CHAIRMAN: That must be right. The difficulty is it wasn't done at all.

A. Um ...

THE CHAIRMAN: Now, I understand, I take your point --

A. Yes.

THE CHAIRMAN: -- that when Raychel is finally dying or has just died, that might not be the point at which Dr Crean says in whatever terms, "Look, we have to question the way she was treated in Altnagelvin".

A. Yes.

THE CHAIRMAN: But in none of the cases that I've examined has there been any volunteering by the doctors to the parents. Now, if I take your point, which I'm sure must have some considerable force, doctor, if I take your point and move away from the day of the death, what the code is saying here is that -- it doesn't put a time on it, but it does prescribe a duty to do it.

A. Absolutely, and I agree with that.

THE CHAIRMAN: So whether it's done two days later or a week later, it has to be done, doesn't it?

A. I agree.

THE CHAIRMAN: And the problem here, the recurring problem, is that it's not done.

A. Okay.

MR STEWART: The hospital had an opportunity to review Raychel's case at the mortality meeting, which occurred on 10 April of 2003, which was some time afterwards, and indeed after the inquest, and as usual in these things, the mortality meeting section of the audit meeting just simply says, "Four cases considered". No details are given. And previously, the inquiry's been informed that that's so that doctors are encouraged to make a full and free, frank and robust exchange of views so that it isn't recorded what individuals think of their colleagues' performance and so forth.

But in a case like this, where the performance would be at a different hospital, is there any reason why notes shouldn't be taken lessons reduced to writing?

A. But the child was being managed in the Children's Hospital during this terminal event, so -- I mean, I think an awful lot of this depends on how morbidity mortality meetings are constructed, what terms of reference they used for how they conduct their business.

I'm sure there are elements or aspects of that case that could have been documented, and I think we've commented, certainly I have mentioned before in the enquiry the reluctance of doctors to maybe make comments in regard to fellow colleagues, and that's been a problem the profession have faced.

I go back to the discussion on the problems on performance of doctors or underperformance of doctors. A feature of that has always been the reluctance of other doctors to comment on a colleague, maybe a close colleague's clinical practice. That's plagued the profession probably from day one.

Q. Yes.

A. I return then to the General Medical Council's Good Medical Practice. It is explicit there that if you now have a concern about the practice of a colleague, then you should raise it, and Confidence in the Future actually went as a discussion document, a consultation document went towards addressing that, and subsequently, the department have put in place very clear procedures for handling underperformance. And also, within the trust, as part of the medical excellence document that I produced -- and the inquiry have a copy of that -- that was specifically drawn up by myself to give clear guidance to every doctor working in the hospital that

they had a responsibility to report concerns that they would have had about a colleague.

Q. Because it's fantastically important, because if somebody's made a mistake once, they might do it again?

A. That's possible.

THE CHAIRMAN: Or if somebody's made a mistake once, somebody else might make the mistake again.

A. Yes.

THE CHAIRMAN: So whether it's a single person or a number of people, the target is to cut out the mistakes.

A. Mm.

MR STEWART: Do you think that at that time Raychel's death should have been considered in any other sort of a review or audit by the Royal?

A. By the trust?

Q. Yes.

A. Um ... I suspect things would be managed differently now, but no doubt the inquiry will seek that confirmation from the Belfast Trust. I think at that time there was a view that -- and the case was promptly referred to the coroner. I've said this in relation to certainly Adam Strain and Claire Roberts as well, I think there probably was an assumption at that time that once the trigger of referring a case to a coroner -- that was the ultimate independent, external

assessment of the cause of death.

I think I have also -- on record as saying that how to conduct -- there was very little knowledge, skill and experience and no guidance also as to how one would go about conducting an investigation. This was an area of learning and development at that time for trust medical directors in particular.

Q. Yes.

A. And I think, again, I go back to this point, because the primary admission of Raychel, her primary intervention in terms of her management of her appendicitis and her after care -- because that principally took place in another environment -- I think that probably was felt that that was sufficient grounds not to proceed with any deeper inquiry in the Royal Trust.

Q. I wonder, can we have a look at the NCEPOD recommendations from 1999. They appear at 220-002-023.

This is just a summary of the recommendations from that year's NCEPOD report. Can I refer you to the third and fourth bullet points on the left:

"The death of any child, occurring within 30 days of an anaesthetic or surgical procedure, should be subject to peer review, irrespective of the place of death. The events surrounding the perioperative death of any child should be reviewed in the context of multidisciplinary

clinical audit."

That's 1999.

A. Yes. NCEPOD was a very familiar system for evaluating initially perioperative deaths and then outcomes on deaths later as this system developed. It was a UK-wide organisation, which the Northern Ireland Department of Health contributed financially to, to the running of NCEPOD.

NCEPOD, however -- and I think I have mentioned this previously at the inquiry, the involvement and the engagement of, principally, surgeons and anaesthetists, but later, as NCEPOD developed, other clinicians, was a voluntary exercise. There was no requirement, there was no statutory requirement for doctors to -- not only engage or to comply with NCEPOD.

And if I can refer to the Organisation with a Memory document again, I'm going to quote from paragraph 13 of the Organisation with a Memory, where it says:

"Some of these systems such as the confidential inquiries and the national reporting systems for incidents involving medical devices achieved good coverage of very specific categories of events and produced high quality recommendations based on analysis of the information collected. Overall, though, coverage is patchy and there are many gaps."

There is still no standardised reporting system, nor indeed a standard definition of what should be reported, and you would be aware also in the inquiry that clinicians in Altnagelvin Hospital, as were clinicians in the Royal, were active participants in NCEPOD.

But I have to stress that --

THE CHAIRMAN: But if I take your quote from Organisation with a Memory, this is an example, this idea of peer review of a perioperative death, that is an example of specific category of event which has been caught by NCEPOD.

A. Mm-hm.

THE CHAIRMAN: So I accept the point you're making that it was part of maybe a patchwork of recommendations and standards and that there was no -- I don't know if there still is a uniform system, but at least, does Raychel's death not fall within that patchwork?

A. Raychel's -- I mean, I think, you know, in a sense -- I mean, I personally -- this is a personal comment. I think Raychel's death is different from the other three children that we've considered in a sense.

But peer reviews were available to clinicians to participate in and, in fact, Dr Crean was heavily involved at a national level on peer reviews. And one of the benefits -- whether a peer review is set up

specifically to look at one individual clinical situation, the majority of these peer reviews, to the best of my knowledge -- Dr Crean would know far better than I would -- they were looking at services provided in, for example, a specific children's hospital, and they would come and do an assessment and evaluation of all the systems and processes that existed within that hospital, give helpful advice and recommendations to the organisation that was being reviewed and hopefully those would be put in place.

The problem with many peer reviews and with the recommendations that were carried out by NCEPOD -- there was no -- there was no guarantee that these recommendations could be implemented. And I think there are other systems that exist within the NHS, particularly if you take SHOT, which has the hazards associated with transfusion, that is a UK-wide incident reporting system for anybody who has a complication of a transfusion, blood transfusion or another blood product transfusion.

Recommendations coming out of that are actually developed into guidance, which are then put in place right across the UK and enforced by the departments. The recommendations go to the four departments of health and that recommendation is put firmly in place.

One of the problems, I think, with adverse incident reporting, NCEPODs, is that there was no obligation to actually put recommendations and findings in place. Many hospitals -- some of these recommendations, for example NCEPOD, made a very important contribution to the work of hospitals out of hours. And obviously, there are resource implications for a hospital to say, "Yes, we can provide that level of cover". And services either have to be reduced or else additional resources have to be found to provide safe levels.

THE CHAIRMAN: On this hazards associated with transfusion, can you explain in sort of summary terms why recommendations from that are put into practice throughout the UK?

A. Because I think the four health departments have signed -- have seen hazards of transfusion as being obviously things that should not take place, there should be sufficient safeguards. Blood cross-matching and typing is a very sophisticated and highly developed area. Errors should not take place there, and the four government departments have signed up to that, and they will make sure that the recommendations of SHOT -- if a concern or risk to patients is identified, the four government departments will follow that through.

THE CHAIRMAN: Is that because it's a narrower or more

specific area --

A. Possibly --

THE CHAIRMAN: -- which it's easier to implement recommendations from?

A. Possibly, and I think that's one of the difficulties of NCEPOD in particular, because initially it started looking at post operative deaths or perioperative deaths. As NCEPOD as a process developed, they started looking at specific management of specific conditions and it became very difficult for it to do anything other than that. So it became quite diverse.

THE CHAIRMAN: Thank you.

MR STEWART: May I pick up on something I think you said a moment ago, and that was one of the reasons why reviews were perhaps not performed at that time was because the matter had been referred to the coroner, and he was deemed a higher arbiter.

Can I just take you back, please, to WS292/2, page 45 and to the third bullet point objective there. One of the objectives of reporting the incident was in order to provide formal documentation to assist in the management of complaints, claims and investigations by statutory bodies. In other words, one of the reasons you might review it is in fact to assist the coroner, not to pass the matter on to him.

A. Yes.
Q. To further that point, can I refer to a document which appears at 314-016-001. This was the complaints procedure that emerged from the Wilson report.
At page 010, 314-016-010, this gives advice about coroner's cases at paragraph 4.18:
"The fact that a death has been referred to the coroner's office does not mean that all investigations into a complaint need to be suspended. It is important for the trust or FHS practitioner to initiate proper investigations regardless of the coroner's enquiries, and where necessary to extend these investigations if the coroner so requests."
So I suggest to you that perhaps that wasn't necessarily a sound reason for not investigating.
A. Well, I accept that.
Q. May I ask you about Solution No. 18 and the change in its use at the Royal. Can I bring up two letters, one is 319-063-001, and beside it can we place 326-003a-001.
This is an exchange of correspondence which took place in February and March of this year between Mr McLaughlin, solicitor to the inquiry, and Messrs McKinty and Wright, who I believe are acting on your behalf, and in the left-hand letter you will see:
"Can you take your client's instructions on the

following matters.
"1. Was there a proposal for decision, formal or informal, within the RBHSC at any level, to stop using Solution No. 18 in post-operative children or to change the circumstances in which it was used, whether at local, ward or hospital level, prior to June 2001."
So it's a fairly tight question.
And on the right-hand side the response is given at paragraph 1:
"Dr Carson's understanding is that a decision was taken by anaesthetists in the RBHSC to change their use of No. 18 Solution. This decision was taken at a local level within the RBHSC."
So on 11 March 2013, it seemingly is your understanding that the decision was taken by anaesthetists to change their use of Solution No. 18.
Can I ask you when you came by that understanding?
A. Um ... I'm unable to recall when I reached that understanding. I honestly can't remember when, whether I would have known at the time or whether it was later. I honestly can't remember.
Q. If a decision was taken --
A. What I was, I suppose, trying to emphasise at that case was that it did not take place at trust level, and I'm not even sure whether the decision was taken at

directorate level. So my understanding was that this was a clinician-made decision. Whether it was taken by them collectively or whether it was taken by individuals, I'm unclear.
Q. You make that very clear or it's made very clear indeed at paragraph 2(d) where it's emphasised the decision was taken at a local level and more precise information may be available from the anaesthetists involved.
You were an anaesthetist yourself?
A. Yes.
Q. May I assume that if the use of Solution No. 18 falls off to practically zero, it must mean that all the paediatric anaesthetists know if there has been a change in the use of it because they're not using it?
A. Um ... Again, I have to say that would have to be determined from the anaesthetists themselves. I was not --
Q. It makes sense, doesn't it?
A. Well, I suspect there were still individuals who may have used solution -- I just don't know. And there were children anaesthetised elsewhere in the Royal Group of Hospitals. I don't know whether, first of all, there was use of No. 18 elsewhere in the hospital and whether any of those anaesthetists changed their practice. I just don't know.

Q. If there's been a change of practice, that would have to work through into other things like training, audit, teaching, wouldn't it?
A. Well, it depends why the change in practice came about. And I know that there were changes -- there were new members of staff coming to join the hospital at or around that time and they may well have brought with them experiences and practices from elsewhere. But these are clinical decisions that are taken by clinicians, and I have no doubt that it does penetrate the teaching environment.
Q. Yes, so someone somewhere would remember this change, wouldn't they?
A. Presumably, yes.
Q. It's said there "Dr Carson's understanding is", you can't remember when you came by that understanding, but do you remember where you got the information from?
A. When was this written? 2013? I suspect it was following the lengthy proceedings of this inquiry.
Q. It's March 2013.
A. Yes. Presumably -- I mean, I've done nothing else but read transcripts and expert reports on this inquiry now for a long time. I'm becoming, as Rory McIlroy would say, somewhat brain dead on this issue.
Q. Well, then, let's look at our most recent witness

statement please, WS331/1, at page 1.

This is signed by you on 30 May 2013. That is to say two and a half months after you informed, through your solicitors, the inquiry about your understanding in relation to Solution No. 18.

Can I ask you, this is a question, question 1, which is in relation to the change of use of Solution No. 18 at the RBHSC. At 1(b) you're asked whether the RBHSC has made any change in its use of Solution No. 18 in the year preceding 10 June:

"I am unable to confirm the accuracy of this statement."

Now, given that it's your understanding that it was, why didn't you say, "To my understanding there was a change"?

A. Um ...

Q. Can we go to page 2, please, on the screen? I beg your pardon.

A. I've got it in front of me here. This question is in relation to --

Q. 1(b).

A. I need to read question 1 first.

THE CHAIRMAN: Yes, please take your time. (Pause).

A. I'm confused and I'm unclear what you're asking me.

MR STEWART: Well, the question is quite clear, whether the

RBHSC had made any change in its use of Solution 18 in the year preceding 10 June:

"I am unable to confirm the accuracy of this statement."

It seems to me to be an evasive answer, if you don't mind my saying so, it isn't answering it directly.

Why didn't you answer it in the same terms as your letter of two and a half months before that saying your understanding was a decision was taken to change and it was taken at local level?

A. I think in both statements you're trying to infer that I'm confusing an issue here. What is consistent in both statements is that this should be confirmed with the clinicians involved. I had no involvement whatsoever in the decision to move away or to use Solution No. 18 in any different way. The decision has to be confirmed with the clinicians involved.

Q. All right then. If we move down to paragraph 1(d):

"If such a change had occurred [and at this stage it was your understanding that such a change had occurred] were you aware of the change?"

And if we can put page 2 beside that, WS331/1, page 2:

"Were you aware of the change --

THE CHAIRMAN: Page 3, I think.

MR STEWART: Page 3, I beg your pardon:

"Were you aware of the change?

"Not that I recall."

A. And by that I meant I was not informed of any change.

Q. No, sorry, if such a change occurred, were you aware of it? We know from your letter of two and a half months before that you were aware of it.

A. I think that the time difference between the two statements is irrelevant.

Q. I think it's absolutely critical because in March you tell us you were aware of it, it was your understanding, it was taken at local level. Two and a half months later "not that I recall".

A. Well, maybe I've received too many requests for statements from the inquiry.

Q. Perhaps you'd like to think again and tell us when you did come by the understanding that there had been a change --

A. I cannot recall when I came to that understanding. I was not involved in making the decision. The decision was made locally by the clinicians, and I've said in both statements that should be confirmed with the clinicians involved.

Q. Well, forgive my asking the question, but it does seem to be an inexplicable inconsistency in your evidence.

A. I would disagree with that.

Q. Right. If you had known about the change away from the use of Solution No. 18, do you think that should have been communicated to other hospitals in Northern Ireland?

A. There would be justification for doing that, yes.

Q. And would that justification have extended to you as part of your professional responsibility as medical director, had you known about it?

A. If I had known about it and it was felt of significance, I would refer the matter to the Department of Health and it would be their decision and their responsibility to implement any guidance for the region, and rather than me as a trust medical director issuing guidance. Do you think every hospital's going to do everything that the Royal Group of Hospitals suggests is appropriate?

THE CHAIRMAN: But let me put it in this way, doctor. There's a certain soreness in Altnagelvin that this change away from Solution No. 18 had been made in the Royal and it was a change of which it was unaware.

A. I can understand that.

THE CHAIRMAN: How and the extent to which that would have affected the treatment of Raychel, we'll only have to guess, but the soreness in Altnagelvin isn't difficult to understand.

A. I can understand that.
THE CHAIRMAN: Yes.
A. But I reinforce the point -- and this is not unrelated to the comments that we were making earlier about NCEPOD and SHOT. If things are of such significance and patients are at risk, the responsibility, I believe, is on the Department of Health to issue clear instruction and guidance to the service. One hospital to another hospital I think is -- leaves it open for inconsistent implementation and for inconsistent message to be conveyed to the service. Whereas if it comes from the Department of Health or the health boards or any other statutory organisation, then that is different.
MR STEWART: But isn't there a grave danger, then, that some important message may fall between two stools, that a doctor says it's a matter for them and the department doesn't know about it?
A. No, I think it clarifies it if the Department implement a recommendation and give clear instruction and accountability to officers within the trusts, be it the chief executive or the medical director, to provide an assurance that these recommendations are put in place. And I can only refer to current work that I'm involved in in RQIA. What I have noticed in the Department is when we carry out an investigation or a review of any

clinical circumstances and if we make recommendations, those recommendations are now increasingly being followed up directly by a letter from the Chief Medical Officer or the Permanent Secretary to chief executives and medical directors in trusts, and I think that's one of the significant advances that have taken place over recent years.

So in other words, there should be no confusion and there's much more effective implementation, and I think Northern Ireland is in a much better position for effective and consistent implementation of recommendations to be put in place now compared to elsewhere.

THE CHAIRMAN: Do you think that's because the RQIA reports go to the Department and the Department then decides what to activate?
A. Well, that is correct. Every review, every investigation we carry out, our recommendations are conveyed to the department.
THE CHAIRMAN: And the typical experience is that the Department then effectively endorses them and writes to each trust on the issue?
A. Yes.
THE CHAIRMAN: You see, what this concern we have about the change from Solution No. 18 brings it also brings the

inquiry full circle, because Dr Sumner had raised basic questions about the use of Solution No. 18 in Adam's case at Adam's inquest. But for reasons that we've already explored in Adam's case, after that inquest the extent to which that was disseminated within the Royal, within the Children's Hospital, was minimised. In fact, you have told me before you weren't aware of the statement that was provided to the coroner about what would be done in future. That didn't go to the Department.
A. No.
THE CHAIRMAN: We then have a change along the Sumner lines in 2001 away from Solution No. 18 and, again, for whatever reason, that appears not to have reached you, that appears, on your understanding, perhaps to have been taken at the most local of levels by the paediatric anaesthetists and others in Altnagelvin and the Department remained in the dark. So that's the -- I mean, that's perhaps the sequence of the inquiry.
A. Yes.
THE CHAIRMAN: Okay.
MR STEWART: Can I ask you, in your view, whether doctors such as yourself acting in managerial positions had a duty to patients in the wider community?
A. Every doctor has a responsibility -- has a duty to all

patients in the wider community. We're paid out of public funds --
Q. Yes, but those --
A. With professional responsibilities.
Q. But those doctors who then took up positions, as you did as medical director, had you got a responsibility towards the wider community?
A. Yes.
Q. And had information come to you or to any other doctor acting in a managerial position, which might have had implications for the healthcare of other patients outside the trust, should that have been communicated?
A. Yes.
Q. At that time, in your work in preparing the consultation --
A. It's a sweeping generalisation, if I may say, but it's a broad, broad brush to -- and I doubt if many medical directors when they embarked upon a career as a medical manager within a trust attached the same level of significance as I suspect you're attaching to it.
Q. Yes, but like all generalisations, it contains a large measure of truth?
A. It's difficult to do in practice.
THE CHAIRMAN: That depends what the issue is.
A. It depends what the issue is, exactly.

THE CHAIRMAN: But if it is a change away from the established use of what has been a standard IV fluid, then at the very least that's an issue to be explained by those who are taking the decision and for the consequences of that decision to be considered for dissemination beyond the trust?
A. Yes, I mean, I don't disagree with that, chair.
THE CHAIRMAN: My problem, Dr Carson, is trying to get anybody in the Royal to explain to me why the decision was made. And if you don't know about it, you can't help me, but I haven't yet heard a single witness in the Royal explain why the use of Solution No. 18 plummeted. It could hardly be more relevant to this inquiry.
A. I can't explain that, chairman.
THE CHAIRMAN: Okay.
A. But I also cannot understand why -- I'm not choosing my words right here. I cannot understand why this has become such an issue locally. I mean, Northern Ireland's 1.8 million. Have there been no other problems with Solution No. 18 anywhere else within the National Health Service? Has anybody else -- is there no other awareness?
THE CHAIRMAN: I think you need to go back to Dr Sumner. When Mr Leckey brought in Dr Sumner in 1995/1996 for Adam's inquest, that in a sense is where this comes

from, but it was Dr Sumner who was saying at that time that in the mid-1990s what he was advocating with Solution No. 18 was not the universal practice in Great Ormond Street, that there were some of his colleagues who would disagree with him, but he was putting this forward as what in his expert opinion the use of Solution No. 18 should be and how it was regularised.

So I can understand that there can be an ongoing debate about this. I can understand if some paediatric anaesthetists thought: well, look, whatever Dr Sumner says, I'm on the side of some of the others in Great Ormond Street.

But my concern is of what didn't happen here was any debate.

A. Yes.
THE CHAIRMAN: It was just let slide away. Claire's death wasn't even then referred to the coroner.
A. Yes.
THE CHAIRMAN: Lucy's death was raised with the coroner in a manner which is rather unsatisfactory, and then, when Raychel comes into Altnagelvin in June 2001, the doctors there aren't alert to the problem. There are additional issues or separate issues which are relevant in Raychel's case, but then they find to their surprise afterwards that Solution No. 18 has fallen out of

favour, if I can put it in that way, in the Royal, and nobody has told them.

Forgetting about facing up to blame, because that's a separate issue, this concerns me as the knowledge not being shared in the service and particularly going back to Adam's case the lack of any follow-up or any real apparent consideration of what Dr Sumner said?

A. I don't disagree and I understand the position. All I'm hinting at is I'm surprised there wasn't a wider debate within the context of paediatric anaesthesia that an awareness around the issues around No. 18 wasn't more fully discussed nationally.
THE CHAIRMAN: Well, I think the nightmare scenario, Dr Carson, is that we don't actually know how many children died of hyponatraemia. I'm not suggesting there was any epidemic of it, I don't want to raise alarms, but we know in this inquiry, of the four deaths we have looked at, only two emerged in the regular way.
A. I accept that.
MR STEWART: Just a couple of matters. In 2000, and in the preparation of the Confidence in the Future document that you worked on, you considered regionality and so forth as an issue for the sharing of medical information, didn't you?
A. Yes.

Q. And indeed, it finds force in three separate recommendations of the paper. Can I refer you to 321-004fi-029 and 030. This is the summary form of the recommendations of the document.

At number 14 on the left-hand side:

"Methods of recording adverse events to be put in place in every organisation, and a regional register established."

And across the page at 15:

"A regional database of performance case studies be established."

And at 17:

"A regional centre to provide advanced training."

So it seems that you were alive to this problem acutely at that time and how information might be shared and disseminated regionally.

A. Yes.
Q. And you said earlier this morning that indeed the Royal Trust had a responsibility to disseminate. When do you believe it assumed this responsibility to disseminate information?
A. I can't specify a time or a place to it. All I know is that when I was asked by the Chief Medical Officer to work on a secondment basis for one day a week and when I was given -- I was given -- when I was there on my

secondment I had two tasks. One was to prepare this consultation document and the other was to work with policy colleagues on the development of Best Practice - Best Care, which was the consultation document that put in place arrangements for clinical and social care governance in Northern Ireland. Those were my two responsibilities during that one day a week secondment.

The basis for my appointment as a chief adviser to the Chief Medical Officer on the area of clinical governance I presume was based -- you'll need to ask Dr Campbell this -- was based on her understanding of what I was doing in the Royal Trust, the experience that I was able to bring to it, the leadership that I was able to bring to it, and these were recommendations that I felt very -- were very convinced about. I believed they were worthy of consideration by the Department.

Some, not all, of the recommendations in this report have been put in place, not all of them, but that was my view at that time, and I think this concept of -- in the context of Northern Ireland, again, and even more so now where we've just five/six trusts, the importance of regional knowledge, regional information, regional recommendations, regional guidance, regional implementation and regional follow-up and assurance is absolutely crucial.

Q. Yes. Can I ask again, when you were medical director of the Royal Trust, at any time during your period as director had the Royal assumed or had the RBHSC assumed a role giving advice regionally?

A. Well, we touched on this at the beginning of today's inquiry. The Children's Hospital as a teaching and training centre would have fulfilled that responsibility by the training of doctors who worked there and the rotation of those doctors to other hospitals. I don't think the Children's Hospital would have seen itself as being a primary vehicle of communicating guidance to the rest of the region.

Q. Would it have seen itself as a reservoir of advice for the rest of the region?

A. Yes, to be sought, and that would have been done, as I said previously, along professional lines. This document here was talking about the professional performance and clinical performance of doctors, and I think it is that -- it's at that level that an awful lot of this good practice gets communicated as distinct from an edict from an individual trust management.

Q. Could there or should there have been an advertisement, as it were, to let doctors and hospitals know across Northern Ireland that they could seek the advice of the RBHSC?

THE CHAIRMAN: I think surely they must have known. Whether they availed themselves of it is another matter. Maybe some of this evidence has been given at different times, but I think there have been occasions when we have heard about doctors from the area hospitals contacting the Children's Hospital or the other hospitals.

A. This happens all the time, chairman. Professionally, if a consultant working in gastroenterology in Altnagelvin wants to discuss an issue with a gastroenterologist in the Royal or the City or the Ulster Hospital, that professional dialogue is commonplace.

MR STEWART: Yes.

A. And there's an openness to help and advise and support colleagues. If colleagues have a difficult issue they may well give telephone advice, they may actually go and do a visit to the hospital to see the situation or they may say, "Send your patient down to Belfast and we'll take over the management and the care". That has been common practice in the Health Service for many, many years.

Q. Yes. The point I was making was slightly different, and that's whether or not steps were taken to ensure that that message went out. I merely make the point because it's something that's made very clearly in the Departmental guidelines.

THE CHAIRMAN: Sorry, just one second. We'll move on to Departmental guidelines in a minute.

Before we leave the screen, doctor, if we look at the recommendations that were made more than 10 years ago now, number 14 "a regional register of recording adverse incidents". Is there yet a regional register?

A. Um ... Not in that sense. I think what I was picking up here in this -- and it goes back to An Organisation with a Memory. One of the consequences of the Organisation with a Memory, as a consultation document, was to establish the National Patient Safety Agency, which then developed what was called as a national reporting and learning system.

Now, there were problems with the implementation of that, it was by no means perfect, but at least in England they had an organisation whose primary responsibility was safety issues within healthcare. It was a national body. They established a national reporting system and learning system for adverse incidents. And the learning that comes out of that, they issued guidance, they issued alert letters, they communicated with the service very effectively.

Now, it wasn't perfect. The reporting system had all sorts of problems with it, and that's one of the difficulties with these largely IT-based systems. But

that was the consequence, and I was aware of that.

We did not have a formal link with NPSA until considerably later. I can't remember the exact date whenever a relationship with NPSA was established in Northern Ireland, the Departmental colleagues would be able to advise you on that. But that was what we were hinting at. And I know that guidance was ultimately released by the Department around October 2005. This document Safety First, a Framework for Sustainable Improvement in the HPSS was put out.

So this publication here was used -- I mean, I was ...

THE CHAIRMAN: Sorry, what --

A. My personal agenda here was to try to move Northern Ireland on.

THE CHAIRMAN: Of course, and I understand that from the recommendations. I just want to look at them.

Number 14. Given that whatever other developments there have been, is there a remaining need, do you think, for a regional register to be established or not, or effectively has that been overtaken by related developments?

A. I think it has been overtaken. I think there's still a debate on the benefits of national reporting because what happens -- and the Department did establish

a reporting mechanism, which trusts contributed to. But the Department were very rapidly swamped with minor -- and they were just inundated with sometime trivial issues --

THE CHAIRMAN: So it becomes too big to be useful?

A. And it was too difficult to spot the really high risk issues. That would result in maybe a working party being established, guidelines being put in place. So I think that the debate has moved on a little bit --

THE CHAIRMAN: Okay.

A. -- and had been overtaken.

THE CHAIRMAN: What about 15, regional database of performance case studies?

A. Um ... Again, the English document was called Supporting Doctors Protecting Patients, and it was largely -- what we were trying to ... What I think we were trying to achieve here was, given that serious underperformance of doctors is thankfully a rare problem, there would have been -- this recommendation was put in in the belief that if there was a database of such cases that medical directors in particular, or chief executives for that matter, could learn from -- in terms of how to handle serious performance issues in their organisation.

Now, a development did take place in England and

that was the establishment of the National Clinical Assessment Authority. It became NCAA, it changed its name later to become the National Clinical Assessment Service. That body in England was established, and Northern Ireland did link -- interestingly enough, here was a national service which was to help trusts and help doctors with performance difficulties deal with those issues and to give guidance to trust medical directors as to whether the doctor -- there was huge concern in the NHS about a large number of doctors being put on gardening leave, suspended, and nothing happening for years. So it established an mechanism, an approach to handling doctors to try and avoid this terrible dilemma, and also to enable doctors who had and who recognised that they had problems opportunities to rectify those, be it through additional training or whatever, or to give guidance, particularly to trust medical directors when the issue was so serious that this needed to be immediately dealt with by disciplinary or by other approaches.

THE CHAIRMAN: And then the final one that Mr Stewart referred you to at number 17:

"A regional centre."

No regional centre has been established; is that right? Or is it by another name or --

A. In fact, a simulation facility was established in Craigavon Hospital. It was for -- largely for the whole area of resuscitation. But at this time there were problems in endoscopic practice nationally and locally, and there was a feeling that there were -- as this was a developing and emerging development in the practice of surgical or medical procedures, that if Northern Ireland could have a single centre that would enable doctors and nurses and clinical teams to practice together and helpfully avoid complications, but more importantly also to -- maybe for those doctors whose skills had lapsed or if they didn't exist at all, this would be an opportunity to rectify training. So whether that is still in existence I am unsure. My information is not sufficiently current to say whether that simulation facility still exists.

THE CHAIRMAN: Thank you. Mr Stewart, I think you wanted to --

MR STEWART: This might be an appropriate moment to take a break.

THE CHAIRMAN: We'll break for a few minutes. Thank you.

(11.47 am)

(A short break)

(12.05 pm)

MR QUINN: Mr Chairman, I'm sorry to interrupt. If I could,

I would like to make a point. Both sets of parents are here today and are most concerned and very annoyed about the comment about brain death that the witness made. I know it probably was in passing, and I know the witness was under some pressure at the time, but perhaps Mr Chairman, through you, we could ask the witness to refrain from using that sort of term again as both these children died of brain death.

THE CHAIRMAN: I understand there's a particular sensitivity. I'm sure that can be avoided.

MR QUINN: It was the sensitivity. Mr Chairman, in relation to assisting the inquiry, if I may ask a document to be called up. It's 139-106-001. It's a document in Claire's case.

I would ask, if you would, Mr Chairman, if I could read out the -- this is a note from Mr Walby to Dr Sands at the Royal Victoria Hospital regarding Claire's case.

The main thrust of this document, I may say, was in relation to alteration of statements, but it does now serve another purpose because if we start at the third sentence:

"Although I did not prescribe the fluids, I was not aware of a contraindication to their use in this type of situation."

Then Mr Walby comes in to suggest:

"Could I suggest we leave this out? The issue of what was and is fluid practice remains under debate and 018N saline remains standard fluid therapy when monitored adequately."

Now, that document is dated 7 June 2005, and perhaps Mr Stewart could now proceed with his examination of the witness in relation to what the therapy was and relate back to his answers earlier when it would seem that the clinicians had brought in a change of practice, but again it doesn't seem to be recognised by anyone in control of the Royal Victoria Hospital.

THE CHAIRMAN: First of all, I take your point about what that says, if Mr Walby is saying that Solution No. 18 remains standard fluid therapy when monitored adequately. That doesn't seem to be consistent with what was happening in the first six months of 2001.

MR QUINN: Precisely.

THE CHAIRMAN: I'll take that point certainly. I'm not sure about the value of going back over this with Dr Carson because he has become aware that he can't help us in precisely when about the change of use in Solution No. 18. So I'm reluctant, Mr Quinn, to go back over that again. But I do have your fundamental point.

MR QUINN: I agree with that, it's the fundamental point that appears in his eight-page statement in relation to

governance and the answers he made that Mr Stewart's already enquired about. Just on that point, I would only like the witness asked fundamental questions about how on earth Mr Walby -- if he knows, how Mr Walby could still be under the impression that Solution No. 18 is standard practice in the Royal Victoria hospital.

THE CHAIRMAN: Yes. This has just been put up in front of you, Dr Carson. You see the concern, in 2005 there appears, on the information which you have about the ordering of Solution No. 18, to have been a very significant departure from pre-existing practice about the use of Solution No. 18, yet in 2005 Mr Walby is writing to Dr Sands about the statement which Dr Sands has prepared in Claire's case for the belated inquest, and it's saying that Solution No. 18 remains standard fluid therapy when monitored adequately.

Can you throw any light on this?

A. I can't throw any light on that at all, chairman, I really can't. I mean, I just have to re-emphasise that as medical director I wasn't engaged in any form whatsoever in relation to clinical decisions around the use of No. 18 Solution.

THE CHAIRMAN: Okay.

A. Unless there was a clear instruction, guidance, from an organisation like the committee on safety in medicines

or whatever, to say that there was a hazard or a risk associated with that, then I would think this would always be left to individual clinical decision-making. I can't shed any further light, I'm sorry.

THE CHAIRMAN: I'm also curious about Mr Walby putting standard fluid therapy in inverted commas.

A. I think you'd need to contact Dr Walby on that. I can't interpret it any further.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Mr Chairman, just a second ago, "as trust medical director I wouldn't have". As a consultant anaesthetist, would you have had different knowledge, are you wearing different hats when you say things like that?

A. Um ... Well, I'm referring to my responsibilities as trust medical director. I find it very difficult to reflect back on my clinical practice in 2000. I mean, I wasn't responsible for anaesthetising very many children at that stage in my career, and I think in our practice, because our children -- the children I was anaesthetising in the cardiac surgical unit, I can't recall whether No. 18 Solution was used or not. I just cannot recall that.

What I would have known is that in children with cardiac disease, the problem that we were faced with

more was fluid overload and sodium retention and high sodiums and heart failure. So the situation that I was dealing with in a clinical situation was different. We also tended to use -- because children's blood volumes are significantly different to those of adults, when you put them on to a heart lung machine, then we tend to be using more plasma and plasma products.

Q. I wonder, can we now come to when you are first made aware of Raychel's death. It is at a meeting, as I understand it, in Belfast on 18 June 2001, and you describe it in your witness statement WS077/1, page 2.

It's the second paragraph down:

"Raychel Ferguson.

"I am unable to recall any notification to myself as trust medical director at or around the time of Raychel Ferguson's death in the Royal Belfast Hospital for Sick Children in June 2001. However, I do recall on 18 June 2001, at a meeting of trust medical directors held in the Department of Health, which I chaired in the absence of the Chief Medical Officer, Dr Raymond Fulton, medical director Altnagelvin Hospital, referred to the death of a young child following an appendicectomy in Altnagelvin. It was not an agenda item. I do not recall the context in which the matter would have been raised. However, on reviewing documents submitted,

including 006-002-241, correspondence from Dr Nesbitt to Dr Fulton dated 14 June 2001, it could be inferred that Dr Fulton considered it necessary to mention the lack of agreement regarding perioperative fluid management in children."

I wonder, can that document you referred to there be brought up alongside? 006-002-241.

It is the letter from Dr Nesbitt to Dr Fulton. Can we try 022-102-317? Yes.

This is a copy of the same letter, I believe, but this particular copy went to Mrs Brown. Is that the letter that you were referring to?

A. I can't recall.

Q. Well, it is a letter from Dr Nesbitt to Dr Fulton of 14 June 2001, and insofar as I'm able to inform you, that's the only such letter bearing that date between those two correspondents.

I want to ask you about --

A. I honestly -- I cannot recall. If that is the same document, then --

THE CHAIRMAN: It seems to fit in terms of the date and the people between whom the letter was exchanged.

A. Right, okay.

MR STEWART: Now, that letter describes -- Dr Nesbitt describes how in fact he contacted the RBHSC, made

enquiries around perioperative fluid management and comes back to tell his medical director that the Children's Hospital anaesthetists have changed their practice and moved away from Solution No. 18 to Hartmann's solution:

"This change occurred six months ago and followed several deaths involving No. 18 Solution."

Now, it seems that from that letter you were able to deduce or, rather, I should say infer, that Dr Fulton considers it necessary at your meeting to mention the lack of agreement regarding perioperative fluid management in children. Can you explain that inference, please?

A. I -- I'm having difficulty following your line of questioning. But what I understood, and I understand obviously as the proceedings have gone on, is that in many of the hospitals outside of Belfast, children having surgery are managed in paediatric wards by junior paediatricians and not by surgical staff or by the anaesthetists once the child is discharged from a recovery area. And it was my understanding that some of the different views on the use of particular types of fluid emanated from the fact that maybe anaesthetists or surgeons and paediatricians have different views on what was the right or appropriate fluid to use

post-operatively in the management of children, and that's the context --

Q. And in particular, which particular fluid are we discussing at that meeting?

A. At which are meeting?

Q. The meeting of 18 June 2001 that you describe in the left-hand page.

A. I should maybe say a few words about these meetings that took place.

Q. Perhaps I could ask you a few questions first, insofar as the chairman permits me. At that meeting, was Solution No. 18 mentioned to you?

A. I can't remember whether Solution No. 18 was mentioned or not at that meeting.

Q. Can you remember whether or not you were told that Solution No. 18 had been discontinued in the Royal?

A. I was not told at that meeting that Solution No. 18 was discontinued in the Royal --

Q. That meeting --

A. -- to the best of my recall.

Q. Could you be wrong?

A. Sorry?

Q. Could you be wrong?

A. The meeting took place in 2001?

Q. Yes. This statement --

A. 12 years ago --
Q. -- 2005.
A. That's -- yes, okay. Eight years ago, right.
Q. Dr Fulton attended that meeting.
A. He did.
Q. That meeting was a meeting of medical directors.
A. Correct.
Q. You were chairing that meeting --
A. Correct.
Q. -- because the CMO was absent.
A. Correct.
Q. Presumably, if she had been there, you'd have been at the meeting anyway --
A. I would.
Q. -- as medical director of the Royal?
A. Correct.
Q. And you're also a consultant anaesthetist.
A. Correct.
Q. So you've got three things that you can bring to that meeting: your professional status as consultant anaesthetist, your role as medical director at the Royal, and the fact that you were chairing it on behalf of the CMO.

At that meeting, Dr Fulton informs you of a death at Altnagelvin.

A. Correct.
Q. Does he inform you of more than one death?
A. I cannot recall him referring to any other death.
Q. You've heard -- have you had a chance to read the evidence given by Dr Kelly? You know Dr Kelly, who was medical director at Erne Hospital?
A. I do, yes. I can't recall whether -- I'm sure I have read it, yes.
Q. I'm going to just refresh your memory, if I may, by reading to you a portion of his evidence about that meeting in June. This occurs in his evidence given to this inquiry on 13 June and appears at page 23, 24 and 25, 26, 27, 28. If you'd bear with me, it's important.

Perhaps we could bring it up. 13 June 2013, pages 23 and 24.

It starts at the bottom of page 23, line 24:

"Yes. [Dr Kelly says] The June 2001 meeting was the a meeting of the medical directors across the province. I can't recall how many were present. Members of the CMO office would have been chairing that meeting and, during the coffee break of that meeting, I went to my colleague, as it were, Dr Fulton from Altnagelvin said, 'How are you, how are things?', and he said, 'Fine, but we've just recently had a tragic death', and he described some details, but only short details, of what

had happened in the Raychel Ferguson case. The name wasn't mentioned. I shared with him that I'd just come back from a meeting fairly recently with Moira Stewart. I'd shared with him some very brief details on the Lucy Crawford case. I'd shared with him the complexity of it and that there may have been some fluid issues involved in that and that we had been advised by the Royal that they no longer used this Solution No. 18 that was -- that they had seemed to change practice or guidelines.

"So we had this discussion and out of that discussion we both went there's something odd about this, we haven't come across this before and here we are with a problem. So I said to Dr Fulton, 'I wonder has anybody else heard of this problem' and we went and had a discussion with another group of medical directors. And in my witness statement, I, to the best of my ability, tried to recall who was present and might have participated in that meeting. So I hope that's helpful to the inquiry.

"We began [and he describes this conversation] to hear of occasional reports, near misses, that seemed to relate to No. 18 Solution. One of the medical directors, I can't remember which, said that he had attended a conference recently where there had been

a paper or abstract presented on this issue. So that's the context. That was again still all during the coffee break. Dr Fulton and myself had a further conversation and said, "If the Royal's changed its guidelines, maybe there's something we need to think about regionally here and Raymond Fulton asked me 'Should we raise it at the meeting?' and I said 'Most definitely let's raise it'. But it wasn't a matter of raising it; it was raise it and ask for them to look at a regional guidance on this issue. There's something in this."

Now, it seems then that Dr Kelly may have left and Dr Fulton then goes into the meeting.

At the top of page 26 we find, line 4, Dr Kelly checking with Dr Fulton, again over the summer, that it had been raised:

"... and he assured me that it had. I also checked with Western Board later that they had taken action on it."

He goes on then -- I'm sorry to read so much to you. Can we have pages 27 and 28? 13 June.

Page 27 is where he, Dr Kelly describes his meeting with Moira Stewart.

At line 6:

"Yes. So the phrasing that led up to that was to do with electrolyte changes and Moira Stewart indicating to

me that there's significant ongoing debate in relation to fluid management in terms of rehydration. So that's the context of what was happening."

And if we go down to line 17:

"So Dr Stewart, out of that aspect of there's a change in debate, said 'We no longer use No. 18 Solution'."

And Dr Stewart is from the Royal, I think:

"I obviously expressed surprise as it was still in existing guidelines, it wasn't removed from all guidelines. I was surprised. And the message she said to me was 'We've had some problems with it in the past'. That was it, no identification of cases of what happened, no identification of any deaths, no identification of where the cases might have come from, et cetera. That was what I understood she was saying to me."

And this meeting, he goes on to say, was on 31 May 2001. It's a week before Raychel was admitted to Altnagelvin.

Line 18:

"It was literally, as I said, like a passing comment 'We've had problems before with this fluid'. It wasn't about deaths that I perceived at the time that had led them to change their practice. That's how I interpreted

that conversation."

Over the page to page 29, line 7:

"I don't know the answer to that question. My impression was he was aware things had changed ..."

That's Dr Fulton was aware things had changed:

" ... but I don't know the extent to what that meant when he was talking to me. It would be fair to say that, as that conversation proceeded, we were both alarmed that there had been a change in practice that we didn't seem to be aware of. I think it would be fair to say Dr Fulton and myself were quite annoyed at that time."

So that's the context of what's happening outside of the meeting room door. Dr Kelly and Dr Fulton have shared information, both have received from separate sources the information that Solution No. 18 has been discontinued at the Royal, both have had deaths, and they're quite annoyed, and Dr Fulton's going to go in and raise it at the meeting.

The reason he's raising it at the meeting is because Solution No. 18 has been abandoned and he's annoyed and he wants to raise that issue. He's not going in there just to tell you about a death, he's going in there to tell you about Solution No. 18.

Do you remember that conversation at that meeting

that day?

A. What I said in my statement on -- can I just refer to it?

THE CHAIRMAN: Yes. 077 --

A. I've got a copy of it here.

THE CHAIRMAN: But for the chamber it's witness statement 077/1, at page 2.

A. Can I premise this by just giving some indication about the purpose and the function of these meetings of trust medical directors? From the establishment of trusts in 1993, and thereafter, it was commonplace for senior officials in the Department to meet with members of the executive team from trusts. In other words, the Permanent Secretary would have met on a regular basis with the chief executive. The undersecretary with responsibility for finance had regular meetings with directors of finance.

The Chief Nursing Officer had, from the very beginning, had regular meetings with the directors of nursing in trusts. There was no similar -- I was conscious in the early 90s, mid-90s, that in particular that there were no equivalent opportunities for trust medical directors to meet with departmental officials, and I urged the CMO -- and the CMO felt likewise, I have to say in fairness.

So during the period from about 1997, we managed to have, I would say, infrequent meetings with the Chief Medical Officer as trust medical directors. And you're quite right, I attended those as trust medical director from the Royal.

The purpose of those meetings was to share issues in terms of how to interpret Departmental policy, to discuss the development of issues in relation to the development of clinical governance and a whole range of issues that the Department were wishing to see happening within the service, and it was an opportunity for trust medical directors to raise issues.

Certainly, in my time there, I do not recall -- I do recall that many of them would have an agenda. I don't recall that they were actually minuted, they may have been later. But what I do recall -- and I've stated this in my statement, at that meeting at which the Chief Medical Officer, for reasons I cannot recall, was not there and I would frequently have chaired those meetings on her behalf.

At that meeting, I certainly do recall and did recall the fact that Dr Fulton raised this issue of a death that had taken place in Altnagelvin. It was not an agenda item, it may have been raised under any other business at the end of the meeting, and whether a coffee

conversation took place between Dr Nesbitt, Dr Kelly and some of the other medical directors, two at least of whom I know were anaesthetists, one from Musgrave Park Hospital and one from the southern -- or Craigavon area trust -- so a discussion may have taken place there and certainly I was aware of the death that took place in Altnagelvin.

I go on in my statement to say that I fed back the outcome of the meeting in its totality to the Chief Medical Officer and I did indicate to her the issue about the death that had taken place in Altnagelvin.

Q. I want to ask you some very specific questions, please, if I may. I want to know -- it seems, I'd suggest to you, highly likely that if Dr Fulton was annoyed about this, that he would have come in and said, "We had a death in Altnagelvin and Solution No. 18 was involved, and you stopped using it and you didn't tell us about it".

A. I can confidently say I was not conscious of any annoyance on the part of Dr Fulton.

Q. Were you conscious of the use of the word "Solution No. 18" is the question?

A. I cannot recall that.

Q. I suggest to you that it's highly likely that given his conversation with Dr Kelly he would have come in and

said "Not just one death in which Solution No. is implicated but two deaths. I've been talking outside to a fellow medical director and they've had a death".

A. That was not -- I cannot recall that being conveyed to me in that context at all.

Q. And what is more, my fellow medical director's been speaking to somebody from the Royal, your hospital, Dr Carson, and told him only a matter of a fortnight ago that they stopped using Solution No. 18. Is it not highly likely that would have been raised as well?

A. It wasn't raised.

Q. That wasn't raised?

A. It was not raised in the context of the meeting, no. I do not know what was taking place outside of the meeting.

THE CHAIRMAN: Do you understand, doctor, why it would have seemed natural for Dr Fulton to have raised this? Because in effect, as a result of what Dr Fulton has learned from his informal exchange with Dr Kelly, he's now become aware -- well, I think Altnagelvin was already aware of a change in practice in the Royal which they were already sore about, but he's now become aware from Dr Kelly that there's also an issue about a death in the Erne, which turns out to be Lucy's death, and he's also aware from Dr Kelly that Dr Kelly had known or

had heard about the change of practice in the Royal just shortly before, a week before Raychel was treated.

So I think the question is perhaps that it would have been natural for Dr Fulton not just to mention that a child had died in Altnagelvin, but to go on to add, "This may be the second related death and it may also relate to Solution No. 18, for which the practices have changed in the Royal". That seems to be a more coherent -- if you're at a policy group meeting -- right?

A. Um ...

THE CHAIRMAN: Maybe not policy, but if you're at a meeting where you don't just raise one-off issues, here's not one death but two, and allied to that is a potentially significant change of practice in the Royal, which may be relevant to the two deaths and which hasn't been passed on to the area hospitals, that seems to me, at this remove, to be an entirely natural, normal way for Dr Fulton to present that.

A. I certainly remember Dr Fulton referring to the death in Altnagelvin. I do not recall Dr Fulton referring to any other deaths. I just can't recall that. And certainly, at the end of that meeting, I do not recall -- and I note in the -- I note in the consolidated chronology that has been prepared recently by the inquiry, the

statement enclosed in the box against the 18th:

"Dr Raymond Fulton meets with Ian Carson and the medical directors of other trusts to discuss Raychel's death."

That was not on the agenda and that was not the purpose of it.

MR STEWART: That point is taken.

A. And the agreement a need for regional guidelines, there was no agreement at the meeting that regional guidelines were required. What I did do at the end of that meeting, having heard what Dr Fulton had expressed, I fed that back to the Chief Medical Officer and referred to a recent death in Altnagelvin.

Q. Yes.

A. That was subsequently followed up by direct phone calls from Dr Fulton and ultimately a chief executive to the CMO, and we know what happened as a consequence of that in terms of developing guidelines. So I felt that I'd not only fulfilled my responsibility as chair of that meeting to give feedback to the CMO, but the other developments took place following that.

Q. Yes. When you said a moment ago Dr Fulton told you about the death in Altnagelvin, would he not have told you that the patient was declared dead at the Royal, just as Lucy had also died, as it were, in the Royal?

MR McALINDEN: Mr Chairman, my learned friend has dealt with at length about the recall of what Dr Kelly has said to Dr Fulton, and then has been asking this witness on the basis of what Dr Fulton may have said to this witness. Perhaps it would be fairer and more appropriate for my learned friend to formally put to Dr Carson what Dr Fulton actually says he discussed with Dr Carson.

MR STEWART: Dr Fulton will give evidence next week. Dr Carson was --

MR McALINDEN: I am --

MR STEWART: I'm asking him for his recollection.

MR McALINDEN: I am sure that the inquiry has the benefit of a number of statements from Dr Fulton where this issue has been addressed and they are aware of the content of those statements, and so perhaps if he's going to be asked about the content of the conversation, my learned friend should put the information in those statements to him to comment on.

THE CHAIRMAN: Okay. Do you have --

MR STEWART: I don't have that here, but of course, what Dr Fulton's saying may or may not be correct, and that is why it may not necessarily be the right thing to put to this witness. But what is correct is to ask this witness what he remembers in the light of what we do know about the context of the meeting.

MR McALINDEN: He has not been asked what he remembers. It has been put to him that certain things would have -- [OVERSPEAKING].

THE CHAIRMAN: I'm sorry. He has been asked what he remembers.

MR McALINDEN: Yes, but it has definitely been put to him that certain things would have been said to him, and that is different.

MR STEWART: Nothing has been put to this witness whatever. The suggestion has been made by the chairman as to what might have been likely or natural in those circumstances and the individual witness response required to those as recollection probed. It is not necessary to put a counter recollection to him. I was asking about whether or not you recall any mention of those two deaths and whether they might have been mentioned as happening in Belfast.

A. I cannot recall mention of two deaths. I can only recall Dr Fulton making reference to the tragic death of Raychel Ferguson following an appendicectomy in Altnagelvin Hospital. I do not recall any reference to any other deaths and I do not recall him making any reference to me that "The child died in your hospital".

Q. Fair enough.

A. I do not recall that.

Q. Can I ask you this? Did he make any reference to you of other problems being experienced by other clinicians in relation to the use of Solution No. 18?

A. I do not recall any further discussion.

Q. Right. Can we have a look, please, at Dr Kelly's witness statement, which appears at WS290/1, page 24. At (b) and towards -- this is where he describes that self-same coffee meeting and his discussion with Dr Fulton.

The third line from the end, he writes:

"We were both surprised at this paediatric fluid regime issue and decided to ask other medical directors if they had come across the problem. Discussion with the other medical directors identified the following: medical directors were aware of previous problem cases in this area.

"2. I was made aware that anaesthetists in particular were aware of near misses in relation to the use of hypotonic solutions."

Can you recall whether Dr Fulton might have mentioned to you, first of all, that other medical directors at that meeting were aware of previous problem cases?

A. I can't recall. He may well have. I can't recall.

Q. He may well have?

A. I cannot recall it.

Q. I see. You were a consultant anaesthetist, would you recall if mention was made that anaesthetists at the meeting, sitting around that table, were aware of near misses in relation to the use of hypotonic solutions? (Pause).

A. I can't recall that discussion on that day. I'm having real difficulty --

Q. Could it have happened?

A. Sorry?

Q. Could it have happened?

A. Could what have happened?

Q. Could there have been a discussion about hypotonic solutions, near misses and problem cases?

A. There may have been, but it was certainly not an agenda item and it may have arisen towards the end of the meeting.

Q. I'm not asking what was on the agenda.

A. Yes, well I'm just saying -- [OVERSPEAKING].

THE CHAIRMAN: Let's take it as read that if it's not an agenda item and it's raised under any other business it does come at the end of the meeting and it comes at a point in the meeting where Dr Kelly unfortunately has had to leave to go back to the west. So it's not an agenda item, but the fact that it's not an agenda item,

the fact that it's raised under any other business or in whatever way does not mean that any discussion about it was absolutely minimised.

So I think it's entirely legitimate to explore -- but if Dr Carson can't recall, Mr Stewart, then we'll just have to keep pushing on.

A. Chairman, I think what I want to emphasise was that the linkage -- any linkage or comments from Dr Fulton or Dr Kelly in relation to these two children specifically dying in the Royal was, to the best of -- I can nearly honestly say that was not raised with me. But what I did do as a consequence of that meeting was to pick up the concerns that were expressed by Dr Fulton and presumably Dr Kelly in his discussions with Dr Fulton, those were relayed and forwarded to the Chief Medical Officer.

MR STEWART: Was anything put in writing by you about those concerns?

A. No.

Q. Can we just go back to --

A. I gave a verbal update to the Chief Medical Officer of the meeting and the issues that were discussed.

Q. Was that normal when you chaired a meeting on her behalf?

A. The meetings were not minuted. These were -- this was

part of the Chief Medical Officer's structure of advice that she would have received as well as Central Medical Advisory Committee, special advisory committees. This was an opportunity for her to have advice sought from chief -- or from medical directors in relation to healthcare policy.

Q. But because it wasn't minuted, would that not make it even more important for you to give a written briefing to her about what may have arisen at the meeting?

A. Chief Medical Officer's office was next door to mine. I was in daily contact with her, and I never thought of documenting or writing up the meeting to that effect.

THE CHAIRMAN: Let's go on.

MR STEWART: Was the meeting noted by any Departmental official?

A. The meetings were at that time, to the best of my knowledge, not supported by any administrative staff or officers of the Department.

Q. All right.

A. To the best -- that may have changed and it may have changed latterly, but at that time certainly they were not, because the only person who would have been able to do it would have been my secretary.

Q. 021-018-037. This is an e-mail you send to Stella Burnside in 2004 and it's about:

"Various enquiries have been raised as to whether or not there are minutes of this meeting."

I think it's just before the UTV broadcast, and Stella Burnside's come to you, and she writes to you:

"Further to your query re: medical directors' meeting with the CMO, the early meetings were quite informal, as you've told us. They were set out to provide a two-way channel of communication between CMO and trust MDs. They were somewhat 'ad hoc' in nature and tended to mirror in some respects the specialty advisory committees. A draft agenda may have been circulated with notification of the meeting and a request to MDs to submit items for discussion. Very few papers were circulated in advance, due to the absence of any secretarial support for the meetings. Until relatively recently we were dependent on medical officers from the Department to keep brief notes."

"We were dependent on medical officers from the Department to keep brief notes."

You said a moment ago there was nobody.

A. The point of the question being?

Q. You told us one moment ago that there was nobody there taking any notes.

A. I do not know who was in attendance at that meeting on June 2001. I don't know whether there were

medical -- members of the -- medical officers there.

Q. By officers you mean directors?

A. Sorry?

Q. By officers you mean directors in that context?

A. No, within the Chief Medical -- this needs to be ascertained from the Department. The Chief Medical Officer had in her department myself -- well, there was, if I remember rightly, Paul Darragh was acting as a deputy chief medical officer, below that there were senior medical officers and medical -- there's a hierarchy just like junior doctors working in a hospital sector the Civil Service have a structure, and when I refer to medical officers I would have been referring to one or other of those members of staff.

Q. So a member of the Department staff may have taken notes of the meeting?

A. They may have if they were in attendance at the meeting.

Q. Did anyone ever make any effort to go and find those notes if they were taken?

A. I don't know.

Q. Well, you go on in the e-mail to say:

"I have checked with the CMO's secretary. I know that the chief medical officer disposed of all her files in 2003."

You write this in July 2004.

Can I ask you about the CMO's practice of record retention?

A. No, I'm not prepared to comment on the CMO's --

Q. How long would the Chief Medical Officer normally keep files for?

A. I don't know.

Q. Well, you did act as a deputy chief medical officer and indeed acting as chief medical officer. You should know the routine for the retention of Civil Service files.

A. There are many aspects of the culture of the Civil Service that I never came to understand or fully grasp even when I left the service.

Q. Can you think why a chief medical officer would dispose of all files prior to August 2003, less than a year later in July 2004?

A. I have no idea.

Q. Did it strike you as usual?

A. I cannot comment on that because I have only worked in the Department for a period of four years as deputy CMO. It's not a career --

Q. Would that not give you ample time to work out whether or not that would be usual?

A. I was a very busy member of staff. I had a huge number of issues to deal with at that time. I had particular responsibilities as Deputy Chief Medical Officer that --

not least including the implementation of the 20 recommendations in the human organs inquiry, developing recommendations for consultant -- I had a whole personal agenda that I was responsible for. The CMO -- you'll have to raise these questions elsewhere.

Q. Do you remember what you did tell the CMO in relation to that meeting?

A. I can't remember what the full agenda for the meeting was. I would have covered every item on the agenda by way of feedback and I did recall telling her about the death of a child in Altnagelvin Hospital as relayed to me by Dr Fulton.

Q. When you went back to the Royal, had you any reason to make any investigation at the Royal about the death you'd been told about?

A. It didn't cross my mind to do that, no.

Q. Well, if you'd been told either that Solution No. 18 was implicated or that the child had died in PICU, either way you'd have had something to investigate, wouldn't you?

A. I depended on devolved responsibility within the organisation. I as trust medical director -- there seems to be a failure to grasp the extent of the remit the trust medical director has in a hospital the size of the Royal Trust at that time. I -- yes, if I had

nothing else on my agenda, I could have gone down and investigated every incident, every death that took place in the hospital, but that was not a focus of my attention at that time.

Q. If, for example, you were told at this meeting of a death in which Solution No. 18 was implicated and the allegation was made that the Royal had stopped using it, that is certainly something you'd have to investigate, isn't it?

THE CHAIRMAN: I think, Mr Stewart that comes back to how much information Dr Carson received at the meeting --

MR STEWART: Yes.

THE CHAIRMAN: -- and the more information he received, the more one might think that there was to investigate, but we can't lose sight of the fact that while this inquiry has been focused for years on deaths from hyponatraemia, that may not have emerged in any clear way from the discussion at the end of the meeting on 18 June 2001.

MR STEWART: Thank you, sir.

THE CHAIRMAN: I'm not saying it's impossible, but let's not translate our constant focus on it into assuming that that's how it was viewed backwards.

MR STEWART: Yes. In any event, in consequence of what you told the CMO, plans were put in place to start putting together a working group to look at the issue and look

at the issue of hyponatraemia as well. Did you play any part in assembling the party who would make up the working group.

A. I had no role at all. No role whatsoever in the development of or in the establishment of the working group.

Q. Did you discuss the matter of Raychel Ferguson with Dr Taylor, Dr Bob Taylor?

A. In the context of?

Q. Well, in the context of what you'd been told at the meeting, the death from hyponatraemia.

A. After the -- my recall is patchy here. After I fed back information to the Chief Medical Officer, I can't remember whether in the light of a phone call or whether something she may have said to me at or around that time -- she may have asked me to gain further information for her, and that was what triggered an e-mail from me to the Chief Medical Officer about -- in July of 2001.

Q. Yes. I'm really asking --

A. And as part of my -- obviously a -- within that e-mail there was an attachment of a document which Dr Taylor had prepared, and I must have at some stage or other sought the advice of Dr Taylor and he furnished me with a piece of information which he then relayed to the CMO.

Q. Yes.
A. That's my recall.
Q. I know it's difficult to remember this far back, but might I refer to document WS008/1, page 15. This is five weeks before that again. This is 26 June 2001. It's a week or so after your meeting with the medical directors and it's the Sick Child Liaison Group meeting in the Antrim area hospital.
If we go down to the middle of the page there's a paragraph beginning "Hyponatraemia". Under "Chairman's business":
"Hyponatraemia. BT."
And that is, I assume, Bob Taylor.
A. Bob Taylor.
Q. "Presented several papers, which indicated the potential problem for the use of hypotonic solution fluids in children. Work to take place on agreed guidelines from the Department of Health on this subject."
So there, within eight days of your meeting, and presumably your reference back to the CMO, there's Bob Taylor talking about -- and he knows all about work with the Department of Health on the production of agreed guidelines. He seems to be very quick off the mark.
A. I think he was a member of the working group.

Q. Yes, but this is 26 June.
A. Yes.
Q. This is very early on. How could he have become so clued in to what's going on --
A. I don't know.
Q. -- that early? Could it be because you mentioned it to him?
A. It may well be.
Q. What in particular would you have mentioned to him? Because he referring there to potential problems, he presents papers on potential problems with the use of hypotonic fluids in children. That's Solution No. 18, really.
A. Yes.
Q. So did you discuss Solution No. 18 with Bob Taylor?
A. I cannot recall.
Q. Who else would have had the information you had to communicate it to Bob Taylor in relation to --
A. Sorry, who else had what?
Q. Who else would have known about the Department of Health proposals to put together agreed guidelines, who else would have known about --
A. I mean, I was only in the Department one day a week. Presumably after I had given feedback to the Chief Medical Officer, she raised the matter with members of

her staff, including Dr Darragh, who I think, if my recall from reading transcripts here is that he was the person who was charged with setting up the group.
Now, Dr Darragh may have lifted the phone to Dr Taylor and said, "Would you like to sit on the working group?" I mean, that's only a suggestion. I can't confirm that.
Q. Then we come to the e-mail that you mention, which is at 021-056-135. This is where you write to the CMO herself and you copy in Bob Taylor --
A. Yes.
Q. -- and Dr Fulton.
A. Correct.
Q. And you attach to that e-mail documents on the subject of dilutional hyponatraemia in children, drawn up by Dr Bob Taylor and his colleagues. I wonder, can you confirm for us if documents 043-101-223 and 043-101-224 are indeed the documents referred to in the e-mail. Do you recognise that?
A. I think that is the correct -- I can't confirm it, but I think that is the document, yes.
Q. I think Dr Taylor all but confirmed it was himself.
A. Right. Okay.
Q. I wonder if we could go back then, to 021-056-135. Can I ask why it was that you were putting together this

little informative briefing paper for the CMO on this subject.
A. I mentioned earlier, it may well have been when I gave the feedback to the CMO in regard to the meeting on 18 June, she may have asked me to find out more or she may have rung me subsequently to the hospital to ask me to do this. But my feeling is that it was in response to a request from her, and again I can't -- I'm not absolutely sure. I don't think -- let me put it this way, I didn't do it spontaneously. Let's put it that way.
Q. You describe there the document drawn up by Bob Taylor and his colleagues and how it reflects current opinion among experts in the management of these children. It does not yet command full support amongst paediatricians. And part of the explanation you understood lies with the views held by paediatricians concerning risks of hypernatraemia.
Then you go on to say:
"The problem today of dilutional hyponatraemia is well recognised. See reference to BMJ editorial."
That was the lesson for the week that appeared at the end of March 2001, I assume?
A. I actually can't remember what the BMJ editorial was.
Q. Just for the sake of memory, can we see document

070-023b-217. This is the editorial from the BMJ of the week of 31 March 2001. It's "Lesson of the week", and you see on the left in bold type:

"Do not infuse a hypotonic solution if the plasma sodium is less than 138."

A. That was the second reference in Dr Taylor's document that he gave me, the first one being the Arieff paper.

Q. Yes, indeed. If we go back to the e-mail again at 021-056-135.

A. Sorry, there may well -- I can't recall. There may well have been an editorial which appears on the first or second page of the BMJ. This is the lesson of the week, but there may have been an editorial comment on this, which I can't recall either --

Q. I see.

A. -- but that might have been what I was referring to, which may have used this terminology "dilutional hyponatraemia is well recognised". Do you get the point I make?

THE CHAIRMAN: We can check for that, doctor, thank you.

MR STEWART: That seems sort of natural. Then you go on to say:

"The anaesthetists in the RBHSC would have approximately one referral from within the hospital per month."

Did you discover that for yourself or was that information brought to you by Bob Taylor or somebody else?

A. I wouldn't have known that. It must have been relayed to me and I'm assuming by Dr Taylor.

Q. So if they're getting a monthly referral, the problem with dilutional hyponatraemia is indeed well recognised at the Royal at that time.

A. Sorry?

Q. If they're receiving a monthly referral, the problem of dilutional hyponatraemia is indeed well recognised at the Royal in --

A. One has to make that assumption, yes.

THE CHAIRMAN: In other words, it's not a one-off event?

A. No.

THE CHAIRMAN: Okay.

A. I'm only relaying what Dr Taylor led me to believe. Not my area of clinical expertise.

MR STEWART: There was also, you continue, a previous death six years ago in a child from Mid-Ulster.

A. Yes.

Q. Where did that information come from?

A. I don't know whether that is an error on my part or whether I have misinterpreted something that Bob Taylor told me. And I know there's been confusion around this

because nobody's ever been able to trace a child from the Mid-Ulster, and I honestly can't recall the background, including that statement. It may have been an error of -- it -- somebody has suggested that it was actually the Ulster Hospital and it might have been referring to another chat. But I honestly can't -- I can't confirm and I can't vouch for that statement.

Q. Very well. Bob Taylor thinks --

A. And it may be totally erroneous. Sorry, go on ahead.

Q. "Bob Taylor thinks [you continue] that there have been five to six deaths over a 10-year period of children with seizures."

A. Yes.

Q. Five or six deaths over a 10-year period with seizures --

A. Yes.

Q. -- that's a fairly startling piece of information, isn't it?

A. It is, but -- and, again, it doesn't make it clear in my e-mail to Dr Campbell here. My recall here that this -- Dr Taylor, as you know, who was involved in the Adam Strain case, had obviously been researching the subject of hyponatraemia for a number of years. This is now six years or -- five or six years after the death of Adam Strain. He had been in discussion -- I know he had

been in discussion, because he told me so, with colleagues across the UK. My recollection is that this is not five or six deaths in a 10-year period in the Children's Hospital, but it had been five or ten deaths across the UK over that five or 10-year period.

The reason that -- another reason that would substantiate that assumption is he said he had not seen any Cochrane reviews. Cochrane reviews are carried out on a national basis. They're not solely triggered by an event in Northern Ireland. So I think my recall of that figure of five to six deaths over -- was information that he had personally gathered from paediatric anaesthetists and colleagues in paediatric intensive care across the UK.

Q. Well, why didn't you say that?

A. I don't know.

THE CHAIRMAN: Sorry, does that mean --

A. I can't comment on that.

THE CHAIRMAN: What you're suggesting is that there'd be no reason to refer to the absence of Cochrane reviews if these deaths were in the RBHSC because there wouldn't be a Cochrane review of a death in the RBHSC?

A. No, what I'm suggesting, chairman, is that if there'd been five or six deaths over a 10-year period in the Royal Belfast Hospital for Sick Children, I would have

known about it. That's what ...
MR STEWART: Let's explore that.
THE CHAIRMAN: Sorry, just one second. Is a Cochrane review a review of a death or is it a review of a pattern of events?
A. Chairman, I've nearly forgotten the background to Cochrane reviews. But I know that when NICE was set up, the National Institute for Clinical Excellence, if there were issues that NICE were going to adjudicate on, new medication, new medicines, the use of new treatment methodologies, if NICE was going to pronounce on behalf of the NHS and government that such-and-such a treatment was appropriate, as part of their build-up to making that decision they might have commissioned what was called a Cochrane review.
And these were not -- they were international, these were experts gathered from around the world to look at a particular treatment, and they would -- on the balance of reviewing all of the research literature, they would adjudicate and make a finding, and that would be known as a Cochrane finding, and transmitted, for example, to NICE, and that would have helped decision-making at government level around treatment modalities.
So it was a very sophisticated form of research, audit, assessment of international proven literature.

Very high international standing.
THE CHAIRMAN: Thank you.
MR STEWART: He doesn't tell us where these five or six deaths occurred. He didn't tell you where they concerned, did he?
A. That's correct, I'm not aware of that.
Q. So why didn't you ask and find out?
A. Um, I can't answer that question.
Q. Because you said a moment ago "if these had been five or six deaths here I would have known about it".
A. I'm interpreting that he made it quite clear to me at the time that they were in the UK and not in the Children's Hospital.
Q. Because what this inquiry knows is that in the six years prior to July 2001 there had been five deaths in the Royal. There was Adam Strain, 95. There was Claire Roberts in 96. Dr Taylor shows a death in 1997 in his bar chart. Then there's Lucy Crawford and Raychel Ferguson. There are five deaths in the Royal in that period. Did you know about them?
A. I've indicated in my witness statements when I was made aware of the deaths.
Q. Yes. So we could indeed be seeing here a report to you by Dr Taylor of five or six deaths in the Royal, couldn't we?

A. Mm-hm. If that's how you interpret those -- those particular cases, that's one interpretation.
THE CHAIRMAN: Doctor, the reason you said those would not have been five or six deaths in the Royal was because if there had been five or six deaths in the Royal, you'd have known about them?
A. That would have been my expectation, certainly, chairman.
THE CHAIRMAN: It would have been your expectation. But I'm afraid, as we've seen before, your expectations haven't always been lived up to in the sense that you haven't been informed of things you should have been informed of.
A. Okay.
THE CHAIRMAN: You weren't aware of Adam's death as I understand it; is that right?
A. I have to refer back to my witness statement. Adam Strain ...
THE CHAIRMAN: In 1995.
A. I think I -- it was a year later, around the time of the coroner's inquest that I became aware of Adam Strain.
THE CHAIRMAN: So there was one you weren't aware of. You weren't aware of Claire at all?
A. That's correct, until, I think, maybe Dr Walby made a phone call to me when I was deputy CMO.

THE CHAIRMAN: Yes, but that was after the documentary and after Mr and Mrs Roberts had been in touch.
A. Yes.
THE CHAIRMAN: That's two. Then there's Lucy who I understand you weren't aware of, and Raychel, who you became aware of after the --
A. Medical directors' meeting, yes.
THE CHAIRMAN: As a result of that. So there are four. And the other one that Mr Stewart referred to appears on the chart that Dr Taylor provided at an earlier stage to the inquiry.
A. I didn't know anything about that one at all.
THE CHAIRMAN: So this doesn't appear -- sorry, there's good reason for me to believe that the reference here is not to five or six deaths over the UK.
A. Chairman, you would have to confirm -- ascertain that from Dr Taylor.
THE CHAIRMAN: We will be hearing from Dr Taylor, but the -- when you were suggesting earlier that the reference to the Cochrane review militates against these being deaths in the Royal and being deaths in the UK as a whole, I'm not sure how any Cochrane review would have picked up the hyponatraemia deaths in the Royal.
A. Nor would it, chairman, and the purpose of Cochrane reviews was not to do that. It was to gather

international opinion based on research papers, whether something was of significance. In other words, a Cochrane review, for example, could have looked at the international literature on Solution No. 18, for example. But it wouldn't have picked -- it was not designed -- or its intention was not to follow through individual deaths.

THE CHAIRMAN: Okay.

A. I mean, in 2000, at this time in 2001, when we say there -- certainly one could indicate there were four deaths that had taken place in the Royal. Two of those deaths took -- the preliminary events took place outside the hospital. And I have to say, when I made a comment earlier on this morning that I think in many ways the death of Raychel Ferguson was different from the other deaths, and I still believe that because I think if I had -- if Adam Strain's case had been reported to me as trust medical director at the time of his death and I had instituted an investigation, I would have been investigating other important issues. For example, the arrangements for paediatric renal transplantation were where the appropriate -- what went on in surgery, what went on after surgery and so on and so forth, and it may have emerged that -- and likewise in relation to Claire Roberts, I would have wanted to discuss other

issues, who was in charge of the patient, what communication took place between and following admission, medication, and so on. There were other important, what I would call governance issues in those two cases.

I think even the child, Lucy Crawford, there were aspects of Lucy's admission that were slightly different. Now, the common theme in all of these subsequently has been solution -- the misuse of Solution No. 18 and the development of hyponatraemia. If I, in 2001 -- I don't think I would have made -- I don't think there were sufficient triggers at that time, even in light of the meeting that took place -- and particularly in light of the meeting that took place in the Department for me to have carried out any special investigation.

THE CHAIRMAN: I'm sorry; I don't quite understand that, because is that not exactly what happened?

A. Sorry?

THE CHAIRMAN: Is that not exactly what happened when the committee was set up for the guidelines?

A. I'm sorry, I --

THE CHAIRMAN: I'm not sure what you mean by special investigation.

A. Well, what I've taken out from the line of questioning

to date is why didn't I do something more in the Royal.

THE CHAIRMAN: Yes.

A. And I didn't feel that there was any need for me to carry out any further investigation within the Royal in relation to these deaths because it was now going to be embraced, for example in relation to the guidelines that were going to be developed.

THE CHAIRMAN: Okay. I understand. I think we'll break, Mr Stewart, for lunch and we'll come back at 2 o'clock, doctor. Thank you.

(1.10 pm)

(The Short Adjournment)

(2.00 pm)

MR STEWART: Good afternoon.

A. Afternoon.

Q. We had left it before lunch with looking at the figures you received from Dr Taylor at 021-056-135 and the death figures which you then e-mailed on to the Chief Medical Officer.

We were discussing whether or not the revelation to you of five or six deaths over a 10-year period should have been something that you should have looked at.

You didn't ask Dr Taylor about these figures?

A. I didn't explore this any further with Dr Taylor, no.

Q. Did you explore it any further with anybody?

A. Not that I can recall.

Q. And you clearly felt it was unnecessary to explore it any further?

A. No, but I understood that work was going to be done in terms of developing guidelines on infusion or on the use of intravenous fluids for children.

Q. Did you know how many deaths there might have been of children in the Royal Hospital in a year at that time?

A. If you'd asked me did I regularly have conveyed to me the outcomes of deaths from any sector in the hospital on a regular basis, the answer to that was no, deaths were not reported to me, but I am aware, obviously, from the transcripts during the duration of the inquiry that in relation to the morbidity/mortality meetings in the Children's Hospital, I think the figure of somewhere between 20 and 30 a year.

Q. That's right. Perhaps we can look at Dr Taylor's comments on this at WS157/2, page 7.

In response to a particular question at number 26:

"How many patients died annually in PICU in 1995/96?"

It's running between 20 and 30, the 25 mark annually.

Therefore, if you go back, please, again to --

A. Sorry, can I interject? The question was how many died

in the intensive unit in children's. I suspect that the majority of deaths in Children's Hospital may well have been, but there would have been other children dying, I suspect, leukaemia and so on that didn't actually end up as an intensive care patient.

THE CHAIRMAN: Yes.

MR STEWART: Very well.

A. In which case it might be slightly more than that.

Q. It might be. Can we go to 305-011-585. This in fact is a great deal more detailed information that would have come from an audit committee, and presumably would made itself known to you at some stage.

This is an audit of PICU deaths in 1994, and it gives total admissions, total of deaths from various -- where they'd come from and so forth.

At the bottom you'll see "Discussion". An overall mortality rate has been calculated at 9.1 per cent and, interestingly, it has been benchmarked against other paediatric intensive care units; that's important information.

So I take it that annual mortality rates would have come to you as medical director?

A. I'm saying annual mortalities rates did not come to me.

Q. They didn't?

A. No.

Q. Here's part of your hospital that is doing a --

A. Yes.

Q. -- audit of annual mortality rates and going outside and benchmarking it against other hospitals, and surely mortality rates must be one of the classic red flag signals of something going wrong in a hospital. Why would they go to this extent and not communicate it to the medical director?

A. All I'm indicating is that at that time there was, to the best of my recollection, no formal mechanism of reporting from any sector in the hospital through to the medical director's office. We had audit departments and a lot of this activity -- this is presumably an extract from some of their audit activity -- was managed locally, professionally by the different directorates. If there was concern, I would have expected and anticipated that -- if the concern the overall mortality rate had exceeded that of similar other intensive care units, I would have hoped that would have been brought to my attention.

Q. Yes. So you relied upon the system working and any results being brought to you?

A. Yes.

THE CHAIRMAN: Just to get it clear, the fact that what's happening in the RBHSC PICU is similar to other

comparable hospitals is reassuring and not something that needs to be drawn to your attention, but a figure which was out of kilter in the sense of being worse than other hospitals, you would expect to be drawn to your attention?

A. I would expect it to be drawn to not just my attention but I think it should be brought to the attention of others as well, including the health boards and possibly the Department, because quite often -- I mean, I know that there was -- in the trust we had a number of departments that would have benchmarked their systems process, qualities and outcomes, and I know that PICU in the Children's Hospital had a network of other national paediatric intensive care units that they would have shared data, and there was another system called ICNAR(?). I can't remember whether that was a system that was -- that the paediatric intensive care units fed into, but I know that adult intensive care units contributed figures to that national database, and I know that, certainly as far as the adult intensive care, there were excellent performers in that area.

But I would have expected outliers, I mean if there's a significant divergence, even a small divergence from national norms, that that would be brought to my attention.

THE CHAIRMAN: Okay, thank you.

MR STEWART: So you can see where this particular question is going. If you have got five or six deaths over a 10-year period from hyponatraemia, and you have about 25 a year dying in PICU, you have 250 deaths over a decade, five or six deaths amounts to something like 2 per cent of the deaths, and that's a sizeable statistical group. What I'm asking you is, when these figures came to you, did you not think, "Are these plausible, are these right? I should find out?"

A. I would rely on clinical directors and individual consultants giving me assurance that these figures were acceptable.

Q. But these came to you and you gave them to the Chief Medical Officer?

A. In the letter? You're referring to the five or six --

Q. That's right.

A. Yes.

Q. You relayed this information.

A. Yes.

Q. And, of course, you're not only her adviser on clinical governance matters, you're the medical director of the hospital this information is coming from. Why did you not investigate this at the time?

A. I conveyed earlier my understanding that these five or

six deaths were -- my understanding of what Dr Taylor was telling me, these were five or six deaths of children who died with seizures was across the UK.

Q. But I have asked you a moment ago, did you go to Dr Taylor and ask him about these figures, and you said no.

A. I didn't investigate it any further --

Q. You didn't.

A. -- that's correct.

Q. Can I suggest to you that's something you should have done.

A. There are many things that I should have done in my 10 years as a trust medical director that I have no doubt would have added to and strengthened the quality of service in that organisation.

Q. Apart from adding to and strengthening the protection for patients, you might have discovered cases where there might have been sub-optimal care because Solution No. 18 was involved. There might have been an iatrogenic component to these deaths. There might have been cases for referral to the coroner. There might have been parents who could have been told what happened to their children.

A. That's a possibility.

Q. Mr and Mrs Roberts may not have had to wait until 2004

to learn that their daughter died of hyponatraemia.

THE CHAIRMAN: Can I just add to that, doctor. If it is the case that the five or six deaths to which Dr Taylor was referring were deaths in the RBHSC and not in the UK, is that something that you think he should have made clear to you? Because that puts a different perspective on the deaths which were being raised.

A. Yes, it would have put a -- shed a different light on it and it would have certainly have every potential to trigger my curiosity further. At no time did I feel or was I aware or did I get a sense, did my sixth sense -- and, I mean, I'm not naive on these issues, I've been involved in handling serious issues in the trust for many years. If I had felt that there was something here that was indicative of either poor performance by individual doctors or if there was a substandard service within the hospital, then that would have encouraged me or triggered me to do -- take further action.

THE CHAIRMAN: I'm being a bit more specific than that. You said to me before lunch that you're interpreting the e-mail which was put on the screen as being five or six deaths over 10 years in the UK. Now, if it is the case that Dr Taylor was actually telling you about five or six deaths in 10 years in the Royal, whether they started in the Royal or were referred in from the Royal,

is that something which you think he should have specifically mentioned to you? Because that does put a different light on what's happening in Northern Ireland.

A. I mean, again, it's terrible to say with the benefit of hindsight and learning from this and other inquiries, I think that would have been a line that would appropriately be taken.

THE CHAIRMAN: Because then you might have said to him -- you might have had a discussion, which might in some cases lead nowhere, but might start to -- let's look at it a bit more closely, and if you look at it a bit more closely you might let it drop or you might take it further again?

A. That's possible. The other -- I mean, there was significant awareness of serious failings in hospitals across the NHS at this time. This was contemporaneous with the Bristol hearts thing. I was asking exactly the same questions in relation to the management of cardiac cases in the Royal. I was determining what the outcomes were.

MR STEWART: What year --

A. That was being triggered by events, for example, in Bristol.

Q. Remind me what year the Royal Bristol Infirmary report

came out?

A. 1995 or 96.

Q. 95. This is 2001.

A. But this data's come to me or you're bringing it to my attention collected in September 1996.

THE CHAIRMAN: Because these things all have a knock-on effect. Bristol led to Alder Hey, didn't it?

A. Bristol led to Alder Hey.

THE CHAIRMAN: Which head to human organs.

A. Yes.

MR STEWART: Can I ask, did the CMO come back to you and say, "Those figures you sent to me, I find them interesting, startling, surprising. Can you give me some more information on them?"

A. Not that I can recall.

Q. Did you subsequently and in the months that followed that e-mail when the working group comes together and starts its work, did you speak again with Dr Taylor about the matter?

A. No, I had no further -- I was not involved in the work of the guidelines group, and I had no reason to intervene in clinical matters in the Children's Hospital.

Q. He didn't tell you that he himself had conducted an audit of all infants and children admitted to PICU with

hyponatraemia?
A. I cannot recall him mentioning that to me. I may be wrong, but I cannot recall it.
THE CHAIRMAN: But before lunch, again, when you were saying that it was pointed out that within a few days of this issue being raised at the medical directors' meeting that Dr Taylor had papers which he was in a position already to present to the sick child liaison group. Do I understand that you were saying that Dr Taylor had been working on dilutional hyponatraemia for some time?
A. Chairman, I'm only going by what I've read in the context of the proceedings of the inquiry. I understood that Dr Taylor had done further research -- I mean, following the -- at or around the time of the inquest of Adam Strain and subsequent to that, and his interest in that area continued and I assumed that that was the background to that.
THE CHAIRMAN: Well, if you can help me. Don't guess an answer, but do you know if that research was prompted by Adam's death?
A. I don't know.
THE CHAIRMAN: Okay.
MR STEWART: Do you know whether he made any attempt to reveal that research before Raychel Ferguson's death?
A. The first part of the question?

Q. Did he make any attempt to reveal his researches before Raychel died?
A. Not that I was aware of.
MR UBEROI: If I might point out Dr Taylor doesn't know when the research -- when it started, when it went on et cetera, and the question has succeeded it by saying that the research definitely took place. We simply don't know. Dr Taylor is to give evidence and no doubt he can speak further to this topic.
MR STEWART: We do have evidence of the documents which accompanied the e-mail, which seems to be the work of Dr Taylor and his colleagues.
MR UBEROI: Yes, but my understanding is that document succeeded the death of Raychel Ferguson.
THE CHAIRMAN: Okay, well, it's an issue we'll take up, Mr Uberoi, with Dr Taylor on this.
MR UBEROI: Thank you, sir.
MR STEWART: I wonder, can we move on a little to 2003, by which stage you've left the Royal and you're in post as Deputy Chief Medical Officer. But, nonetheless, you receive a letter from Mr Walby -- I beg your pardon, you don't. Mr Walby receives a letter from Mr Brangam, the trust solicitor, in January 2003. It appears at 064-022-063.
16 January 2003. This is in the lead-up to the

inquest into Raychel's death. Mr Walby, he receives this letter from the solicitor on behalf of the trust and it's in relation to the preparation for the inquest.
The second paragraph:
"Dr Crean has indicated to me that the facts surrounding an earlier matter, Adam Strain deceased, were not on all fours with the present case, but I believe it would be prudent for you to speak directly to Dr Ian Carson in relation to this matter, particularly given it would appear that the Department has some knowledge of the circumstances surrounding this particular incident."
And we see annotated on it in Mr Walby's characteristically spider-ish hand:
"Spoken to IWC."
That is, I take it, yourself?
A. That's me.
Q. Were you contacted by Mr Walby?
A. Yes, and I think I made reference to that in one or other of my witness statements. I did receive a phone call from Dr Walby at or around -- I'm not absolutely -- I can't confirm offhand the date or when that took place. I have a funny feeling it was at or around the time of the inquest into Raychel.
Q. I assume it would have been before the inquest because

they're preparing for it.
A. I presume that as well.
Q. But were you discussing the case of Adam Strain or the case of Raychel Ferguson?
A. I can't recall the content of the discussion, but I do know that he did phone me and it's been reinforced by --
Q. And what information would the Department have held in relation to these cases?
A. Well, I think -- this is probably conjecture on my part now because I can't actually recall what he said to me.
Q. Yes.
A. My supposition was -- and I indicated -- sorry. I indicated earlier in the inquiry that it would have been common practice for a trust medical director to phone the CMO's office or -- and the Director of Public Health and the health boards if there was a matter that was going to attract public attention, be that a coroner's inquest or some media attention.
Now, I'm assuming that it would have been at or around the time of Raychel's inquest, and he was informing me that, you know, the inquest is taking place, because I wouldn't have known in advance when inquests were due to be scheduled. He was probably informing me of that, and he would have known that the trigger for the Departmental working group was something

that I was obviously aware of, having informed the CMO in relation to our discussion earlier on.

Q. This particular comment is made in the context of differentiating the case of Adam Strain and Raychel Ferguson. You see:

"The earlier matter not on all fours to this one ... but prudent for you [nonetheless, as it were] to speak directly with Dr Ian Carson."

What could you lend to his knowledge of the difference between the two cases?

A. I wouldn't have been able to say anything to Dr Walby that he didn't already know about the cases.

Q. Mm ...

THE CHAIRMAN: What would you have been able to tell him about Adam's case in January 2003?

A. Um ...

THE CHAIRMAN: If there's to be a discussion, as suggested by George Brangam, about differentiating Raychel from Adam, what would you have been able to contribute to a discussion about the differences between the two cases, unless you knew about Adam?

A. I can't think of what I could have contributed at all.

THE CHAIRMAN: The reason you're being asked this, doctor, is because the letter seems to presuppose that you did know about Adam or at least that by January 2003 you

knew about Adam.

A. I did know about Adam. I knew about Adam at the time of his inquest --

THE CHAIRMAN: Yes.

A. -- in 1996.

THE CHAIRMAN: Right. But then you would need to know about it in sufficient detail to differentiate what had happened in Adam's case to what had happened in Raychel's case. For that to happen, an outsider looking at this might wonder, does that suggest you know the details of Adam but you also then know the details of Raychel. Because you can't contribute meaningfully to a discussion about the difference between two cases if you don't know the details of two cases, perhaps.

A. Well, certainly I didn't know the details of either of the two cases to the extent that I now know them today.

THE CHAIRMAN: No, of course. I'm not going that far. But in order to contribute to a discussion about the differences between the two cases, you'd have to have some level of knowledge about the facts of the two cases in order to give an opinion about whether they are similar, about how similar they are.

A. I understand, I think I understand what you're trying to get at, chairman, but I don't understand the basis of George Brangam's letter at all, I have to say.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Moving on, the inquest happens, and in February of 2003, immediately after the inquest, it looks like 20 February, a circular goes round and it appears at 006-039-389. (Pause).

This is, if I can perhaps -- I don't know whether you can see it from there it's headed "Ministerial submission".

THE CHAIRMAN: It might not be filed yet if that's part of the Departmental papers.

A. What date, sorry?

MR STEWART: It's February of 2003. It's from Dr McCarthy. It's copied in to yourself and a number of others and it is in relation to the inquest verdict on Raychel Ferguson.

A. Right.

Q. It is a document which has been generated because the minister is going to visit Altnagelvin Hospital on 20 February. It seems a wholly unrelated, organised visit.

I think it is thought possible that he might be asked questions arising out of the Raychel Ferguson inquest and a possible line for the minister to take, should he be asked any questions, is appended to the minute. It comes from Dr McCarthy, who, of course, was

a doctor with the Department and was on the working group for hyponatraemia.

This is copied to you and it's suggested that if the minister is asked "What about the Raychel Ferguson case?", and her death and the inquest, that the minister was to say -- well, it was suggested that he might say, "I'm concerned about this incident, I want to make sure that the lessons we learn from this unfortunate event will prevent a similar case occurring in the future".

I wonder whether you or anybody else, CMO, thought of bringing to the minister's attention those five or six deaths referred to in your e-mail to the CMO of July 2001.

A. I would have been -- as deputy CMO would have been copied in to a huge amount of internal circulars within the Department and I would not have personally seen that as being a sufficient trigger to link -- make the linkage between those two documents to the minister.

Q. Yes. And there's always, when you are suggesting things to ministers and whatever, you always must have in mind the idea of possible damage limitation, possible risk limitation to reputation. You'd want to protect a minister from any difficult questions.

And a very difficult question might be "What about other possible deaths?" Given what you knew and what

you put in that e-mail to the CMO, I have to ask you, did you at any time tell the minister about what you knew?

A. No, I didn't.

Q. Did it ever occur to you that information should go beyond --

A. I wouldn't have had a direct line to the minister.

Q. You wouldn't?

A. No.

MR STEWART: Thank you, sir. I have no additional questions.

THE CHAIRMAN: From the family, Mr Quinn?

MR COYLE: Nothing, sir, thank you.

THE CHAIRMAN: From the floor before I come to Mr McAlinden or the solicitor for Dr Carson.

Anymore? Mr McAlinden?

Doctor, thank you very much. Unless there's anything more you want to add.

A. Well, chairman, can I just again apologise for the inappropriate language I used earlier.

THE CHAIRMAN: I understand.

A. It was foolish and not in character, I have to say.

Chairman, the only other thing that I would draw to the inquiry's attention, and it goes back to the Organisation with a Memory document, because I think not

only was it -- it was in a sense contemporaneous and it was certainly -- it was contemporaneous with some of the incidents that the inquiry has looked at and it also preceded and pre-empted anything that was put in place subsequently by the Department.

One of the criticisms I think, probably rightly so, that the inquiry might allege is that local investigation is either inadequate or insufficient and doesn't actually get to the hearts of matters. That was well recognised in Organisation with a Memory.

I've mentioned that many other audits and surveys, reviews, were not only patchy in the way in which they covered the totality of knowledge but also patchy in the way in which they disseminated it. But I think one of the other things that was developmental and very poorly established in the Health and Social Services at that time was the conduct of local investigation, largely because there was very little -- there was a poor framework within which local investigation could take place.

Subsequently, I was responsible in the Department for issuing a memorandum of understanding in relation to the investigation of patient and client safety incidents, whether they were expected deaths or serious untoward harm. Now, that guidance, which we issued to

the service at that time, was around the handling of an investigation, who had priority, who had primacy in any investigation that should take place, for example, the police, the coroner's office, the Health and Safety Executive, and the role then of the service in supporting those external investigations and inquiries.

That was about the process. It did not go -- no guidance, to the best of my knowledge, has ever been issued to the service on how to conduct an investigation. A lot of work has developed around root cause analysis and the Royal Trust under Dr McBride, when he succeeded me, certainly were very much at the forefront of developing those techniques.

But I go back to the Organisation with a Memory, because in the conclusions to Organisation with a Memory, they cover a section on inquiries and investigations. I'll just read a small section of this, but I would encourage the inquiry to look at this part of Organisation with a Memory.

It's paragraph 5.6 of the conclusions:

"As we have noted, there are a number of different provisions and mechanisms for holding internal or external inquiries into individual adverse events or into clusters of events. Yet, on the evidence we have considered, such inquiries and particular external

inquiries are not always effective learning tools for the NHS."

And they cover a number of other points, and I'll not go into any other details other than highlighting.

First of all, the threshold for inquiries or investigations is unclear.

Secondly, there is no clear framework or source of advice on the conduct of investigations.

Thirdly, an inquiry recommendations are not always sufficiently helpful or focused.

Fourthly, the implementation and follow-up of recommendations is patchy.

And, finally, there is no systematic mechanism for sharing more widely the learning from individual local adverse event investigations.

That was very much an indictment of the NHS at that time. But I think that was true in England, it was also true, sadly in Northern Ireland, and I think we have moved, hopefully, from that low nadir, if you like, to where we are at the moment, and no doubt the inquiry will be brought up to speed in terms of current developments. But it would be helpful maybe for the inquiry to look at that.

THE CHAIRMAN: One of the frustrating things, doctor, in that context is that Altnagelvin was moving at

least at a pace with developments, if not ahead, by bringing in the lady who was referred to earlier on to talk about critical incident reviews and then drawing up a critical incident review protocol.

So Altnagelvin shouldn't be faulted for not having a process in place. The difficulty then is that when one looks to see about the implementation of the process, one of the other points you have highlighted there comes in about how well they're focused or conducted, because there wasn't a starting document, which may or may not be so important, but there wasn't an end report to Mrs Burnside.

A. No.

THE CHAIRMAN: And that does worry me rather more.

A. And I'm not criticising Altnagelvin. We know there are weaknesses that have subsequently been uncovered, but I think this was -- what I'm trying to do is to relate it back to the other deaths that took place.

THE CHAIRMAN: Yes.

A. And the failure to trigger maybe a more fulsome investigation at that time. The system and the service was not good at that.

THE CHAIRMAN: Thank you very much indeed, doctor.

Ladies and gentlemen, unless there's anything more this afternoon, we'll resume at 10 o'clock on Monday

with ...

MR STEWART: Mrs Brown.

THE CHAIRMAN: Mrs Brown, of course, and then we've got Dr Nesbitt and Dr Fulton. Those are next week's three witnesses. We'll sit Monday to Wednesday next week.

Thank you very much.

(2.38 pm)

(The hearing adjourned until 10.00 am on Monday 2 September)

I N D E X