Thursday, 19 September 2013

(10.30 am)

(Delay in proceedings)

(10.37 am)

THE CHAIRMAN: Ms Anyadike-Danes?

MS ANYADIKE-DANES: Good morning. Could I call Professor Swainson, please?

PROFESSOR CHARLES SWAINSON (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Professor, you have provided one report for the inquiry in relation to this part of its work, dated 20 August of this year; is that correct?

A. Yes.

Q. The reference for it is 226-002-001. Is there anything in your report that you wish to amend or change?

A. No.

Q. Thank you very much. So we can take that as your evidence and then build on it in the course of the hearing today.

Do you have your CV there, professor? It should be 226-002-029. Perhaps we'll just pull that up. From that, we see that you became a doctor in 1971.

A. Yes.

Q. And you became a fellow of the Faculty of Public Health in 2002, a fellow ad hominem of the Royal College of

Surgeons in 2007. We also see your present post is -- you have a position as EHealth clinical lead for the Scottish government and you have held that since 2011. You are medical director and vice-chair of the Scottish Advisory Committee on Distinction Awards. Is that for the professionals?

A. Yes.

Q. And you have had that since 2009. If we turn to your career summary, perhaps we will pull up 029 as well as 030. If I ask you just to confirm some of the particular aspects of your career that are of interest to us here or bear on the work that you've done for us.

You were a practising clinician and retired from the NHS in 2010.

A. Yes.

Q. And your particular discipline was in renal medicine; is that right?

A. Yes.

Q. And you retired as a consultant?

A. Yes.

Q. And you were elected chairman of the RIE physicians' committee in 1991 and you played an influential role in the 1990 part of the NHS then reforms in developing clinical directorates and preparing for trust status.

A. Yes.

Q. So you have some view as to what the change might be in the responsibilities between prior to that and subsequent to it?

A. Yes.

Q. Thank you. Then, in terms of your administrative rather your managerial roles, you were the clinical director for medicine from 1992 and appointed medical director for the Royal Infirmary of Edinburgh in 1996 and medical director for the Lothian University Hospitals in 1999. And you had a period when you were acting chief executive in 1999 and you returned to that position in 2002; is that correct?

A. Yes.

Q. How long were you acting chief executive in 2002?

A. 2002 was about eight months.

Q. Thank you. Then you were appointed medical director to the NHS board in 2003 and that position carried on until 2010. In addition to that, you were director of studies for the University of Edinburgh from 1986 through to 2006.

A. Yes.

Q. Then if we look at some of the salient features of what you've done in some of those positions. If we look at 030, on the right-hand side, under the NHS board, you had the executive lead for clinical governance, which

you shared with the nursing director, and for risk management. And you wrote the healthcare governance and risk management strategies that were approved by the board in 2005 and 2008.

A. Yes.

Q. And part of your role or task was to ensure that there were effective systems for guideline development and the implications and for the promotion of research and evidence-based medicine. Was that an important part of your role?

A. Yes.

Q. You say that you also established a research governance framework on reporting and systems for approval and monitoring so that whole system, that of validating the position that you've taken in relation to any given task?

A. Yes.

Q. Thank you. If we pull up the next page, 031, and have alongside it 032. You go on to say that in the course of your work there you built relationships with the medical Royal Colleges, the local universities, the postgraduate dean and other health boards, as well as the GPs and the community health partnerships and the local departments for social work. How important a role was that for you to build those networks for the

hospital?
A. That was very important because I was the medical director to a population-based health board, which covered all aspects of healthcare for the population of Lothian and surrounding areas. So building relationships with other important contributors to healthcare in that system was very important for its effective functioning.
Q. If we look now with the work that you have done at the national level, you say you were a member of the quality assurance subgroup of acute services review. Was that a rolling programme from 1997 to 1998?
A. Yes, it was a little over a year's review of how the acute services in Scotland were to be developed.
Q. If we translate that into here, that would include intensive care?
A. Yes, that included intensive care units and specialist services such as children's hospitals.
Q. And that might include paediatric intensive care?
A. Yes.
Q. Thank you. You also say that later you worked with the working group that established the clinical standards board for Scotland.
A. Yes.
Q. And you were chair of the Scottish Patient Safety

Programme steering group for the NHS. What exactly did that involve?
A. The role there was to try and ensure that different interests and groups came together to fulfil the government's strategy for quality improvement that was extant at that time. That started in about 2009 and we stood that group down earlier this year -- its work has been taken over by others -- but it was essentially to ensure that the government objectives for the Scottish Safety Programme were delivered.
Q. And you were also a member of the Health Department clinical governance working group.
A. Yes.
Q. What specifically did you do or were you concerned with when you were a member of that group?
A. That was right at the -- that was at the beginning of the clinical governance. We started with a group called the clinical resource and audit group, which was chaired by the chief medical officer. And in 1996, that group began to consider ways in which the quality of care could be brought into consideration by the new trust boards and by the Department and everybody else as opposed to purely financial and administrative arrangements. And the term "clinical governance" wasn't used until after Donaldson and Scally published their

paper, I think in 1997, but we began that work then. And we considered how the NHS in Scotland was to be organised in order to deliver against that framework. So how would we deliver national standards, how would we assess that they were being met, what kind of resources might need to be deployed to achieve that? Those kind of considerations.
That led us to establish a special health board in Scotland with responsibility for developing standards, the monitoring and the implementation of those, and the assessment of the trusts in Scotland against those standards.
Q. Thank you. So in other words, you really were involved from the very embryonic stage of developing those things right up to seeing how those standards were actually being implemented and what the system was for making sure they were delivering the original objectives?
A. Yes.
Q. You've a number of peer-reviewed articles, and they're there in your CV for people to see. I was going to identify two in particular. One is published in 1985 and it's "The learning process in medical education". The other was published in 2006 and it's entitled "The shape of things to come: the clinician in management".
If I ask you about the first point, what exactly

were you seeking to deal with when you produced that paper on the learning process in medical education?
A. I can't remember at this distance the exact things we were talking about, but the discussion at that time was how best to enable, particularly medical students in the last two years, how to effectively learn and have an effective transition from being a student to being a working doctor. It's been a particular interest of mine over most of this period you're talking about. One of the particular issues in New Zealand was the selection of medical students and how to improve the quality of care for the Maori population, the indigenous population in New Zealand, who were very under-represented in the healthcare professions, and particularly in medicine, so we were interested in that particular piece of work and subsequent work afterwards, when I returned to the UK, to identify means by which Maori students could be selected on grounds other than academic attainment, which was the general standard at the time.
Q. And in considering how you could improve the quality of their education, did that extend to how do you integrate what is being learnt at the ward-based level into what they might have learnt at university?
A. Yes, because the medical course is very much

a combination of those things in the latter years where the work all takes place and the learning all takes place in a working environment, supervised by tutors and so on, and the student is building on the theory and concepts they've acquired in the, if you like, university part of their education, and learning how to apply that. One of the concerns that we had is how the final year examinations taken by those students reflected both the academic content of their study, but also the practical implications of what they were going to be doing the following year.

Q. Thank you. Then if I ask you about your second paper, which is "The clinician in management"; what were you seeking to address there?

A. I think that was largely about anticipating the future and learning how to cope with a variety of things that might happen, ranging from changes in government policy or guidance and how medical directors were to handle that, plus changes in the way doctors worked, the introduction of new techniques, perhaps, and the growing importance of new systems that were actually pretty well-established in the UK by that some time, or certainly in Scotland, particularly around the appraisal of doctors and the assessment of education programmes and their relationship to fitness to practise.

Q. Thank you. What I'm going to do now for the rest of your session with us is -- I'm not going to go through each and every item that you address in your report. Your report has been shared, it's published and it is out there and people have had an opportunity to see it.

In the course of a number of days' hearings there have been witnesses whose evidence has gone to some or other of the points that you cover in your report, and I'm not going to go through that in any great detail either because the evidence is published in transcripts and the chairman has heard it.

What I would like to do is to tease out some points, maybe some themes, with you and ask you to comment on them, and also to add to that your own observations, if necessary, to supplement the points that I put to you.

One of the first matters that I'd like to draw out with you is the whole sort of clinical governance context. You did say when you were responding to me on your CV that the term clinical governance really came to public attention with that paper, which Professor Scally was a joint author of. Nonetheless, I think in your report you say that that activity was going on because you had to have activity like that as an organisation in order to know what quality of care you were delivering. Is that right?

A. Yes.

Q. So although the term was new, the activity wasn't; would that be fair?

A. No, the activity was there, but I guess it was less prominent before Donaldson and Scally drew attention to its importance, but it was there.

Q. You go on to talk about accountability and you say that, in 2001, there wasn't a statutory accountability for the quality of care to patients, and in your view that probably didn't happen in Northern Ireland until 2003. But that doesn't mean that the trust and the chief executives and, in fact, all of the clinicians who are part of delivering care -- that doesn't mean they didn't have responsibilities in relation to the delivery of that care. And you'll have seen the chief executive at the time, Stella Burnside, has accepted that, that she had that responsibility.

A. Yes.

Q. What I want to ask you is, having accepted that responsibility, at that level of chief executive, what were the implications of that in terms of the systems and structures that she would need to ensure that she was able to discharge those responsibilities?

A. Well, the chief executive of any organisation, and indeed the board, would depend on a flow of information

from within the organisation to inform their view. They could not be expected to know the detail of every clinical encounter, for example, in a hospital. But they would need to have a flow of information and summarised views and some numbers that would tell you what's going on.

So for example, I imagine there was a very good flow of information from the finance reporting system, which would tell a chief executive about expenditure at quite a level of detail and on a monthly basis. Similarly, for the number of patients treated and the time it took them to be treated, there would be a good flow of information about that because those were major areas of accountability at that time.

But in order to discharge a more general duty of care, again the chief executive would require a flow of information, and the kind of sources of information that that might come from would be things like complaints, so if you get a regular review of complaints you can see what the themes and concerns are, and if they're organised by department you can see where there might be hotspots or spots of good practice.

Similarly, one of the other areas I think that's important is when national reports or guidance are produced, as they have been since 1948, that's then an

opportunity for a trust or an organisation to look at its own standards and procedures and see whether those conform to what's being recommended by a reputable professional body. So you can use external references to judge the quality of care as well as getting some flow of information from the inside.

In the particular incidence of hospitals in the NHS, of course clinical audit was well-established in the 1990s, and most hospitals would have a published programme of clinical audit, a committee which would report on the findings of those audits as well as the number and quantity that were done and where they were done. And again, the conclusions from those audits about whether they were meeting the required standards would be another flow of information that would come through, probably, the professional routes of the medical or nursing director, and it could be brought to the attention of the chief executive or the board.

Q. Is it part of the chief executive's role to ensure that she does have adequate channels of communication?

A. Yes, it's the channels of communication that are important because that's the vehicle by which you learn what is going on, in both formal and informal senses.

Q. So if an event occurs, which you learn about in another way but you should have learnt about it through, let's

just say, clinical audit or you learn about trends which should have come to you through mortality reviews and audits, if you see that that isn't working, if I can put it in those layman's terms, is it part of the role of the chief executive then to adjust the system to make sure that the information is coming through the appropriate channels and she or he is receiving quality information on which they make their decisions?

A. Yes, I think that would vary from chief executive to chief executive, but if a chief executive had a particular interest and felt a particular responsibility towards the quality of care in the days before that became the statutory accountability, then if you weren't getting the information that you thought you should be getting then you could enquire as to why not and put in place mechanisms to ensure that you did get it.

THE CHAIRMAN: Professor, is the statutory responsibility issue a red herring? Because even without statutory responsibility, if I took that point to its limit and -- and I know in Northern Ireland the trusts did not have a statutory responsibility for quality of care until 2003 -- that would mean that until 2003, if that's the test for accountability, then a trust could have had a disclaimer up at the front door of the hospital to say

that the trust is not responsible for the quality of care provided to patients, which would be absurd.

A. Yes.

THE CHAIRMAN: But they were being sued regularly, rightly or wrongly, because of a suggestion that they didn't provide quality care.

A. Yes.

THE CHAIRMAN: And if they were being sued for failure to provide quality care without having a statutory responsibility for care, it must follow that they did in fact have a responsibility.

A. Yes, and I think the chief executive illustrated that pretty well for you in her evidence, but I agree, it's a slightly artificial distinction. And of course, it moves on all the time, so I think what people would regard as their statutory accountabilities in the different countries of the UK with regard to quality of care are very different now from what they were when the legislation or the order was first enacted.

THE CHAIRMAN: Not in the sense that the statutory responsibility has changed, but what is expected of them to fulfil that responsibility has changed.

A. Yes, exactly so.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Then in the light of the evidence that

you've read from the transcripts and the other evidence of witness statements and so on, do you have a view as to whether the trust adhered to the expected standards at that time in 2001?

A. I think when you look at the --

MR LAVERY: It's a pretty broad question.

THE CHAIRMAN: It's a sweeping question and I think, in some ways, you've put it in your report that your view on Altnagelvin Trust is neutral in the sense that they had some failings and some strengths; is that right?

A. I think when you look at the published information about how they met particular standards that had been published and were extant at that time, the ones I referred to in particular were the 1992 charter, Health and Social Care, then it's clear that they did not meet two of those standards in this particular case. But my view over their position generally in the firmament of trusts and hospitals across the UK would be that some things they were good at and some things they fell short on, and that would be typical of many organisations.

MS ANYADIKE-DANES: In the light of the -- perhaps more of the transcripts that you've read of the evidence that's actually been given, do you have any concerns about the strength of the framework for controls assurance?

A. Yes, I do. When I took the lead for risk management, I required quite a bit of education and training in that area because my medical training had not particularly prepared me for that. One of the things I introduced very quickly to my own organisation was a risk register and that the risk register should be considered by the executive team prior to the board and then the board would look at it roughly quarterly. The risk register is a very important opportunity to consider carefully the risks that the organisation faces and how you're going to deal with them. So that's one mechanism I would have expected to see more clearly in organisations, certainly by 2001, because risk management had been well developed in the public services since the mid-1990s.

Q. When you say you introduced that into your own organisation, was it your experience that a risk register was something that, by 2001, was a fairly commonplace tool?

A. Yes. The difference would be, I think, that the risk register's been in existence for quite a considerable time. They were often managed by the finance director and largely refer to matters of finance. The approach I took -- and I know was adopted much more widely at around the same time -- was that the risk register

actually had to cover the work the trust actually did, which is looking after patients. So there had to be quite a clinical flavour to the risk register in a clinical organisation. So that would be one area.

The second is that once you've established that kind of mechanism and once you're clear about the kind of standards you're looking for, you need to monitor against those standards, and you need to monitor the things that appear to be important to you or the areas that you consider to be at risk. I haven't seen a great deal of evidence of that. Whether that was the same or different from other hospitals in Northern Ireland at the time, I couldn't say, but it was not the same as the regime that I was used to and had introduced in Scotland at that time.

Q. Well, when we actually come to elements of care, you have identified a number of failings, the trust -- not just you, but also the inquiry's experts have, and the individual personnel within the trust have made certain concessions about elements of the care that was delivered to Raychel. And those failings were at a number of levels: clinical, nursing, governance.

But what I would like to ask you is, given that they were happening, how should the trust have known, which is a development of the earlier question I put to you as

to what the channels of information were? But how should the trust have known that there were those sorts of deficiencies in its systems and structures and standards, without waiting for an actual death to occur? What was the means by which the trust would have recognised that they had those weaknesses?

A. Well, I think the hospital trust is really no different from any other organisation in that respect. I have already spoken about the usefulness of a risk register, but the key things to me are the fact that you audit and monitor those standards which you believe to be important, and you do that on a frequent enough basis to enable change to occur and then for the chief executive or directors of the organisation and the board be assured that (a) the standards are being met or, if they're not being met, there's clearly a plan to enable the organisation to meet them in the future, and as you do repeated monitoring, you see an improvement in the position. It's really exactly the same as recovering a poor financial position, for example. You can do that with complaints, you can do with that critical incidents and so on.

So the second area that I think would be certainly extant at that time would be a review process, a review of complaints and of clinical incidents. Clinical

incident reporting has certainly grown since the early 2000s, but was in place in many organisations by then and enabled a senior team to be able to look at how many incidents were being recorded, what nature, where they were occurring, and then to be able to see that action was being taken to address them.

I understand from one of the transcripts I read that there was a Datix reporting system available in the trust and that's a very well-known, very commonly used system which we had in my organisation, and that gives you a rich source of information about things that go wrong or things that do not meet the standards that people expect.

THE CHAIRMAN: Professor, can I take you back? Let's look at one thing in particular. The lack of understanding or knowledge about who prescribed post-operative fluids, which seems, on the evidence I've heard, to be a rather unusual, if not unique system in Altnagelvin, where the anaesthetist did not prescribe the immediate post-operative fluid. How should that gap or failing have made its way to the people who would have done something about it before Raychel's treatment?

A. Yes, I have thought about that one quite a bit and I'm not clear what kind of monitoring you could put in place that would report that as a particular problem to the

executive team or, indeed, to anyone else.
THE CHAIRMAN: In a sense, does that need to be raised by the anaesthetist who's unhappy that his understanding of the standard procedure across a number of hospitals is not being followed in Altnagelvin?
A. Yes, that could be one way of doing it. The problem with incident reporting and mechanisms of that nature is that, of course, you don't get the opportunity to look at anything until you have an incident.
THE CHAIRMAN: Yes.
A. It's much more difficult to deal with concerns that you might have about practice which is different from what you've experienced elsewhere or that you regard as uncommon or odd. First of all, who do you talk to about it? Normally, you'd talk to your, if it was a consultant you'd talk to your peers, and in this context the head of department or the clinical director. And then you would expect them to deal with it.
But in terms of how you could monitor a situation like that, I find that very difficult unless things happened as a result.
MR LAVERY: Mr Chairman, of course we must remember as well what Mr Gilliland said when he gave his evidence that, even in the Ulster Hospital where he works today, there's still ongoing changes in relation to fluid

management and they're continually trying to improve.
THE CHAIRMAN: I think the problem here, Mr Lavery, is a rather strange one, which is that, in effect, the anaesthetist who was going to prescribe post-operative fluids was advised by nurses "No, that's not the way we do things in Altnagelvin, they're prescribed back on the ward". I'm not sure if that's unique, but it was certainly unusual.
MR LAVERY: Yes, I have to accept that and I think it was accepted.
THE CHAIRMAN: That's why I'm asking the professor. The professor said in his report, in a number of ways, the critical incident review was sound, and Dr Haynes said that when we were here much earlier in the year. He said there were sound elements to the critical incident review. But if you take it back a step and if there hadn't been a previous incident as a result of the confusion, let's call it that, over who prescribed post-operative fluids, I think the professor's evidence really suggests it's a bit more difficult to see how that gap is picked up in the system to be put right in order to prevent an incident occurring.
MR LAVERY: Yes, I think the trust accept that and I think Professor Swainson did say in his report that no one individual can be blamed for that and in fact it was

a systems failure.
THE CHAIRMAN: Yes, but the point of my question to the professor is: how do you identify the systems failure before it becomes an incident? Because we know in this case it's a contributory factor to what went wrong in the care of Raychel after the operation.
MR LAVERY: Yes, I accept that, Mr Chairman.
MS ANYADIKE-DANES: What went wrong with Raychel has been described in a variety of ways as being a number of things that in her case came together. And if some of those things had been different, the outcome may have been different, but they weren't different and they all happened and they came together and the ultimate result was her death.
But of those things that have been criticised or commented on adversely, there may have been ways in which that practice, which has been criticised, could have come to light as opposed to the sort of example that the chairman put to you. If I give you an example maybe you can help or you might be able to think of a better one.
For example, there was a real question as to the nurses on the ward effectively being those who were left with the task of having to recognise when they had a sufficiently serious concern to warrant contacting the

surgeon because the surgical patients were patients of the surgical team, and then they had the difficulty of trying to find a surgeon to come and assist them, and if a surgeon wasn't there, they would have to resort to one of the paediatricians, and this was not a paediatrician's patient.
That, as I understand it from the evidence, that particular concern of the difficulty of getting hold of the surgeons and the feeling that they were the people who effectively were left making important decisions in relation to post-operative paediatric care is something that nurses had raised. They'd raised that in meetings, the director of nursing was aware of that. If that's a problem and that can be seen as being a risk area for patient care, those meetings that the nurses would have had -- with, first, the senior sister, the sister may have had with the director of nursing -- is there not a channel for that sort of concern to get itself to the chief executive if anybody considers that that is a real risk area?
A. Yes, I think you've raised a good example of how a concern that one group of staff have about a particular problem can be raised within the organisation and can be raised with those who would help you resolve it. Whether that particular concern will

get to the level of the chief executive, I'm not entirely sure, but it would certainly get to the level of the nursing hierarchy and the nurse director, and that would be the opportunity to have a conversation with your opposite number, for example, the medical director, and he can take it down through his systems if you can't do it together at the ward level. But that's a good example of how, without waiting for an incident, concerns about problems in communication or anything else or care could have been resolved.

Of course, the extent to which people deal with that depends to a large extent on what the consequences of that difficulty are. If it's portrayed as a difficulty in getting hold of the staff for something which everybody else thinks is very minor, then you can understand that that might not get very far in the organisation. But if it's for something major like the prescription of drugs or the prescription of fluids or some major component of the care, then you would expect that to be taken seriously across an organisation.

Q. Thank you. So what I was really asking about is the means by which the trust could have been alerted to the sorts of things that came together in Raychel's care to contribute to her death, how the trust would know about that, and you've indicated there are some ways in which

they would know about some of those problems and other problems they may not have known about until you actually have the incident.

Of course, when you do have the incident you have an opportunity to examine that closely, identify all those different strata that have come together and that, presumably, is part of what feeds into any change in practice to avoid that happening again, and that's the way that works.

A. Yes.

Q. That's the point the critical incident --

A. That's the purpose of a review, yes.

Q. Then if I can ask you then about knowledge. You have mentioned in your report particularly NCEPOD and the reason I raise that is because obviously that became an issue in the course of the surgical clinicians giving their evidence as to the extent to which they were aware of it and its implications for practice and therefore the decisions that were made around Raychel's own care.

When the chief executive, Mrs Burnside, was giving her evidence, it was 17 September, page 49, starting at line 3, but we don't need to pull it up. What she said was in relation to NCEPOD:

"It was voluntary, it was anonymous reporting. It was a profession trying to improve and influence the

improvement in its own practice, and that was very particularly surgeons in critical care, anaesthetists, so it was a national survey, but the recommendations were not national guidelines -- and that's a phrase I think Dr Swainson uses. They were not national guidelines, they were not adopted by the Department and commissioners and used as a parameter of quality measurement."

That's a chief executive's take on the significance of NCEPOD. I wonder if you'd like to comment on that.

A. I think that the way she's expressed that is probably accurate from the point of view of a chief executive, but I would take a slightly different view from the point of view of the healthcare professionals involved and, by implication, the rest of the organisation.

My view about all of the confidential enquiry reports is they are all voluntary and they were all non -- statutory until they were taken over by the National Institute for Health and Excellence, three years ago, I think. Their recommendations were all about national guidance, they were not mandatory to anybody in the United Kingdom. And they weren't guidelines, they were national guidance based on the recommendations of a professional group who had looked at the deaths or serious complications of care. In this

case, following surgery, but there are confidential enquiries into childbirth and so on as well that you may be aware of.

I don't believe any doctor in the United Kingdom would ignore these. These are professional recommendations aimed at improving the quality of care, which is something that every doctor, nurse, healthcare professional, I think, is interested in. I'm very surprised that people said they didn't know about them because they are widely published, they are widely distributed. My understanding is that they always go to the medical director of an organisation, that they go to the Royal Colleges, that they go to the people on the ground who have contributed to those reviews, so if you're a local reporter, as they're often called, contributing information about deaths or complications then you would also get a report.

I think they're very important benchmarks, they're very important ways in which you can examine your own standards and processes within an organisation when you don't necessarily have the resources to do that all the time, covering all those fronts. These are extremely useful summary views.

Q. When you held a managerial role, or even when you were senior consultant in your hospital, what would happen in

your hospital when the NCEPOD report was published?
A. The NCEPOD was -- a number of national audits and other reports and would come into my organisation. They were disseminated to the relevant clinical directors or equivalent, and the expectation was -- in fact the requirement, as far as I was concerned, was that these reports would be reviewed and discussed and then each department affected would respond as to how it was going to approach these recommendations, whether it was going to adopt them entirely, whether they had already adopted that practice, whether there were some they were going to adopt of the recommendations and some perhaps they couldn't, whether there were resource implications, because that was important to me as a director to ensure that those resources were then made available, and any other implications for the organisation.

And in general, those reports were acted upon. I can only remember a very small number of occasions when the response to a report of that nature, a CEPOD report, in fact, was delayed or appeared tardy. The vast majority of directorates and, if you like, clinical units would respond to those usually within two to three months at the most.
Q. Would you have been surprised or even concerned at a senior consultant surgeon not being aware of them, not

having any sort of discussion with his team as to their implications for practice? Would that have surprised you?
A. Yes.
Q. And concerned you?
A. Yes, it would. The Royal College of Surgeons strongly supports the National Confidential Enquiries with respect to surgery, as do the other Royal Colleges for the ones that pertain to them. So I find it surprising that a fellow of the college would not be aware of the report, even if they hadn't been sent a personal copy.

They're also well trailed in the medical press. The British Medical Journal, for example, would always refer to them and probably have an article or editorial describing the main findings.
Q. Altnagelvin itself had two contributors to the work. That's how it operates, isn't it?
A. Yes.
Q. There's local contributors who gather the information, which is then going to be submitted. One of them was a consultant surgeon, which is Mr Bateson, as you probably know, and then there was Dr Hamilton, as the consultant anaesthetist, and they were the Altnagelvin local contributors.
A. Yes.

MR QUINN: Mr Chairman, can I just make a point here? I recall, Mr Chairman, what you said at an earlier stage about these recommendations, and that was -- you asked -- I can't remember which witness it was, but you did ask very clearly -- if they couldn't implement these recommendations because of budget constraints, should it be noted somewhere, should it be noted and logged in the hospital records somewhere? Perhaps that question, for completeness, could be asked again.
THE CHAIRMAN: Professor, what you said a moment ago in terms of each relevant department responding to the recommendations was that one of the options was to say, well, we can do it in part, but we can't do something else because there are resource issues. Then somebody would look at the resource issues and decide whether there is enough room for manoeuvre on those to re-organise or to bring in somebody new or, alternatively, just to say, "Unfortunately, we can't do this". I think the question being asked is, in that event, would you expect to find some sort of exchanges on that and some sort of paper trail? It doesn't need to be prolonged, but you would expect to find something?
A. Yes, there may be many reasons why a recommendation couldn't be implemented, but if -- the view I would take is that if you can't do something and you make that

clear --
THE CHAIRMAN: And you go as close to it as you can do?
A. Yes.
MR LAVERY: Dr Nesbitt, Mr Chairman, said during the course of his evidence that in a hospital the size of Altnagelvin, a district general hospital, the consultants would have known each other, there was a good working atmosphere, there was a good relationship within the hospital. And effectively although a lot of the staff may not have been aware of the recommendations, they were effectively being put into effect.
THE CHAIRMAN: Dr Nesbitt said that, but Mr Gilliland said he wasn't aware of the recommendations.
MR LAVERY: He did say that, yes.
THE CHAIRMAN: I'm not sure those two pieces of evidence can stand together. I can't accept Dr Nesbitt's evidence that there would have been discussions and so on if Mr Gilliland said, "I didn't know about them in the first place".
MR LAVERY: Yes, but it was put to Mr Gilliland also in the context of perhaps more junior doctors being scared, if you like, to contact him, to call him at home over the weekend and he says that wouldn't have been the case.
THE CHAIRMAN: If that isn't the case, it rather proves the

point because if he had been alert to the NCEPOD recommendations about surgery being conducted by junior surgeons and they weren't afraid to call him, then the reason they didn't call him, it seems to me, is there wasn't a system in force because the NCEPOD recommendations just had not been followed, full stop. Isn't that right? I don't doubt that Mr Gilliland would have been disturbed from time to time at home and that's unfortunately part of the job of a surgeon and many other specialists, you are contacted at home and your staff aren't scared to contact you. But if you're not being contacted about late-night surgery for a 9-year-old girl to have her appendix removed, a reason for that in Raychel's case seems to be that the NCEPOD recommendation was just not -- certainly not followed and, query, was its existence known of at all?

MR LAVERY: Mr Gilliland has said he didn't know of the existence of the recommendation, but Dr Nesbitt, when he gave his evidence, said that always in his experience a junior doctor, if he had a concern, would contact the consultant. But in this case there was no concern and Raychel was in the hands of more experienced junior doctors.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Mr Chairman, the point that my learned

friend Mr Quinn put, that was actually a point that was drawn out of Dr Nesbitt in his evidence on 3 September. It starts at page 72. What was put to him is:

"Where a view is taken not to adhere to the recommendations of, for example, NCEPOD, that view should be noted and authority taken from the board about not following it."

And what Mr Nesbitt said in response is:

"That didn't happen. It's a very valid point. I wouldn't argue with it."

So he was, I think, acknowledging the point that has been put to you, Professor Swainson, that if for very good reasons, which presumably the organisation can stand over, it's not going to follow a particular recommendation from NCEPOD, then that's recorded and everybody understands, we're not doing this and, more to the point, understands why we're not doing it so, if circumstances change, that matter can be reviewed to see whether we want to adhere to our current position or maybe the time is now when we will work to bring that recommendation into force. Would that accord with what you would understand as practice?

A. Yes, that would be good governance, in my view.

Q. Thank you. In your report -- we don't need to pull up the particular section, but it's at 226-002-010 -- you

registered it regrettable that there wasn't a clear framework from the Department that would have ensured that serious clinical incidents were reported by trusts and disseminated to the other trusts. By "the Department", do you mean the Department of Health?

A. Yes.

Q. What might that framework have been that would have achieved that so far as you're concerned?

A. The context here is how do organisations in a common health service learn and are able to take action to prevent serious complications or deaths? And given that you have a system where there are a number of independent organisations that have no particular duty to talk to each other about these things, it seems to me that you do need a framework in place to be able to share serious information and to share learning.

In hindsight, it's kind of easy to see that over the passage of time with the various cases you've been talking about -- that's why I said it was regrettable that there wasn't a system in place. But in Scotland, all I can refer you to is what we had there at that time, which was that the chief medical officer, who met regularly with the trust medical directors, one of the discussions we had was exactly about this: how do you share information about things that go seriously wrong

in order that others can benefit from that? And the system we adopted was that we would let him know, we would let his office know and send in a brief summary of what the case was and that would be disseminated to the other trusts in the country.

THE CHAIRMAN: I presume, professor, like in all of these things, you then have to take a view on how serious the incident is before you report.

A. Yes.

THE CHAIRMAN: Otherwise you could end up reporting everything and that becomes counterproductive.

A. Exactly.

THE CHAIRMAN: When you say you were discussing that with the Scottish CMO and that led to a system being put in place, can you put a timescale on that? Roughly when was that system put in place? Because we know, to be fair to Altnagelvin, they did report Raychel's death to the Department.

A. Yes.

THE CHAIRMAN: So this is an example of such a system working.

A. Yes.

THE CHAIRMAN: Was that in place in Scotland, to the best that you can recall, before 2001?

A. I think it was at around that time. I'd have to go back

and check exactly, but it was around that kind of time.
THE CHAIRMAN: Thank you.
A. And it was, as you say, aimed towards particularly serious issues and especially death, preventable death.
THE CHAIRMAN: Yes, perhaps a death or perhaps some other serious incident from which lessons could be learnt across the board --
A. Yes.
THE CHAIRMAN: -- rather than just within a hospital.
A. Yes.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: And if we look at information sharing from the perspective of the Children's Hospital or the trust within which it formed part, in your report you refer to the fact that:

"The Children's Hospital was an independent organisation and that, as such, it had no obligation to report ..."

I'm now reading directly from your report. It starts at 226-002-009, but we don't need to pull it up:

"... with no obligation to report changes in clinical practice to other paediatricians in Northern Ireland or elsewhere."

You go on to say:

"It had no duty to share changes in thinking or

practice."

But you qualify that by saying:

"I would have thought that there was a professional obligation to share significant changes in practice with other colleagues in the Province, particularly if the change is driven by an adverse incident. After all, it is the only specialist paediatric centre in Northern Ireland."

I don't know if you've had an opportunity to consider what the commissioning relationships were with the Children's Hospital or, more specifically, with paediatric intensive care, which was a service that was provided throughout the region. If you've got a hospital or a centre that provides that kind of service, and in fact is commissioned to provide it, does that change, does that bring with it any kind of greater duty to share information from within that specialism to district hospitals for whom that might be important?
A. I think so. I have not seen the details of the commissioning document, but if you -- commissioning services at that time included some consideration of the quality of the service. So I think there would be an opportunity in the commissioning process when the provider organisation meets with the commissioners, who I think in this case were the four Health and Social

Services boards.
THE CHAIRMAN: Yes.
A. There will be regular review meetings of how that commissioning contract was doing. There would at least be an opportunity there to mention any serious issues of quality that were occurring. So, for example, unexpected deaths might have arisen in that conversation. But apart from that very formal mechanism, which might or might not have delivered that, depending on who was present and their view, I still think that there was a professional responsibility to share matters of serious concern where you are the expert in the field or at least you're the best there is available and you would appreciate that other practitioners would not have the same level of knowledge or insight that you do, or indeed may not have seen the consequences of what happened because they weren't in the single specialist unit where the case arrived.

If I can give you an example from my own practice. Before I was medical director, I was the lead consultant in renal medicine in my only unit and we had an incident where we strongly suspected poisoning from a particular batch of filters used in dialysis treatment, and we suspected that these were defective and effectively contamination was coming in from the water supply.

We immediately alerted the department to that happening and telephoned all of the other units offering dialysis in Scotland at that time -- there were only five, so it wasn't too difficult -- to let them know this particular batch of filters was suspect. That's before we really knew whether they were, it's just that that was our immediate recognition of the problem which led us to suspect the filters and immediately put that in train. We felt we had to do that because we were in the position of having that specialist knowledge and experience and it was important to share it.
MS ANYADIKE-DANES: You'll know from having read the evidence that there is an issue as to whether at some point the Children's Hospital changed its practice in relation to the use of Solution No. 18.
A. Yes.
Q. I don't want you to comment on that in particular, but just to use this as an example. If that had happened because of concerns that some children, or the category of children, might be at risk to developing dilutional hyponatraemia in certain circumstances with that fluid, and that had resulted in the Children's Hospital therefore no longer using that fluid, is that the sort of thing that was sufficiently important, sufficiently relevant to the practice in the district hospitals,

which you think that a paediatric centre like the Children's Hospital ought to have disseminated or communicated?

A. Yes, I think that's a good example of the kind of thing that could have been. A good deal depends on the context. So if, for example, the context is one where you believe children are being harmed by the administration of this particular fluid and you therefore review the literature, which you know at that time had raised a number of concerns -- although there wasn't a definitive position, I think, agreed at that time, then -- and you decided to change the fluid used in the post-operative management of children and indeed withdraw it from your pharmacy to make sure it couldn't be used, when you do that because of serious problems you had encountered with children post-operatively, that's the kind of thing I think you would share with other colleagues in a way that would alert them to the problem. So not to criticise them for the use of the fluid, not to raise undue alarm, but just to say, "We've carefully considered this, we have changed our practice and we think you should know that (a) we've done it and (b) this is why we have done it".

Q. Yes, so in a way you're not necessarily being prescriptive about what they should do, what you're

doing is your are communicating to them what you are doing and why you are doing it.

A. Yes, you are sharing information, you are spreading the learning, you are using your unique centre of expertise to help the rest of the medical community.

THE CHAIRMAN: There's one argument that that's easier to do in a comparatively small community like Northern Ireland, so the opportunity to do that is perhaps better here than you have in Scotland and perhaps easier in Scotland than it is to do for England or Wales -- or certainly for England.

A. Yes, that's probably true. In Scotland, as I'm sure in Northern Ireland, you have at least annual meetings of small specialty groups of the doctors concerned in a particular specialty, and that might be quite a small number of people. You probably know them all quite personally. So there is a good opportunity, informally or at a meeting of that nature or whatever, to share information like that.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: In addition to doing so informally, which might happen when one's seen the product of a mishap in relation to it from a transferring hospital or it might happen in one of these small groups that meet periodically throughout the region, it could happen

in that way informally, but is it also something that the hospital itself might communicate more formally than that?

A. Yes, I think, again, it depends on the seriousness of the issue. If it's in relation to things like perhaps supply or cost or labelling or something of that nature, then you might not take such a formal position. But if it's in relation to the safety of people under your care or the quality of care you're giving and you're aware of a serious potential adverse event that might not be common but is clearly linked to the use of whatever it is you're using, then I think that is a more serious and important professional obligation.

Q. Thank you. Then sticking with sharing of information from the perspective of the Children's Hospital, in these cases the Children's Hospital was either the hospital where the children started, so they were admitted to that hospital, or they were transferred from a district hospital because it has the only paediatric intensive care in the region. So when that happens and the child, although legally dying in PICU itself, but nonetheless all the damage, if I can put it that way, has been done in the transferring hospital and the specialists in PICU have an opportunity to consider the care that was delivered that has contributed to the

death from that referring hospital, what sort of obligation do you think that those specialists have to communicating back to the transferring hospital their views as to what happened whilst the child was receiving care from them? Not necessarily in a blame way, but an analysis of how the child developed the ultimately fatal condition.

A. I think there are two very important channels of communication that would normally be used. The first is a formal one, which is the discharge summary from the hospital where the child dies back to the referring hospital and copied also to the child's general practitioner. That's a fundamental aspect of recording care and of what has happened to a patient. So the discharge summary might be written quite circumspectly, but it should be quite clear that if there is a major complication of care that's occurred, that that should be highlighted to the -- simply for the purposes of good communication so that the doctors who referred the patient understand what exactly has happened or at least, in this case, the Royal Belfast Hospital's interpretation of that.

The other important aspect of the discharge summary, which is I think is very relevant, is that the general practitioner gets the same summary of information which

enables them to be able to discuss that with the family. For example, when they begin to enquire. General practitioners are often the first person that a family may speak to, the first professional the family they speak so. So that's one aspect.

The second is perhaps less formal and probably on the level of a conversation, at least to begin with, and possibly followed by a meeting if that was considered appropriate, where the doctor who's been responsible for the care in the final hospital has a conversation with the doctor who referred the patient -- or doctors, if there's more than one -- to explain to them the final diagnosis and the causes of what happened and explain that in a rational and entirely professional way to enable people to ask relevant questions and to enable people then to review the practice and the care that occurred to that particular child and take steps to prevent it happening again.

So I think the communication from the final hospital where the child dies back to the referring hospital should be occurring at those two levels.

Q. On that discharge summary, if it's going to perform that role, that sounds like a summary that should be compiled after perhaps the notes have been considered, so that some sort of informed view can be given as to what the

specialists think has happened.

A. It'd be very helpful to have the notes or to have records of the treatment that's been given, sometimes perhaps in summary form, but yes, it'd be certainly helpful to have the notes. And in the case of a death, you would probably want to write that letter after you had at least a preliminary post-mortem report, if not the final post-mortem report.

Q. And that discharge summary or the letter that communicates the views of the specialists, is that a document that you would anticipate, when it's received at the transferring hospital, then becomes part of their critical incident review, because that's something that they're going to consider in addition to their own investigations as to what happened?

A. Yes, it certainly feeds into that process.

THE CHAIRMAN: In short, professor, in the last two cases, I'm looking at, in slightly different ways, Lucy who was transferred from County Fermanagh to Belfast, and Raychel who's transferred from Derry to Belfast. The evidence I've heard is that in both cases there were significant concerns in the Children's Hospital in Belfast about the standard of care provided.

A. Mm-hm.

THE CHAIRMAN: But that was not, on the evidence, followed

up in either a formal or an informal way with the referring hospital. Do I gather from the essence of what you've said over the last few minutes that that's just not good enough?

A. I find that really very surprising.

THE CHAIRMAN: I mean, I have to say to you, a particular concern that I have about that is that if the Children's Hospital will not identify and raise those issues with the referring hospitals, what chance is there that doctors who are somewhat detached from the Children's Hospital -- what chance is there that the Children's Hospital will do that internally when the death is as a result of some inadequate standard of care within the hospital?

A. Yes.

THE CHAIRMAN: To put it crudely, if you're not going to turn in people who you don't know very well, you're not going to really face up to it with people who you work with every day.

A. Yes, I would exactly agree with that. I can perhaps give you an example of my own practice which dates back to, I think, 1990 or 1991, before I ever became involved in medical management. One of the problems that faced kidney doctors at that time was a problem of over dosage of a drug called gentamicin. It's a particular class of

antibiotic which, if given in excess, results in damage to the kidneys. We would get patients from referring hospitals with serious illnesses because they required an antibiotic, but they were given excessive doses of the antibiotic and developed kidney poisoning. In several cases they developed severe and permanent damage to the middle ear, so they lose their sense of balance.

On every occasion, we would not only spell that out in a discharge summary quite clearly back to the referring hospital, that this was a problem that had caused the kidney problem we were treating and needed to be addressed, but we would follow that up with a phone call to the referring consultant to explain that in more detail, to go through it, so they would understand the importance of monitoring kidney function at the time they give such an antibiotic.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you.

The only document that I think we've been able to find from the Children's Hospital that might be construed as seeking to summarise for external purposes what happened is the inpatient/outpatient advice note. That can be seen at 317-041-001. This format of this is structured to go to the doctor.

A. Yes.

Q. So therefore, this is the information that the Children's Hospital will be providing, and this is what is recorded in relation to Raychel. If this was going to go to Altnagelvin or even to the GP, for that matter, for the purposes of educating them as to how the specialists at the Children's Hospital saw what had happened to her, is this the sort of thing you had in mind or did you have in mind something more detailed?
A. No, this is what I would call an immediate discharge summary, in this case an advice note, which is written almost immediately after the person is discharged or, in this case, died, which gives a very brief summary of what happened. And I think you can see that under the comments section. But it says nothing about how that arose or what the possible significance of that was.

A discharge summary would be in the form of a more considered letter or pro forma with a degree of commentary, which would enable the doctors receiving it to understand not just the bald facts which are recorded there, but what gave rise to that particular sequence of events and the importance, perhaps, of some of the underlying treatment or other things that had occurred.
Q. So that kind of information, irrespective of the form it's put on, that kind of information goes to Altnagelvin, that feeds into their process and assists

them, that kind of information goes to the GP, who is therefore a resource point for the family, presumably they have -- usually families have a better relationship with their GP than they do with the specialist.
A. Yes.
Q. Their GP can take them though it, particularly in a fatality where there's all sorts of sensitivities about when and how you can communicate information, work through it with them and help them, insofar as it can be done, understand why their child died.
A. Yes.
Q. That would be the importance of allowing the GP to have that kind of information --
A. Yes, exactly.
Q. -- and deal with any questions and all that sort of thing?
A. Yes.
Q. Thank you. And would that be irrespective of whether the hospital had in mind having a meeting with the family? Would you still provide the GP with that kind of information?
A. Yes. Yes, of course.
Q. Thank you. Just staying with the issue of information and the Children's Hospital specifically. What I want to ask you about is how the Children's Hospital might

have or ought to have, in line with the standards prevalent at the time, compiled information, data, on the outcomes for the patients in paediatric intensive care.

The Paediatric Intensive Care Society produced standards in 1996. We have seen them here. The reference for them is 315-015-015. I'll just see if we can pull that up -- yes. So this is the 1996 and it has come up at this stage because this is just the particular place. It deals with data collection and audit.

If you see there, it says:

"In order to assess the performance of an intensive care unit, it is necessary to collect information and undertake audit."

Then it goes on to deal with the sort of thing or the sort of details that should be collected:

"Details of all admissions, collection of patient data, analysis of morbidity and mortality. In addition, data should be collected with particular attention to age, previous health status, duration of stay, diagnosis, diagnostic category, severity scoring, nurse dependency scores, therapeutic procedures, outcomes and complications."

So a whole raft of information, which, according to

this standard for Paediatric Intensive Care Society, ought to be being collected. This is 1996, of course. By 2001, in your experience, was that kind of data being collected in paediatric care units throughout the rest of the United Kingdom?
A. Oh, I don't know about the rest of the United Kingdom, but that's the kind of data that was certainly collected in both adult and paediatric intensive care units in Scotland. Certainly the one I was responsible for.
Q. So if one highlights in particular the analysis of mortality, to what extent, if you were collecting information in relation to that, would you be able to identify whether a condition like hyponatraemia had been implicated in the child's death?
A. I think the purpose of the collection of data is then to be able to analyse it and to draw appropriate conclusions in order to improve the care of these very sick children or adults. So it's the analysis of the data that's really important. In my experience, the analysis would usually focus on two kind of aspects. One would be on the common things that are going on in the intensive care unit, so if there were common complications, for example, of a chest infection following the insertion of a tube into the trachea, then if that was a particular problem, particularly if your

trend analysis showed it was getting worse, then that would trigger a whole discussion and further examination of why were we getting more of that complication. And you'd put some actions in place and you would expect, as your monitoring continued, to see that either stabilising or, hopefully, coming down and being resolved.

So the analysis of all this certainly focuses on the common things that are going on with the majority of patients, but they'd also focus on the unusual. So if you get unusual complications of care occurring then the doctors -- most doctors I know undertaking this analysis would spot that and if they began to collect one or two or three events over the course of a number of years they would want to draw that to everyone's attention.

Because the rare things are very important because (a) they don't happen very often so you need a period of time to collect them. But secondly, if they're rare and fatal, it really is important to try and put something in to place to prevent them happening. You really want to understand that situation rather better.

So that, in my experience, is what the analysis of these audits would have concentrated on.

Q. And if you were collecting information like that, how

often would somebody be reviewing it? Because it's all very well to collect it, but in order for it to be of any use, somebody has to be looking at it, understanding what it means and interpreting it.

A. The major analysis would be carried out, I'd imagine, every year. The majority of intensive care units -- in fact all of them in Scotland at least and, I think, across the UK -- will prepare an annual report, which is nowadays publicly available, probably not in 2001, but certainly available within the institution and across the healthcare system. So that would be annual. But there's plenty of opportunity during the course of any one particular year, if an unusual number of odd things happened, for the person looking at that data to alert their colleagues to the potential for something unusual going on.

I think most of the doctors who maintain these databases -- there are two things. One is they'd probably look at the data every month to see if there's anything odd happening, but secondly, as they're the ones who often input the data or validate it when others are putting it in, they would spot something unusual at or soon after the time it was entered or noted.

Q. There was a report done on paediatric intensive care, the "Framework for the Future" report --

A. Yes.

Q. -- which was a report that was considered in Northern Ireland as well. It was a report for the National Coordinating Group on Paediatric Intensive Care, specifically to the chief executive of the NHS Executive, but the outworking of it were shared in Northern Ireland as well. 1997 is the date of the report.

If one goes to 315-016-054, this is how the report deals with audit and research here. It talks about the implications for audit and the requirement to build up a picture of the current pattern of care for critically ill children within that area. The second significance of audit is:

"It relates to ongoing clinical audit of the standards of care being provided."

Then it goes on to -- if we go over the page to 055 -- how you're going to do that, and I think this echoes something of which you have said. If one looks at paragraph 116 it talks about clinical audit. They're saying that's well-established in 1997. The view was:

"All those providing paediatric intensive care should collect, as a matter of routine, information on case-mix, including illness severity, method, type and source of admission, the mean and median length of stay,

main therapeutic interventions and the outcome for critically ill children who have been treated in the hospital."

And of course, the outcome might be death.

Then over the page, at 056, it goes on to develop that by saying that, at present, the only outcomes that they were at that stage recording and considering were mortality or survival. But then they go on to want to drill down a little bit more into the data to look at how the care has reflected the quality of life, which is an even more subtle thing to try and assess.

So if that was happening in 1997, or at least that was what was thought ought to be happening, what you have just been describing to the chairman as the benefits of doing it and what you would anticipate was going on, is that something that would relate to 2001? The systems that you described in relation to paediatric intensive care, data collection, how that would be used, are we talking about 2001 or are we talking about 2013?

A. No, I think we would be talking, certainly in the early 2000s, that a majority of units would have responded to that report very positively and started collecting the data. It depends partly on how well they were set up for data collection in the first place. There is a cost to collecting data, so the more data you collect then

you have to consider whether the people working in the unit can collect it at the time or whether somebody has to be given particular time to do it or whether indeed somebody else is employed to input it, in a very large adult unit, for example.

But by certainly 2001 to around that time, I would have thought that the majority of intensive care units would have been collecting that level of data, and certainly they'd be collecting data on morbidity and complications as well as mortality. And they would be collecting some process data in terms of treatment that was given. That might have focused on the respirator side of things, but would probably also include antibiotics and common drugs that were given.

Q. When you talk about the costs of -- all these things have costs in the same way as you discussed with the chairman the cost of perhaps implementing all of an NCEPOD set of recommendations. But does that not require decision-making?

A. Yes.

Q. Somebody makes a decision as to what is the kind of data that we're going to collect --

A. Yes.

Q. -- and so somebody has to or a group of people have to turn their minds to: what do we require, why do we

require it and what is the best way of collecting and compiling it?

A. Yes. That's right.

Q. In terms of the evidence that we've heard about the data that was being collected, the PICU system had a separate system from the rest of the hospital and its data, which we've been given to understand is not particularly unusual, that did happen. Would that be your experience?

A. Yes.

Q. And the last actual audit of PICU data was done, at least that Dr Taylor who was a consultant paediatric anaesthetist recalls, was done in about 1994, and there hadn't been one as at the time of Raychel's death in 2001. His view of the data that was being collected is that it had its failings and largely those failings were due to the way it was inputted because the data is obviously only as good as the person who's putting it in, and he hasn't explained whether there was a validation system. But in any event, the clinicians were putting the data in themselves, the PICU secretary was the one who would collect it and make it available to anybody who wanted to use it. So he described that as a flawed system and one that couldn't really be relied on to give you, with any degree of accuracy,

a picture as to what was happening in relation to certain sorts of things, certainly in relation to the incidence of hyponatraemia.

And you probably appreciate that the CMO at some stage wished guidelines in relation to hyponatraemia to be developed and for those purposes a working group was established. And as part of that, Dr Taylor was asked to put together a background piece and he took it upon himself to, in addition to doing that, to actually compile a bar chart to indicate the incidence of hyponatraemia. We can look at it, it's 007-051-103.

That bar chart was sent to the person who was chairing the working group, Paul Darragh, and it has found its way into other places as well. Dr Taylor has always said that that was a draft, it was raw data and shouldn't be relied on. That's not indicated on that. Can I just pause there and ask you that: if you were providing a chart like that, which should be qualified in that way, is that something that you would expect to see on the chart itself?

A. Well, either on the chart or in an accompanying letter or document that came with the chart --

THE CHAIRMAN: He says that the meeting at which this information -- the bar chart was not before the working party, he gave the information, but he says he

emphasised that it was imperfect.

MR UBEROI: I might also add that in the covering e-mail alluded to by the witness, he referred to draft documents.

THE CHAIRMAN: Yes. So what happened, perhaps curiously, is that this chart was not put before the meeting, but that the doctor who'd prepared it provided the information on the chart at the meeting, but says that he told the meeting that it was draft or couldn't absolutely be relied on, which would seem to be the equivalent of what you would expect on a covering note.

A. Yes.

MS ANYADIKE-DANES: Then would you have expected, though, Dr Taylor to be able to access -- we're talking about 2001 now -- accurate information to provide to any meeting which concerned the incidence of hyponatraemia? Would you have expected a system to have been in place which would have allowed him to do that?

A. Yes. All data collection systems are at risk of being inaccurate because of data input and the risk rises exponentially with the number of people inputting the data. So it is extremely important, when you're compiling an audit system, particularly one which is dealing with very serious issues, including death and major morbidity, to agree precise definitions for

things. Death is fairly obvious, but other things are not. And to agree who puts them in and probably under what circumstances, because you don't want them to be distracted, for example, while they're inputting the data. They should have time to do that.

So it is very important, when you use a data set like this to drive an argument for change or improvement, to understand the limitations of the data and be very clear about that.

Q. Yes.

A. And just looking at this, one immediate observation would be that if you didn't know some of the background, you would imagine that between 1991 and 2001 there had been a low level of hyponatraemia up until 1994, and then in the intervening three years there was a sudden increase in the number of cases. The explanation might be rather more mundane, which is that the 1997 report was being enacted and actually more was being recorded subsequent to 1997 than in previous years. So I guess that's an illustration of how important it is to understand the genesis of any diagram like this and its limitations before anybody else puts a good deal of weight on it.

Q. Yes. Dr Taylor, in fairness to him, was doing the best that he could with the information that was available to

him, which he has readily conceded was imperfect. But that's all that he had.

A. Yes.

Q. What I want to ask you about is whether that should have been all that he had. In fact, three deaths are missing from there. Adam was a death in which hyponatraemia was implicated in 1995. That death is not on there. Dr Taylor was aware of it, but it wasn't in the system. So if he's asking for the information to be generated by the system, it's not coming out of the system.

But the other two, Lucy Crawford and Claire Roberts. If we start with Claire Roberts. She died in October 1996, so you can see that death is not there either. What they did have in relation to Claire on the PICU system, if we just pull this up, 090-055-203 -- that's a PICU coding form. We've been told by the DLS that the PICU coding form was mainly to record admissions and treatments. It wasn't to record diagnosis in that way. But nonetheless if you look down, you certainly can see the admission and you can see the treatments and therefore the resources that have been used. But you can also see that there is some diagnosis on it or appears to be. "Hyponatraemia" is there, "hypernatraemia" and "hypokalaemia", which she developed.

So the term hyponatraemia is associated with her and she has a case note discharge summary -- I'll give the reference, but not to be pulled up, 090-009-011 -- and in her case note discharge summary, under "other diagnosis" is recorded:

"Hyponatraemia after cerebral oedema and status epilepticus."

The "other diagnosis" is "hyponatraemia". So hyponatraemia is there on the paperwork, if I can put it that way, in relation to Claire. But nonetheless, it did not find its way into the PICU system so that when somebody like Dr Taylor wants to interrogate it to see what the incidence is, he can't get that information from it.

If I give you the other example, which is Lucy Crawford --

A. Can I just respond to that one?

Q. Yes, of course.

A. So in relation to the guidance issued in 1997, that's actually a pretty good list of the kind of things they were asking for, and it does include a number of procedures, it includes fluids that were given, it includes complications as well as the fact that the child died.

Now, I don't know how the PICU system was set up,

but there the doctor or somebody has gone through that and recorded all these things that they think are relevant that they want to code and put into the system. The question I would have is: was the system set up to deliver that? Were there codes in the system for all of these things or not? And it may be that one of the things that intensive care units had to do following the 1997 report was to either buy a new system or do some work configuring the existing system so that all of these terms could be coded, if you see what I mean. You might need to enlarge the dictionary very considerably. If your dictionary had been relatively short and confined to kind of Florence Nightingale's work -- discharged or died, or whatever the three categories were -- if that's all your dictionary was, and that was the state of affairs in 1996/97, then you would have to work quite a bit to change your system to include a much larger number of terms that are described very well by that report.

Q. You said that that was obviously what the doctor wanted to have recorded. This is a senior paediatric consultant anaesthetist who signed that, Dr McKaigue. So if your system couldn't record the things that the clinician thinks ought to be recorded, then does that not become a point of discussion as to what are we going

to do about this? Do the clinicians really think that's quite important and decisions have to be made or is that just them simply giving a list of all that occurred in relation to that child and they don't envisage a need to have it all recorded? Some decision-making would have to take place, would it not?

A. Yes, it would. You'd need to ask him, but I imagine he wouldn't have spent time constructing this list if he didn't intend to put it into the system, if he didn't intend for it to be of some use.

THE CHAIRMAN: If you look at the bottom line of the form, professor, the form is to be retained in the unit for the coding clerk.

A. Yes.

THE CHAIRMAN: So that sort of gives the game away, that's exactly what it's to be used for.

A. I think there's a distinction, though, because the coding clerk might not be the coding clerk for the PICU system; I would think it's more likely to be the coding clerk for the hospital. So in the main hospital system, Patient Management System or Patient Administration System, all of these things would be coded because these are covered by what are known as ICD10, or in those days it would have been ICD7 or 8, codes. That's the international coding classification system used in

hospitals in the United Kingdom to record both what happens and also what is done to a patient.

So that list could be retained for that purpose as well as inputting into the PICU system. It's not clear to me which.

MS ANYADIKE-DANES: If it was going to both then you would certainly hope, if you were doing any interrogation of the systems, to find out the incidence of hyponatraemia. You would get it one way or the other.

A. Exactly, but if the PICU system didn't have those terms in it and they couldn't be entered, then you wouldn't be able to retrieve it later. That would be one weakness of it. And one of the reasons for keeping a written form is that you have got a backstop, you've got something you could go back to and look through manually later if you really had to.

Q. So if you knew your system was rather limited in its categories, that would suggest that you would go and look at -- well, actually, it'd be very difficult, would it not, because you don't know what you're looking for? Nobody's going to tell you this is the file you ought to look at because in there is a PICU coding form that has "hyponatraemia" on it. That then makes it very difficult to investigate.

A. Yes, it does, and you were asking earlier about how

Dr McKaigue had wanted to record things and couldn't, that I'm sure would lead to a conversation and discussion between consultants, who would need to agree what it was they were going to record because they would need to commission somebody from the IT department or a separate supplier to ensure that those fields were available for coding within the system. So there would have to be conversation and agreement about what we're going to do going forward.

Q. If we just look at Lucy, that has an additional document and I'm going to ask you your interpretation of it. Her equivalent of the PICU coding form is 319-019-002. So this is now 2000 as opposed to 1996. It's signed off by the same consultant, McKaigue, and you can see his list, what she arrives with, what happens, and then the resources used, the central line, the arterial line, CT scan, and also some diagnostics. Hyponatraemia is included in there.

A. Yes.

Q. How she's coded -- I'll pull up two pages for you to see, 319-067e-002 and then 003. If I can have them alongside each other. So you see that this is Lucy, Dr McKaigue is the consultant. You see when she's admitted, the time and discharge, that's the date of death and so on. The transferring hospital, the Erne:

"Primary diagnosis, cerebral oedema. Other diagnoses, hyponatraemia."

And you see the codes that you've been referring to.

A. Yes.

Q. So that would suggest it's in the system somewhere, or would it? I should have asked that as a question.

A. Certainly of the things we've just been talking about, they're now coded in the system and so they could be retrieved, yes.

Q. So if you were seeking to see what the incidence of hyponatraemia is and that's your search word, then the way it should work is that this should become available to you?

A. Yes.

Q. Thank you. And in the course of your work as medical director, or even your work as an executive in the hospital, how important to you was the compiling and retaining of data?

A. Well, in some senses very important indeed. So for example, audit data was very important in terms of two aspects, really. One was identifying whether there were deficiencies in care in a department, and therefore steps needed to be taken by the clinical director and others locally to improve that position and a re-audit would happen to show that that was happening. It's also

a superb opportunity to find excellence in a department, so if an audit or data set you're looking at shows that the performance and the quality of care is excellent, that's also extremely important to be shared with others so they can see which aspects are being dealt with particularly well and learn from that and find out how they could do it too.

It's very important for public assurance, so I would use data a great deal in my bi-monthly reports to the board, both as a trust and then as a health board. The use of data to me has always been extremely important in demonstrating whether or not we have good quality services, whether we have excellent services that we can be proud of, or whether we have services where further work is needed to bring them up to the standard of everybody else. So in those senses, data is absolutely vital.

It's extremely important also to keep data so you can -- at least for a period of maybe five years, maybe longer, depending on exactly what it's about -- see the trend over time and you can be assured that in the organisation things are getting better or they're staying the same or they're getting worse. Is that what you're asking about?

Q. Yes.

A. So data in those senses is absolutely essential and really has been, I think, since the 1990s.

MS ANYADIKE-DANES: Thank you very much.

Mr Chairman, I was going to go on to ask the professor to deal with the review. Since that's a different area, I wonder if that might be a time to take a short break.

THE CHAIRMAN: Yes. Professor, we have to take a break for the stenographer, so if you'll allow us 10 or 15 minutes, we'll resume then.

(12.18 pm)

(A short break)

(12.42 pm)

MS ANYADIKE-DANES: Mr Chairman, I should draw your attention to something which my learned friend Mr McAlinden has kindly pointed out to me. It relates to the risk registers. There was a circular sent out from the Department in 2002. We will get these paginated so people can see them, but suffice it to say it's titled "Governance in the HPSS: risk management. HSS (PPM) 13/2002". What it essentially says is that although risk registers may be something that are going to be required in the rest of the United Kingdom, for Northern Ireland purposes, the trusts were not to institute that until Northern Ireland had been able to

develop its own system. And that didn't actually come in until 2003, and that's referenced in the same thing, "Governance in the HPSS: Risk management and controls assurance, 5/2003".

So we'll get those, but it would appear that, whatever was going to happen in the rest of the United Kingdom in 2002, the Department here didn't want trusts to respond to that until they had issued their own guidance, and that didn't happen until 2003.

Can I ask you, before 2002, were trusts in any event keeping, if they're not called risk registers, something to perform that function?

A. Well, certainly mine was and I'm aware of others that were, because it was -- during the 1990s, risk management had been one of the kind of dominant themes running through the NHS, as it were, prior to quality and safety. So certainly in 1996, I was then at that point compiling and developing a risk register for my organisation. I'm aware that other medical directors in Scotland were doing that as well.

Q. Thank you. I want now to take you to the review that was conducted at Altnagelvin into Raychel's case. You say in your report, which we don't need to pull up, but it's 226-002-013, that:

"The trust should have been aware of these gaps

[those gaps being the gaps that were identified] in clinical care, but these were not addressed until after the tragic death of Raychel."

That picks up a little bit a line that the chairman was exploring with you: how do you know that you need to know something until something has happened like the death of a child? What did you mean by that statement in your report that the trust should have been aware of these gaps in clinical care?

A. Well, I think I was highlighting there two particular aspects. One was whether Mr Gilliland had the opportunity in his normal working timetable to devote time to going to the paediatric ward when he had children that were there. That seemed to me -- I was unclear about whether he routinely did that or whether there were days when he didn't do that when there were children there, and that may well have been because he had other constraints on his time.

Q. You mean in terms of a post-take ward round?

A. A post-take ward round. In those circumstances, I find it difficult to believe that a clinical director at least wouldn't have been aware of that sort of constraint and time pressure.

The second area was in relation to the NCEPOD report and the issue of whether the junior doctors should be

informing the consultants about patients admitted under their care and certainly before they were going to undertake surgery. If that report had been examined and the practice at Altnagelvin examined against that standard, then they would have known that that was not routinely happening. So it was those two particular aspects that I was concerned about.

Q. Thank you. Then very shortly after Raychel's death, the trust establish a group to look into and investigate her death, and they use their critical incident protocol to do that. We can pull that up. It's 095-011-059a. In terms of a protocol, do you have any comments about that?

A. No, I think it's, in general, a good protocol. It indicates that the relevant people are informed. Importantly, there's a record made of the incident. And then the rest of the protocol goes on to describe what should happen next and what the review team or meeting should do. Interestingly, the chief executive is to be kept informed throughout the investigation and then there's to be a written report and conclusions with recommendations and timescales. So that's a very good process.

Q. So that's the output. And if you have that and you've got your timescale, that allows you to revisit and to

see whether the recommendations have been complied with within the timescale and, if not, why not, and also, presumably, how effective they've been in addressing the original assessment of the problem.

A. Yes, exactly so. The output of a critical incident like this, as you can see, drives the clinical audit and other data collection.

Q. So this is a good example?

A. It's a good example, yes.

Q. Thank you. Then if I ask you about the kinds of investigations that actually happened into Raychel's death. This was obviously a protocol to guide the critical incident investigation. If we leave the investigation that Dr Fulton, who was in charge of this process as medical director, to one side and if I ask you: in your view, was there any other sort of maybe lower level or slightly different investigation that should have been carried out by any of the clinical or nursing teams?

A. Yes, I think the consideration of a critical incident would normally occur at multiple levels in an organisation, perhaps sometimes the bigger the organisation, the more the levels. Starting from the top, this was a very serious clinical incident and so it was quite right that the chief executive is informed, is

part of the process, as indicated by the flow chart, and that the lead director to take charge of this is the medical director. That seems to me a good way of doing it and ensuring these sort of right things for the organisation are considered. And it also gives a level of authority, which is important.

But irrespective of that process, I think there are other processes that ought to be occurring at the level of the clinical team, which may not be investigated in detail by the trust-wide process simply because they might not go into that level of detail or, if they do, they might expect others to carry it out, or indeed the team examination of what went on would inform the trust-wide critical incident review, and indeed, in many organisations, that would be the kind of way in which some of the work would be sub-divided, as it were.

So one area that I haven't seen much evidence of in the paperwork I've been provided with is what happened within the surgical team for a start. So here you had a situation where the consultant didn't know the patient was in the hospital, didn't know that they'd had an operation, subsequently didn't know the things that flowed from that operation; for example, there was no temperature, normal white count and the appendix was normal, so that side of things. And then subsequently,

there's a whole issue about the prescribing of fluids and the supervision of the post-operative care and who was to be monitoring the post-operative situation in order to ensure that the child recovered in the way that everybody expected after a completely uncomplicated operation and not a severe illness.

So I would have expected some kind of meeting between the principals involved, either the surgeon or the clinical director for surgery, but preferably the surgeon, together with the junior doctors and probably the nurses, to look at the detail of: well, where did we go wrong, what sort of things were happening that we could begin to put right, what is our understanding of what led to this tragic, tragic event, what were the roles we played individually and how could we consider doing things differently, what latent defects are we discovering in how we work and how can we put those right? So it's a huge opportunity for learning.

I think it's very important for the functioning of a team to be able to have that discussion because people will be feeling terrible, really terrible, over an event of that nature, particularly when it's such an unusual event. I imagine the death of a child in that ward would have been appalling for all of those who were concerned. And that flavour comes out very much from

people's witness statements and what they have said here.

So to enable people to deal with that, I think having the conversation about what went on and reviewing everyone's part in it is extremely important because it enables people to say what they really feel, to say the problems they have encountered and also to reflect on some of the really good things that happen that they might want to reinforce.

It opens up a lot of possibilities and it enables a much richer discussion to occur at the operational and detailed level of the people who are involved than any trust-wide organisational review will do, unless they convene themselves, rather as this inquiry has done, and call all these people in and interview them, which would be the alternative way of doing it.

Q. So the result of that kind of discussion could be something that would feed into standards and practices elsewhere?

A. Yes.

Q. If I give you an example and see if you think this is a possibility. One of the issues was to do with record keeping, and let's assume that the consultant surgeon has got his team together and that would include the very junior doctors who responded at the latter part of

that main day of her treatment. It may emerge from that that he would have expressed a little disquiet that Dr Devlin hadn't recorded in Raychel's notes the fact that he had been called at a particular period of time and had administered an anti-emetic because, when Dr Curran comes later on, he can't readily see that that has happened and exercise any judgment about the significance of the fact that it hasn't alleviated the vomiting, for example.

A. Yes.

Q. That might lead, might it not, to some sort of issue as to whether we need to reinforce our training about record keeping, which could go somewhere else, to the training subcommittee or something? Is that the sort of thing you have in mind?

A. Yes, that is the kind of thing. Just to use that example, as I recall it, the trust policy for the prescribing of medicines to children requires two people to agree that something needs to be given and administered, and I think that was demonstrated by the two anaesthetists who were looking after the child at the beginning, but didn't happen subsequently. There's that.

I think the issue that has been referred to before in transcripts and in witness statements about

difficulties getting hold of the junior surgical staff, so the nurses were concerned and had difficulty getting hold of people -- that's the kind of thing that could be discussed at that kind of operational level. And I'm sure those people would find a solution to that if they were empowered to do so. So that's one kind of meeting of the immediate team, which I think is important.

It has another important effect to, which is, I think, it helps to build the team, it helps to build the confidence of people in each other. If they have an open acknowledgment that they can discuss these things when they go wrong, I think that generally raises the level of trust and effectiveness of a team.

Q. Would you have expected, in 2001, for that sort of meeting to be taking place after an event like Raychel's death?

A. Well, certainly, where I work, that's what happens, so that would have been my expectation generally. I can well understand there are differences between hospitals, which vary considerably in all sorts of ways, but that's certainly what I would have expected in 2001.

Q. Then you said that was one sort of meeting.

A. Yes. The other sort of meeting I would most certainly have expected is that this case would have been discussed in the surgical mortality and morbidity review

meeting. Because it was unusual and a death in a child, I would have expected it to be forensically examined. My experience of surgeons is that, certainly in 2001 and in the years before that, is those mortality and morbidity meetings are taken seriously and the surgeons concerned are very concerned to examine deaths -- and particularly unusual deaths -- but also took the time then, and still do now, to examine complications. For example, bleeding or wound infections or whatever it is.

I haven't seen any evidence that that has happened. It may well have happened, it may just not have been recorded, but that again is an extremely important forum to have the discussion and for at least two reasons. The first is that you're able to discuss this with your peers, so these are consultants who are working in not just the same institution, but are facing the same daily pressures and difficulties that you are, so there will have been other surgeons who would have been on call at other times and operating on children and so on and looking after children in Ward 6. And that would enable them to share experiences, share their knowledge about what goes on and take a serious look about what they could do to prevent such a tragedy happening again. And that will almost certainly have brought up the whole issue of ward rounds, about the supervision of junior

staff, about communication in the evenings and so on and so forth. And I would have thought that was an important mechanism.

I can well accept that that might not have been recorded. In 2001 those were not commonly recorded or reported through the organisation. It was seen, I think, as a largely professional domain. But as the medical director, I would have expected my doctors to be doing that and, in fact, I know that that's what they did do. So that's the second kind of meeting I would have expected, a purely internal one.

Q. In terms of the critical incident review which you say was happening at sort of a higher organisational level, would you expect the medical director to have been informed that either of those sorts of meetings that you're talking about have actually taken place, or that they were going to take place?

A. He may have expected that the routine mortality and morbidity meeting of the surgeons would include this case and I think he would have expected some feedback from that meeting into his review, probably through the clinical director. That would be the normal route. It wouldn't necessarily be written down, but I think there would be some clear messages or recommendations coming from the group of surgeons, because, after all, this is

their opportunity to improve things, this is their opportunity to enable some change perhaps in systems that they find frustrating to work in. That's one good reason for doing it. Yes, I would have expected some two-way traffic between the medical director and the surgeons.

Q. Then if we go to the conduct of the critical incident review itself, so the process that was instituted by Dr Fulton. Can you comment on, in your view, how that should have been conducted, who should have been part of it, what should have happened to the outcome of it?

THE CHAIRMAN: Can we approach it in this way: on the evidence I have heard, professor, and subject to anything that you're about to add to your written report, there were some aspects of the critical incident review which were actually handled pretty well.

A. Yes, there were.

THE CHAIRMAN: And there were many relevant lessons learnt, which were entirely appropriate to learn.

A. Yes.

THE CHAIRMAN: Perhaps not all, but at least some of them.

A. Yes.

THE CHAIRMAN: So this wasn't some sort of hopeless review at all.

A. No.

THE CHAIRMAN: It touched a number of the bases. So could we focus on any areas in which the review was, by the standards of 2001, defective? On the protocol, which is on the screen in front of you, I'm not so much worried, subject to whatever you say about the lack of a written report to start with, I'm more worried about the lack of a written report and recommendations at the end.

A. Yes, I'd agree. It's the output that is important. But in the process, it says there to:

"Clarify the circumstances surrounding an incident and identify further investigations."

That requires people to be able to stand back and look a little laterally at all of the things that were going on. And to be fair to the people concerned, to do that well, you do need a bit of experience. You need to have done this before or to have other people in the room who have undertaken a review before in order to understand how wide and how deep you need to go. And I don't know what the experience of the people was.

THE CHAIRMAN: To put Altnagelvin in perspective, what had happened was that in order to help draw up this protocol, they had brought over to the hospital a lady who was the co-author of a book.

A. Miriam Lugon?

THE CHAIRMAN: Yes. Which of course must be a very positive

step for the hospital to have taken.

A. Yes.

THE CHAIRMAN: And it does suggest they were taking this area seriously. This is obviously before Raychel died. It's on the back of her contribution that they draw up a protocol and, as you've indicated, the protocol, in its essence there, is entirely appropriate and should work well if it's followed. And in various aspects it was followed. But as I understand the evidence, this was the first time that there had been a critical incident review using this protocol, so subject to correction, nobody who was involved had any previous experience. Does that perhaps explain some of the shortcomings?

A. Yes, I think it does. I notice that at one or two points in the evidence you have heard that Miriam Lugon's book was referred to, and somebody had a copy that they referred to quite a bit, it was well thumbed, I think, was the phrase. I can't remember who that was, but that book I know quite well and it does go into this issue of circumstances and identifying all of the circumstances that could be important, and it particularly talks about looking at some of the latent conditions that might exist in your environment that allow things to happen. That was one of the things

I was referring to in my report.

But whether or not you're able to examine those properly and think about them, I think largely depends on whether you've either got someone advising you who's experienced or whether you're experienced yourself. So the kind of things I think were -- the critical incident review concentrated very much on the immediate, more technical aspects of what went wrong, so there was a heavy emphasis on Solution No. 18, a heavy emphasis on the proper supervision and administration of fluids, an emphasis on the checking of the urea and the blood electrolytes when somebody was on intravenous fluids, the recording of fluids, the recording of vomit, better record keeping. All of those things which are kind of more immediate and concerned around the immediate things that went wrong.

There was some reference to the ability to contact the junior staff. I think Sister Millar raised that, I think, at the initial incident, and it was recorded. But I'm not sure how much that was followed through and if people understood the implications of that. And there was certainly reference as well to the fact that Mr Gilliland hadn't been able to get to or didn't go to the ward that morning and perhaps didn't on other occasions, and that was in the context of doing other

things. So this whole business of the surgical team actually having a life and work somewhere else in which the paediatric ward didn't really figure as part of the routine day, although that was acknowledged, I didn't see anything that followed that through and, as it were, dealt with it.

Then that leads on to a whole lot of other related issues around staff training and education, which is that if you're looking after children on an occasional basis and if very occasionally terrible things go wrong, what should be the educational and training response that an organisation would need to put in place to try and prevent that? That's really quite a difficult question, but does need examining. So what would you do, for example, with the postgraduate programme for the trainees, particularly the surgical trainees? Well, here is an excellent example where you've got an incident which involves at one level the administration of a fluid that has led to a serious complication. So that could trigger, for example, an educational session within the normal programme for these doctors about fluid management after surgery. And that, of course, opens the possibility of other people contributing to that and thinking more deeply about what fluids they were using, how, who monitors it, who

prescribes it. And although all of that came along later and then the national guidelines came, if there hadn't been national guidelines, would that consideration really --

THE CHAIRMAN: I think, to be fair to Altnagelvin, they had started to change things in advance of the Northern Irish guidelines emerging.

A. They did.

THE CHAIRMAN: So it's another positive aspect of the review. They just didn't say, "We have notified the Department", which of course you would praise as the appropriate step, but even in advance of the Department's working party cranking up and coming out with guidelines, "We'll do something ourselves in the hospital".

A. Yes.

MS ANYADIKE-DANES: Professor, when you were responding to the chairman, you said that the review had focused very heavily on the clinical issues, if I could categorise them in that way. And when you started to give illustrations of those, they seemed very much the sort of thing that you had previously said you thought might emerge out of either the team meeting, the clinical team, or the mortality review that they would have had. And what you seemed to be doing was distinguishing

between those sorts of things and more systemic things that the critical incident process might have focused on if it was being fed the clinical issues from these other meetings that you've described.

I wondered if I could ask you whether what you had in mind in terms of the kind of investigation that could have happened at that more systemic level is the carrying out of a root cause analysis to look at some of those potentially more systemic failings? I think you refer to the root cause analysis being a tool that was fairly common in 2001. Is that something that you think might have been profitable to have conducted?

A. It might have been, but the root cause analysis is a particular technique that you have to learn. You are required to learn it and understand it and practice it. So for example, I never did the training in root cause analysis, but I was aware of its importance as a tool. In fact, I ensured that one of our clinical governance staff in fact did know how to conduct root cause analysis and they were extremely good at it. So that was in use in my organisation, not on a daily, weekly or even a monthly basis, but two or three times a year, a serious clinical incident would be investigated in that way. And it's a very systematic way of covering all the bases, if you like, and it's a very useful tool.

Although it was in use in my organisation and some others, I wouldn't want to give the impression it was common across hospitals in the United Kingdom, not at all. And indeed, the smaller the hospital, the less likely it would have been in evidence because it would have required somebody locally to have been trained in that to understand it and to be able to apply it.

Q. If we go back to the more systematic approach that you've talked about and looking to what the systems or practices might be that required change or reinforcing, one of the things that came out was the reliance -- which was considered ultimately, I think, to be an overreliance -- on a very junior doctor, pre-reg surgeons, who were really the first point of contact for the nurses, and they were making decisions which may have been decisions that were perhaps too serious for them to make given the level of their training and their expertise.

So the result of that or the change that came from that was to remove them, if you like, from the wards so they weren't the first point of contact. When you were echoing the chairman's view that you thought that at the end of this process it would be very useful to have recommendations in a written report, if that's going to be one of them, that having assessed what's going on,

one of the failings was that the junior doctors who dealt with this really were too inexperienced and we shouldn't really have them as the point of contact for the nurses. If that was to come out of it then would you not expect some system to be implemented to test how effective that recommendation had been and to see whether it causes other problems, for example, the other issue that was identified, which was the lack of access of surgeons to the nurses?

So if you remove the first layer that they were supposed to contact, are you going to change something at the SHO level to make sure they do now nonetheless have adequate contact with the doctors in charge of the patient? Would you expect something like that to be put in train so you could monitor that and evaluate how well that change in the system was working?

A. I think it's that monitoring and evaluation point that's very important. If you recognise that one particular set of circumstances is contributing to what went wrong and you then change those circumstances, then at the time you change it you'd also want to consider what monitoring or evaluation you were going to put in place to ensure that the defect you were remedying was in fact remedied. And so changing the grade of staff who were looking after patients is, in some senses, a reasonable

thing to do, but if you haven't improved the system of communication then it's unlikely to be any more successful. So you would need to check that the change you had made was effective.

Q. And leaving aside the fact of there not being a written report coming out of this process, have you seen any evidence that they had set up a system to monitor the outcome of the process to audit, to review it, to institute any revision to the changes that might need to be made? Have you seen anything like that?

A. Well, there were some audits done subsequently in subsequent years around fluid management and I think around record keeping and so on, but I didn't see anything that addressed the issue of staff communication. I think that was --

MR LAVERY: I think in fairness, Dr Nesbitt did say during the course of his evidence that Raychel's case would have been discussed at mortality meetings, at morbidity meetings. Unfortunately, the minutes of those meetings only go back to 2004 and we don't have the minutes of those meetings, but that was his evidence.

THE CHAIRMAN: I accept that, Mr Lavery. I think the specific point is this: that a concern in Raychel's treatment is the level of seniority of Dr Devlin and Dr Curran who came to Ward 6 on the Friday afternoon and

evening, and that played in with the nurses' concern, which was discussed afterwards, about the level of responsibility which they were given. A decision was subsequently taken that from then on, if doctors were required, it would be more senior surgeons who would turn up.

MR LAVERY: Yes.

THE CHAIRMAN: I think the point that Ms Anyadike-Danes and the professor are on is this: since it was already proving very difficult to get any surgeon to the ward, which is why the junior surgeons were turning up, was there any subsequent monitoring of whether the more senior surgeons did subsequently attend in a reasonable time in response to contact? It seems to me that there must be a risk -- I mean, it's a positive step to say in these perhaps more complex cases or potentially more complex cases involving children who can deteriorate very quickly, the level of experience that a junior doctor can bring is, through no fault of that doctor, lacking, so we'll bring in a more senior surgeon. But if the more senior surgeon is already running left, right and centre, then how do we know how well that system worked? Or more to the point, how did Altnagelvin measure how well that system worked?

MR LAVERY: Yes. Mr Chairman, there's perhaps a dearth of

documentation in respect of that, but I should say that root cause analysis as such didn't come in until 2003.

THE CHAIRMAN: Absolutely, and the professor's said that, but we're really here on the follow-up to the review, so changes have been made, Raychel has died, it's June 2001, changes were made, they're introduced, some of them very quickly, some of them over the next weeks or months. Six months later, does anybody say, "Right, now let's see how things are functioning. Let's see, for instance, are the nurses still exposed or are the more senior surgeons coming reasonably quickly?" It's not by any means the central point in the case, but it's one about governance generally. Is that fair?

A. Yes, I think it is a fair summary.

MS ANYADIKE-DANES: Thank you. Just finally on the review itself, latterly those who took part in the review, in their evidence, some of them have made some frank concessions about the limitations of the process and how things might have been done better. Of course, that's always easy with hindsight to see that. But when you do conduct a review like that, particularly when it's the first time using the system, in your experience, is the very process something that you should, once you have completed that review, then look at it again and see how well did we carry that out, did that satisfy the

objectives we set ourselves for critical incident reviews? Is there any way in which you look at the process itself?

A. Yes. I remember the first critical incident review that happened in one of our directorates, the year prior to this, 1999 or 2000. It was the first time they had to conduct a review about an unexpected death of a patient. So they had quite a bit of support from other people who had done that, including one of the risk management -- a similar post to the risk management coordinator here. And then what we did, after that, when they'd completed the review is we had a debrief of the staff involved, about two weeks later, which looked at the process of the review itself and what they had learned from it and what we could tell other people in the trust about the difficulties of arranging a review, the success factors and anything else that could be learned.

MR LAVERY: Mr Chairman, there was Mrs Brown's evidence that Dr Fulton on the trust board would have been updated over the weeks and months after the incident, and there was a review meeting, a review group, which took place in April 2002. I appreciate, Mr Chairman, it was 10 months after the death, but her evidence was that Dr Fulton would have been updated in the interim.

THE CHAIRMAN: Yes. I think that's updating on what was

coming out of the review, which is close to but not quite the same point that we're on now, Mr Lavery.

It seems to me -- and I think we're about to lead into it -- that the two big, big concerns about Raychel's death are, first and foremost, the death itself and how it came about and, secondly, not so much the review, but the fact that in no meaningful way were the most important people involved, namely the Ferguson family, informed of the outcome of the review, of the mistakes which had been made and the lessons which had been learned. And as Mrs Ferguson's sister said yesterday, if that had been done at the meeting of September 2001, we might not be here today, and I'm afraid at the moment, and subject to anything that anybody says in submissions or later today, that seems to me a major, major concern about what happened.

MS ANYADIKE-DANES: Thank you, Mr Chairman. That was actually the final question I was going to ask on the review.

At the moment you have been discussing about the clinicians, nurses being involved, the senior executives being involved. In your experience, to what extent do the families get involved, and if not necessarily directly, by some sort of communication with them about what was going on and what the outcome of it was? By

directly, I mean literally being part of it.

A. In 2001, I think that would have been extraordinarily rare. I'm not aware of any --

Q. For them to have been in the room?

A. For them to have been involved in a review in that level of detail.

Q. But in terms of informing them that one was being carried out and what the outcome of that was, in 2001, what do you think would be the experience there?

A. A lot of that would depend on the context with which you -- or the process with which you dealt with the family after such an incident. Because the process you use, it depends -- the process you use dictates to some extent both the amount and the timing of the information you might give them. So if you didn't see the family at all and decided you're never going to do that, then you have no opportunity to do that. If you do see them and then the time at which you see them then dictates what you're able to tell them because you will only know at that time what it is you've found out.

Q. Yes.

A. I think in this context I would certainly have expected the family to know that there was a review going on into not just what happened, but what would be done to prevent that happening, and that would have been true

prior to 2001 for one overwhelming reason, which is that families consistently, in my experience over many, many years, have always said that what they are interested in is not just what happened to their own child or relative -- child in this case -- but what is being done to stop that happening again to anybody else. I'm always hugely impressed by that level of altruism in relatives and families. They're certainly interested in what happened to their own person, but also concerned to make sure it doesn't happen to anybody else.

So understanding the process of review and communicating with them broadly the lessons learned and what has been put in place, I think, is a key piece of the interaction with the family.

Q. Maybe we could go on to deal with that now. As you know, there was a meeting established with the family on 3 September. The critical incident review had started very, very shortly after Raychel's death in June. So there's a period of time. Even if the family didn't feel they could actually meet anybody from Altnagelvin in that period of time, what do you think should have been happening in relation to Altnagelvin and the family?

A. The General Medical Council's booklet, Good Medical Practice, is very clear about the responsibility of

doctors in 2001 following the death of a child. Although it doesn't give a timeline, I think it is clear in the intent that you would want to see the family and give them an explanation about what had happened and apologise for any failings that may have been known at that time or subsequently appear, really within a few days of this happening.

Q. And in the context of Raychel's case, who do you think should have been the persons from Altnagelvin doing that?

A. Well, I think it depends largely on where you take the -- where you decide the responsibility for her care and progress really rests. In my view, that essentially was with the surgeon who was responsible for her care. Although he didn't see her, although he may not have been aware of what happened, as far as everybody else was concerned that seems to be the notion, that he was in charge of her care. And although I accept and I agree that he needn't have been involved in the events of the early morning of 9 June when she was having the seizure and all that was happening, because there was no surgical contribution at all -- in effect her care had been taken over by other consultants -- I think in the context that here's a girl who was brought into hospital by her parents for an operation and had an operation

under the care of the particular surgeon, that it would have been that person who would have either initiated or certainly have been part of an early meeting with the parents to explain what had happened.

Q. And from what you have read as the evidence of what had already happened -- if you're leaving a few days, then the first critical incident review meeting has already taken place. From the evidence that you have heard of what happened and what the views were in relation to the clinicians and nurses, what is it that you think should have been being communicated to Raychel's family at that point?

A. I think an explanation of why her brain -- well, first of all, there was gross swelling of her brain that caused her death. I'm not clear whether the Fergusons understood that at that point. Secondly, that that was caused by the sudden drop in the serum sodium levels, plasma sodium, so it's associated with this term hyponatraemia. And I think that this initial meeting would have to spend a little time explaining some of the medical terms and so on involved because otherwise, as these get bandied about, and particularly there's an inquest and everything else coming later, it's helpful for the relatives or parents to have some understanding of what you're talking about.

I think it would also include an explanation that there is a review, we are doing a detailed review of this particular incident and sharing some of the findings of that review, at least some of the earlier ones: we think the solution was of pivotal importance here; we recognise that your daughter was not recovering in the way that a normal, uncomplicated child after an appendicectomy is recovering; the vomiting, although initially acceptable, as the day and the evening wore on was clearly out of line with what was expected, and that was understood, I think, at the time.

So I think the initial communication would include those concerns as well and, "These are the things we are looking at in detail", and would be then followed up by an invitation saying, "We'll provide you with further information as it becomes available and can we agree to meet in X period of time?"

The other very important source of communication, I would imagine, for most families -- I don't know about this particular family -- would be with the general practitioner because the general practitioner is normally the person people turn to because they're in the local area and there's usually some expectation that they would have some understanding of what had happened. Often, they're the person who referred them

to the hospital in the first place.

I go back to the importance of the discharge summary. Although the one we were talking about couldn't have been prepared immediately, certainly within several days it could have been because the post-mortem's carried out quite quickly and the pathologist's report was really quite clear, and other factors were quite well understood, say four or five days after Raychel's death. So again, a properly constructed discharge summary would have enabled the general practitioner to have had some sensible communication with the parents.

And even more, I have to say I was troubled by the evidence, I think provided by Mr Gilliland, that the communication with the general practitioner on this occasion took place in a supermarket at some point after the event. I think I've got that right.

THE CHAIRMAN: Yes.

A. Apart from my surprise at the appropriateness of having a conversation about this in a supermarket, I do understand that in a community like Northern Ireland you do bump into people in the supermarket and it mightn't be entirely inappropriate to make some reference to it, but in my view that would trigger an immediate professional response: look, I need to speak to you, can

we have a phone call on Monday, can I come and see you? Or indeed, if a discharge summary had been provided, there would be an opportunity to have a follow-up telephone call with a general practitioner, perhaps after a few days or a week or the day after the discharge summary had been received, to say "Can I explain this to you any further and tell you what we're doing?", so if the family contact you, you're in a good position to tell them. Those are the kind of things that I would have expected.

MS ANYADIKE-DANES: In fact, what happened was, apart from the discussion that the family had or the information that they were given at Altnagelvin before Raychel was transferred and the information they were given at the Children's Hospital after she had been transferred, after she died they didn't really have a clear idea or an opportunity -- well, they didn't have a clear idea until the meeting of 3 September, which is some considerable time. Is that --

A. That's a long time. That's a long time gap. I don't know whether individuals attempted to contact the Ferguson family by telephone or by other means --

Q. Well, in fact --

A. -- in between times and were unable to meet with them because they were too distressed --

Q. The senior executive did offer a meeting --

A. Yes. She did, yes.

THE CHAIRMAN: Yes, there was a meeting offered.

MR LAVERY: I should say, Mr Chairman, there was the letter that Mrs Burnside wrote on 15 June, in which she expressed sympathy and indicated also that there was an offer to meet the family if they felt that that would have been of any help. That came very shortly after the death.

THE CHAIRMAN: Yes. So that was an appropriate letter?

A. Yes, I thought that was -- that was very good of the chief executive to take that lead in this particular circumstance is good.

MS ANYADIKE-DANES: Then what are you saying should have happened thereafter? That's why I prefaced my earlier question to you with: if the family didn't feel they could meet immediately, what do you think should have happened afterwards?

A. I'm really talking about the doctors. I think the doctors involved had a clear, professional responsibility. I think it's set out very clearly in that GMC Good Medical Practice, to -- I can't remember the exact words, but paraphrasing it, to give a full and frank account of what has happened, particularly following the death of a child. In my

view, the spirit of that is that should be done relatively quickly, not three months later.

So irrespective of what Mrs Burnside and the trust was going to do to meet with the family and others, at an official level, I think there's a professional obligation to be fulfilled. It may be that that was tried and the family felt quite unable to meet with anybody, and I can completely understand that, but I'm not clear whether it was offered.

Q. So then if we come to the meeting that was scheduled and took place on 3 September. What sort of preparation do you think should have been made for a meeting like that at the trust's end?

A. This is a very important and crucial meeting. It's the first meeting that the chief executive and other senior staff are having with the family following an unusual and tragic circumstance. So I would have thought there are a couple of issues that I picked up.

The first is that within the trust, I would have thought you'd have some kind of meeting beforehand for the chief executive to be fully briefed on where the investigation had got to and what the staff currently understood as being the circumstances that led to Raychel's death. So in no particular order, that would include the role of Solution No. 18 and what Dr Nesbitt

subsequently learnt, which I think he did communicate, it seems, I think, from ... He did talk about that in quite a bit of detail at that meeting.

I think the role of the excessive vomiting had been recognised at the critical review meeting the day after. I think I'm right in saying that.

THE CHAIRMAN: Well, it had been, except that at the critical incident meeting Dr Fulton became aware that there was a difference between the family's perspective on the extent of Raychel's vomiting and the nursing perspective on the vomiting. He has said that he wasn't able to form a view on that because what the nurses were in effect saying to him was, "Well, the family thought it was worse than we thought. We thought it was normal or not abnormal". That has now turned into a major issue.

But the chief executive did not know that that was an issue at all until she picked it up at the meeting on 3 September, which means, really, on what you just said a few minutes ago, that she wasn't actually fully briefed going into the meeting.

A. Exactly. I think if she had been, she might have been able to deal with that issue.

THE CHAIRMAN: Or she might have been able to say, "What is the outcome? Has that been investigated? What is the

outcome?"

A. Yes.

THE CHAIRMAN: Because on any view, Raychel was not expected to be vomiting late into Friday night.

A. No.

THE CHAIRMAN: She was expected at that point to be probably off fluids and to be eating, if not normally, then something close to it.

A. Yes.

MS ANYADIKE-DANES: So you would have thought that there would be some sort of meeting where the chief executive would be briefed, she'd know what the up-to-date position was. Leaving aside decisions such as how we're going to manage the meeting, who should be there and that sort of thing, but do you think there should have been any consideration given as to whether we should, ahead of the meeting, involve the patient advocate?

A. Yes.

Q. If I just help you with that, we have heard from the patient advocate, and if you have read her evidence you'll know her extremely limited role at that meeting. But if one puts up even just the first page of her job description, which is at witness statement 325/1, page 8, these tasks and roles applied to 2001, even though this happens to be a version from 2005. Even if

one, as I say, leaves aside the rest of the pages and just stays with the general description of it, the role is:

"To be a focal point for patients and relatives."

And the purpose, you see at (i) and (ii), is:

"To ensure that the patients and relatives are assisted in making known their concerns and dissatisfactions and the administration of patients' and relatives' concerns and dissatisfactions so that the quality of the service can be optimised."

And then there's a list of responsibilities and key tasks, presumably that have been identified as hopefully leading to achieving that objective. And you can see there:

"Assisting individual patients with their complaints. To support patients and relatives in making a complaint. Ensure that each complaint is fully investigated."

At the stage of the meeting of 3 September, there had been no official complaint in that way, but notwithstanding that, do you think that some consideration might have been given to the use of the patient advocate in the way described at (i) and (ii)?

A. Yes, I think the key responsibility I would pick up there is:

"To assist individual patients with their complaints, concerns, enquiries and commendations on a confidential basis."

I think given the importance, given the sensitivity, given the high emotional state of some of the people participating in that meeting, particularly from the family's perspective, that the patient advocate could have fulfilled a very important role there, particularly if she'd had a pre-meeting with the family. Because that would have enabled her, in advance, to understand what the family's complaints, concerns and enquiries were. It would have enabled her to help them frame them in a way that the senior people at the meeting would understand, would have helped them to have -- well, they could have had a discussion about: do you want to ask these questions or do you want me to ask some of these questions? Because sometimes it's very difficult for family members to question senior individuals, particularly clinicians, and the role of a patient advocate, certainly according to this description, could have included that role.

So the key bit here where "patients and relatives are assisted in making known their concerns and dissatisfactions" could have been fulfilled by the patient advocate having a pre-meeting with the family to

determine exactly those things and then to be there for support during the meeting. My understanding of the role here is that the patient advocate is there for the patients or family, in this case; it's not there on behalf of the organisation. And although they might make notes for their own file, that wouldn't have been their principal role in the meeting. And if they were concentrating on taking a minute for the organisation, then they would find it difficult to be able to assist the patient because they would have difficulty listening to the conversation and understanding where help was required. So I think that was an opportunity missed.

MR LAVERY: I think in fairness, Mrs Burnside, when she gave her evidence the other day, said that the role of the patient advocate would be to listen and then subsequently to act with the family as they wished to go forward, and the minutes of the meeting show that, on a number of occasions, Mrs Burnside did indicate to the family that if they did want to meet with any of them subsequently, the door was open and the patient advocate would have been introduced --

THE CHAIRMAN: That's right --

MR LAVERY: -- to the family at the beginning of that meeting.

THE CHAIRMAN: That's right up to a point, Mr Lavery, but it

all rather drifted away because Mrs Burnside recognised that the meeting hadn't gone well. She knew and everyone -- I mean, Dr McCord, it is, who's described the meeting as a disaster. Mrs Burnside knew the meeting had drifted away and ended unhappily. But then Mrs Burnside said she thought that the family was so upset that she shouldn't contact them in the coming weeks and then there was no contact with them whatsoever. So if --

MR LAVERY: She left the door open for them.

THE CHAIRMAN: Look, I will take submissions on this, but frankly I have to say that, at this stage, my view is that that's not good enough. One of the major problems here is Mrs Burnside has told me this was a unique meeting in her experience. She is a chief executive meeting the family and I think the professor has said that's very, very commendable and very, very unusual. If you have that meeting with the family, you have to put some preparation into it. The preparation was absent. The meeting then takes place, the trust side have a record of the meeting, the family don't. The trust side have a record of the meeting, which is sent round three people to give them an opportunity to correct it or amend it. The family never gets a record of the meeting. And then, despite the

trust knowing that this has gone badly and that the family are still upset, that's the end of the contact. I think that the idea behind the meeting was fine, the fact that the meeting was offered through the chief executive is a sign, another sign that responsibility was being taken on Altnagelvin, but it's hugely frustrating that the implementation of that idea was so defective.

MR LAVERY: I accept that there were deficiencies, Mr Chairman. The point I was trying to make was that during the course of the meeting Mrs Burnside realised, obviously, that things weren't going well and did indicate that the family would have more questions to ask.

THE CHAIRMAN: But how would the family have the confidence to come back to the trust, which it had had such a poor meeting with, to get answers to the questions when it wasn't getting answers to the questions in any comprehensible way during the meeting?

MR QUINN: Mr Chairman, if I can come in on behalf of the family, and could I ask Mr Lavery and then the witness how on earth the patient advocate ever satisfied paragraph 1 of the criteria that says:

"Patients and relatives are assisted in making known their concerns and dissatisfactions."

I would like --

THE CHAIRMAN: You won't ask Mr Lavery that, okay?

MR QUINN: I'd like to ask the witness then if he can think of any way that in this case on this day that the patient's advocate assisted the family.

THE CHAIRMAN: But she didn't because she wasn't -- that wasn't her understanding of that meeting.

The lady who was the patient advocate, professor, had done that job on a part-time basis until the start of the week in which the meeting was held. So she knew what a patient advocate did, but she was brought into the meeting on 3 September in effect to keep a record of it. But not, at that time, with the function that is set out here. That's another problem because, as you've said, if she was brought in to fulfil that function she would almost certainly have needed an advance meeting with the family to understand their concerns and to try to agree with the family, look, this is what I can offer you, I can ask the questions, as you've already said. But she didn't do it.

MR QUINN: That's the point I'm making. Mr Lavery is on his feet to defend Mrs Burnside's behaviour in this meeting. But when anyone looks at this criteria, one cannot say in any respect whatsoever how the patient advocate in any way assisted the family.

THE CHAIRMAN: Yes, I've got the point.
A. I wanted to return to one of the other aspects of preparation for the meeting, apart from the patient advocate. That is how the organisation, how the trust was going to deal with the advice from the HSS on creating a climate of openness and so on to give a clear explanation to the family, and I think the phrase used is, for the purpose of avoiding -- excuse me if I just look at what I quoted "an environment of openness". This is from the HSS F20 1998 and, same number, 2002.
MR QUINN: If I may, sir, it's in paragraph 26 of the expert's report.
THE CHAIRMAN: Thank you.
A. "... which seeks to create an environment of openness that encourages parties to resolve duties, reduce delays and reduce requirements for litigation. The trust encourages staff to offer apologies and/or explanations as soon as an adverse outcome is discovered."
I think a pre-meeting would have been essential to develop that theme for the chief executive, not just to be briefed on what was going on, but to be clear with everybody that all the things that they already knew were to be brought out and communicated clearly with the family. I think that would have been a central part of the preparation.

MS ANYADIKE-DANES: Would that have meant that the clinicians themselves, from the medical point of view, would have to reach some sort of agreement as to what they thought had gone wrong so that when one's engaged in the meeting, one actually has some coherent expression of what happened rather than each individual speaking from their own discipline or their own experience of the case at that time?
A. Yes, that would have been helpful, to give a clear picture.
THE CHAIRMAN: And if it's right that the nurses were saying -- and this is one of the things that clearly hurt the family -- at that meeting that they had no concerns about Raychel through the day, would that worry you about whether there was some fundamental point which had been missed?
A. Yes. I do refer to that in the report. Because with that level of vomiting, there are only two possibilities. The first is that that's what happens to every child after an operation, so it's true, it's common, and it occurs. But that actually doesn't seem to be the case. Or they've failed to recognise that this was not a normal post-operative recovery.
THE CHAIRMAN: Yes.
A. There isn't anything in between those two, really.

MS ANYADIKE-DANES: So you were saying, in terms of preparation, that would involve those who were going to be present with the representatives of the nursing staff or the clinicians to actually have been able to help the chief executive by some view as to how they thought things had gone, so one's going in with some sort of understanding of what one's going to communicate to the families.
A. Yes.
Q. If the patient advocate had got from the family the family's concerns of what their expectations of the meeting was you might be able to structure the meeting around not only conveying what you want to convey, but making sure you have addressed the family's particular concerns. If they haven't done that, should there not at least be some sort of plan as to what it is we're going to tell the family, how we're going to approach them in this circumstance?
A. Yes. I don't think you can go into a meeting of that nature without some preparation.
Q. Obviously, one can say that anecdotally, that makes a lot of sense, but in your experience as to how these things might be conducted, is this kind of meeting with its deficiencies, unfortunate as they were, was that something fairly typical or does this have particular

concerns for you?
A. No, it does have concerns for me, because I think it demonstrates in part a limited understanding of what the meeting was really for and what might happen during it. Because this is now three months after and there has been no communication -- at least no formal or written communication -- with the family about what they're worried about, what they're concerned about. So I find it difficult to understand -- sorry, let me rephrase that. I am surprised that that's how it was organised and run, and certainly my experience would have been at that time -- and indeed in years before -- quite different.
But I go back to one of the points I made before, which is, if this has never happened to you before, if you've never had to have a meeting of this nature before, then I can understand that you might not understand the importance of preparation, the importance of the chairman of the meeting, in this case the chief executive, being very fully briefed by everybody else.
Q. Could you really not?
THE CHAIRMAN: Sorry, just let the professor finish the point.
A. This is the first time they'd ever done that and I can

understand the lack of preparation. They might have thought that this is not a particularly difficult meeting and we'll just answer the questions and that will be that and we'll all go home. Because there does seem to have been an element of surprise in that the meeting went rather badly.

THE CHAIRMAN: The meeting, to a degree, seems to have ended up as being counterproductive. Instead of helping the family, on the evidence that I've heard, it's become a source of deep frustration, if not anger, for the family.

A. And that's a terrible shame because, even given the gap between when Raychel died and this meeting occurs, it is at least the first meeting. In my view these matters are not dealt with by a single meeting; this is a process you need to take people through because it's complicated and it's difficult. So at the very first meeting, you might conduct it in a way that would expect at least one other meeting, and maybe more than that, to occur and you'd do it in a way that the family felt they were learning something and were happy to come back and learn more once they had digested what you'd already told them. Because you cannot take this in in a two-hour meeting, that level of detail, of medical terminology, of concerns about what was going on and so

on.

THE CHAIRMAN: Thank you. Let's move on.

MS ANYADIKE-DANES: Is it really the case that in 2001, with a child's death, that it can have been a reasonable expectation that you went into a meeting like that with a family without engaging in some preparation? Would that really have been a reasonable expectation?

MR LAVERY: Mr Chairman, it's not fair to say there was no preparation whatsoever going into that meeting. There had been a number of meetings between the clinicians over the months since the death and ...

MS ANYADIKE-DANES: Sorry, I should rephrase that. I mean preparation for that meeting. That's what I mean.

Could that really have been a reasonable expectation?

A. Yes, it would, particularly if it was the first meeting that those individuals were having, I would have expected some preparation.

Q. You would have expected some preparation?

A. Yes.

Q. Thank you. Given how it went, and you now have seen the evidence as to the outcome of that meeting, what do you think, from a governance point of view, should have happened afterwards?

A. After the meeting?

Q. Yes. Clearly, those who attended in different respects have thought that it was unsatisfactory, it didn't achieve what they wanted. So from the trust's point of view what do you think should have been the result, the next steps?

A. Yes, I think if you have a meeting like that, which is deeply unsatisfactory and you, as the chair -- or any participant -- recognises that, you'd want a debrief, you'd want to get together as soon as possible and reflect on: what did we hear, what happened in that meeting, where do we think we are as a result? If everybody feels they're in a worse position now than they were previously, then you would want then to consider what steps you took next to retrieve the situation and to enable the family to gain the kind of understanding that they want.

Q. Yes.

A. I have been involved in that, later than 2001. Round about 2005 we had a -- there was a death of an adult in one of our hospitals that was essentially caused by a failure to administer the correct dose of antibiotics, and in fact a failure to really -- there's a variety of things around that. But one of the key bits of information -- this was the multiple-resistance staphylococcus aureus, MRSA, which I'm sure you've heard

about in hospitals, a big, big issue, particularly in Scotland and in England. The initial meeting with the family was a little like this, people felt that the right things hadn't been discussed, the family were clearly angry, in fact they walked out, and this came through to me then as "What are we going to do about it?" So I called a meeting of the people involved and went through exactly that debriefing procedure, who said what, what went on, what did you feel you said well and what did you leave out and what was the attitude of the family? And it turned out in the course of that debrief that two of the individuals concerned -- one of them the consultant and one of them the senior nurse -- felt unable to admit that the offending organism was MRSA and that they knew that, but had not communicated that to the family. And as the meeting went on and got a bit angrier, they felt even less able to say that.

So the upshot of that was that my associate medical director who was responsible for that area said he would reconvene another meeting. He telephoned the family and he then wrote to the family and acknowledged the meeting was unsatisfactory and said there was further information we wanted to share with them, which they were entitled to know. They agreed to come back, got the doctor and nurse in the room and one other person

and the pre-meeting briefing was very clear: it was that you tell them exactly what it is they need to know and you don't hide anything further, you tell them all they need to know, which they agreed to. The upshot of that meeting turned out to be praise from the family that people had at last been open and candid with them, and nothing more was heard. That could easily have turned into a piece of litigation.

Q. Thank you.

THE CHAIRMAN: Sorry, just on that last point, whether it turns into litigation or not is really beside the point, isn't it?

A. Oh, it's irrelevant, yes.

THE CHAIRMAN: I will come back to that at the end with you about the litigation defensiveness. But whether the family end up suing or not suing is -- they may go ahead and sue and they're perfectly entitled to. Some do, some don't, and that's just the way it is. But whether a meeting like that avoids litigation or doesn't avoid litigation, the meeting has to take place anyway.

A. Yes.

MS ANYADIKE-DANES: One of the many things that concern the family is they feel they didn't have answers, that there wasn't candour, and one of the focal points for that became the nurses because they felt they had their own

direct experience of what was happening, which was not being reflected in what the nurses were saying.

The chief executive had wanted a meeting where it would be open and candid, she said that, and in her evidence she had encouraged the clinicians and nurses to conduct themselves in that way, and that was in fact one of the only instructions she gave them, apart from being gentle and kind, but also to be that.

A. Yes.

Q. You have read the notes or the minutes of that meeting and you've heard all of the evidence, and there are differing views as to the strengths of what was said or not. But do you have any abiding impression about whether the openness that the chief executive wanted to convey -- and you can only read it from the minutes of the meeting and from the transcripts, but do you have any impression as to how successful they were in trying to do that from their point of view?

A. The impression I have is that the aspect of openness and candour was not as successful as it might have been and I think that's probably the major reason that -- if the family feel dissatisfied with the outcome of the meeting, that's the major reason I would think that lies behind that. In my experience that's usually why people feel that the meeting was a waste of time or they become

angry or very dissatisfied with it.

Q. Thank you. Then to move on: to have a meeting like that, as the chairman has rightly said, was a positive thing, to want to have one and to have the chief executive chair it, that was a positive thing, as was notifying the CMO of a problem which they thought might be something that should be addressed region-wide, and participating in the working party and trying to be part of the design of guidelines that would minimise the chances of such a thing happening again. All those were positives.

A. Yes.

Q. But if I can ask you a little bit about the guidelines because I noted when we were going through your CV that you have had some experience of introducing guidelines and changes in practice.

Can I ask you, firstly, in terms of the process? We can see from the evidence that we've had and the evidence that the chairman has heard that various clinicians were invited to be part of a working group and they were representative, as it turned out, from the hospitals where each of these children had either had their treatment and transferred to the Children's Hospital and the Children's Hospital itself was represented by two consultant paediatric

anaesthetists. They gathered there and we have heard evidence from those who were part of that group that they didn't really discuss the cases with which they had had direct association, either because they had treated the child or because they were aware of the child's death in some way through mortality meetings or so on. And the reason that's been given for that is because we weren't there to discuss individual cases -- I'm summarising evidence -- we were actually there to produce guidelines, to discuss what ought to go into the guidelines and subsequently to design them in a way that would be useful region-wide to cover the situation generally, albeit local protocols might be required. And that's the reason they say they didn't discuss individual cases. Out of your experience of bringing in guidelines, does that surprise you, that they might have been involved in actual cases involving dilutional hyponatraemia but not discussed them with each other when they first met?

A. It does seem a little surprising. It may be that whoever chaired the meeting gave such an instruction and didn't want to encourage any discussion of individual cases, but I think it's extremely difficult to divorce the process of constructing a guideline from the context which has required it to be developed. And indeed, in

my experience, most doctors who are involved in developing guidelines or changes in practice ask themselves the question "Why are we doing this? What is the problem that we're trying to solve?" And they will refer, at least in their own minds, back to whatever cases it is where that problem or set of problems arose. So I think it's extremely difficult to divorce the individual cases that have given rise to the context in which you now want to produce a guideline.

The other aspect of this is that if you are involved in developing a guideline, once you've made good progress, you would want, certainly internally, to check with yourself that a guideline you were producing was material to the case or cases you might have been involved in that prompted it in the first place. So you'd want to test yourself, if this guideline were in place, would it have made any difference to what happened to the patient I was looking after or patients I was looking after? And I would have thought that, in a group discussion around a small number of cases, it would be very difficult to avoid that logic. So we've got so far with this guideline, it's looking good, we think it's consistent with the published evidence that we have, so now looking at the cases we have all experienced, would this guideline make a difference?

THE CHAIRMAN: So you cross-check your draft guidelines against the circumstances with which you're familiar so as to ensure that the guidelines don't need tweaked or added to in some way?

A. Yes, because it would be a great pity if you spent all that time devising a guideline that then had no effect on the kind of cases that gave rise to it.

MS ANYADIKE-DANES: In fairness to them, the counsel for one of the parties who was involved in that, though not at the first meeting, a Dr Jenkins, she said that the intention was from that larger group of people were to be a smaller working party who would actually be engaged in the design. Those members of that working party would go back to their respective hospitals and they would discuss amongst their own colleagues, if you like, their work, and so they became the hub of the discussion and then the members of the small working party would share their contribution to the design amongst each other. But it's still all quite a small group and I'm wondering, even if you were doing that, if you wanted to emphasise, for example, we think that Solution No. 18 really ought to be explicitly mentioned, then I presume from what you are saying you'd be saying the reason why is, unless you do that, I'm not sure it would have avoided the circumstance that we had with the death here

or whatever is the particular feature of the experience you've had that you think is not being reflected or would not have been affected by the design.

So in some way, if I have you right, not only might you be doing that amongst yourselves, but that's the sort of information you'd be sharing amongst your co-working party members who were designing?

A. Yes, I think you would. I think you would be wanting to discuss what you did next in the context of what you had already experienced, which is severe hyponatraemia in a small number of children, if I understand it correctly. I can understand that you might not discuss the individual cases in detail around a table in the sense of comparing notes about what went on, but as I say, I don't think you can divorce the context in which you're doing the work from the work itself. And I still think you'd want to test the assumptions and the conclusions you were coming to against your experience of those cases. I guess that process you're referring to about people going back to base, as it were, would assist with that. That's where you could have a more detailed discussion perhaps of the individual case with the people who are familiar with it.

Q. Then when the guidelines come out, and they are issued -- in fact they are issued by the Department

in March 2002, so it's quite a speedy process from identifying that we've got a problem that we need to address regionally to producing actual guidelines.

When that happens, what is the process that happens at the hospital when they receive a guideline like that in terms of making sure, not just that it's positioned in the appropriate places, as they've been directed to do, but so that people actually understand the change in practice that these guidelines are introducing? What do you think in your experience should be happening?

A. Well, typically, if say a clinical director had that particular responsibility for a new guideline or method of working, they would have in their heads a plan of how they were going to ensure that it was implemented. So certainly you've got the bit about putting posters up, reissuing leaflets and so on. That would be important as reminders to people about what we are now doing as opposed to what we did before.

You would almost certainly have briefing meetings of relevant staff, probably in uni-professional groups, so the nursing staff would be brought together, medical staff would be brought together, at one of their routine meetings, and you'd have an explanation and a presentation of the guideline: this is what it is, this is why we are doing it, this is why it is

important, and this is what we do from now on. So you would combine those visual reminders with some educational input so the staff have the opportunity to ask questions and to ensure that everybody involved understands what is now going on. You get some difficulties with that, of course, because if you do it at a particular time of day, unless you repeat it, you may miss some members of staff, so there's always that risk. You can't get the whole staff group, particularly when people are working on shifts.

But generally, if you have most people there and then other staff will remind staff who maybe weren't there that we have a change here, we're doing things differently. So there's an important educational input.

Then the third bit is that you would then have some monitoring of compliance with the guideline, so you would have some routine audit that checked -- the case of this where post-operative fluids were to be changed, you would check that the next 20 patients or whatever all got the correct amount of fluid.

So you've got reminders and prompts for what to do, you have an educational input, the relevant staff groups, and you have some monitoring that the new guideline is being followed.

Q. If I ask you this, first of all: apart from the

reminders and prompts, is the receipt of a set of guidelines like this considered to be -- or would you, if you received them from the Department like this, consider it to be a significant set of guidelines? I presume that a hospital can receive many practices, procedures, guidelines in the course of its calendar year. But a set of guidelines like this that comes under cover of a letter from the CMO after the CMO has taken particular interest in it, how significant is that or could that be quite normal?

A. No. CMO guidance on clinical matters comes out, in my experience, fairly infrequently. It's much more common to get administrative advice from the CMO and, of course, CMOs always give advice about vaccinations, immunisations every year, that kind of thing. But a CMO-sponsored guideline for a change in clinical practice would be an unusual and significant event and it would be highly unusual not to take very great care over implementing that.

The context, as you say, is quite correct, not in 2001, but by 2006 or 2007, my organisation was getting something like 30 or 35 new guidelines every year and that becomes a different order of magnitude about how an organisation processes and deals with and follows up on that many -- and that's 35 every year, so you have this

cumulative problem. But for one like this I would have thought that was sufficiently important to devote a reasonable amount of time and trouble to getting it right.

Q. Thank you. And then you referred to, apart from putting it up in relevant places and having some education about it and why it was being introduced and so on so that you are really trying to ensure the best possible adherence to it, you then said the other element to it or aspect of it would be the audit. The CMO's cover letter to the guidelines had already indicated that she wanted those guidelines audited and the local protocols which were going to be designed alongside it and there had been differing references in various meetings about the need for audit or monitoring and so on. But even if none of that had been said, are you saying that when you -- not you personally, but when the hospital receives a set of guidelines like this it's incumbent on the trust to institute an audit system for them?

A. Yes. If you're going to adopt a guideline -- I should have said that one of the other steps, as you have just indicated, you would develop a local protocol that fitted it to your circumstances and your organisation. But yes, if you're going to do it you then need some means of monitoring it as being delivered, otherwise

there's little point in adopting it.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Thank you. I just have one final area of questioning for you, which relates to -- in 2003, there was an inquest into Raychel's death, and as part of the preparation for that, the trust engaged experts, and you'll know that one of the experts they engaged was Dr Warde and he produced a report that seemed very much to reflect, at least in terms of the vomiting aspect of it, views of the expert that the coroner had engaged and ultimately that report wasn't shared or at least provided to the coroner or anybody else really at that stage. Given what you have said about openness and so forth, what is your view about that and how -- just if I add a rider so you see the context of it. Not only what is your view about it but, in your experience, what would have happened to a report like that had you received it?

A. I'm unfamiliar with the details of the coroner's system in Northern Ireland, but I imagine it's similar in principle to the procurator fiscal in Scotland, or indeed a court anywhere, which is that it is important that, if the court is to make a determination as to fact, then you have to provide it with all the information that is available. So I'm surprised that

the trust withheld a report that contained a significant opinion about the death in question.

My own experience is that I would have ensured, together with the trust solicitor or the NHS solicitor that we use in Scotland, that all of the staff concerned absolutely understood the requirement to make everything competent available to the coroner. There would be no question of not doing that. And certainly any internal reports that I or other senior executives had initiated in order to better understand the problem internally, we would certainly provide those to a procurator fiscal or other court, and we would accompany that with a commentary of what we had done in the interim to deal with the problems raised. That may be a feature peculiar to Scotland. One of the functions of a procurator fiscal is to not just determine the cause of a death, but also to make recommendations about whether systems should be improved if it's in the public interest.

So organisations like mine would feel it important to bring the court fully up-to-date, at the point they're examining you, with progress you've made against any particular internal or external report so that his judgment can reflect that.

Q. The report wasn't shared on the basis that -- well, the

trust took the view that it didn't have to and it subsequently claimed privilege in relation to it until reasonably recently. And that, of course -- sorry, I don't want to say "of course". At the same time, there was either litigation in being or it was anticipated that there would be. Does that sort of thing have, in your experience, any effect on your duties in relation to the procurator fiscal?

A. I'm not a lawyer, so I couldn't answer that in a strictly legal sense.

Q. I beg your pardon, I should have re-phrased it. I mean, you sitting there as the chief executive, what would have been your approach and would it have made any difference to your approach, the fact that there might be aspects in a report that could have an effect on either actual litigation or intended litigation?

A. The principle I would adhere to is that you make a full disclosure of whatever information you have because of two reasons. One is it helps the process, it can only be helpful. Secondly, if you don't, it'll come out later anyway, if matters proceed any further and you are required to disclose it in any event. So my overriding principle is that in these situations your duty is to assist the court, or whatever, as far as you're able.

I have been advised by solicitors previously not to

either submit a report or submit it in a different form and I've been happy to discuss that, but I have never agreed to not submitting a report that was available that would be of clear relevance to court proceedings.

MR LAVERY: Mr Chairman, I think you have said on a number of occasions that the trust were legally entitled to claim privilege for that report, and really your concern was why.

THE CHAIRMAN: But that's Professor Swainson's point. He's received similar advice in Scotland not to provide a report, not to produce a report, or produce a report in a certain form, and you have just told us that your position has been that you've never agreed not to submit a report that was available which would be of clear relevance to court proceedings. So it comes down to the question of why: why did the trust decide to in this case? Okay?

Can I just pick up that point before I invite any questions from the floor? You may have come across the name of Dr Ian Carson in the papers here, who was the medical director in the Royal Group of Hospitals for some time and then became Deputy Chief Medical Officer. One of the issues which he said -- and has been echoed by others -- is that while this problem has eased a little in recent years, there still remains perhaps

too often a culture of litigation defensiveness. In all of the aspects that you've been discussing this morning, what's produced to the coroner, what's said to the families, how willing people are to face up to each other -- for instance, even in Altnagelvin, the critical incident review, the meeting on 12 June, was not minuted or noted in any way because of concerns expressed about any notes being subsequently available in the event of litigation. Would be I right in assuming that you've had similar issues in Scotland?

A. Yes.

THE CHAIRMAN: And are they still as apparent as before or has there been any change or easing of that culture?

A. I think there's been a very considerable change over the past 10 or 15 years by everybody. Certainly in 2001, if it was clear that litigation was being contemplated or had actually started, then there was, I think, a very natural defensiveness from solicitors and from those individual doctors who sought their advice. I can well understand that. But I think that that has changed tremendously in the past 15 years and I think there's far more of a culture now of openness and sharing and an understanding that there really isn't much to be gained by hiding key documentation or facts or opinions.

I was also very much guided by the advice I had

from -- I remember attending a couple of conferences at an organisation called the Association of Victims of Medical Accidents, who were advised by one of the large London solicitor firms, in which they made the point that at a meeting with a family or relatives or a patient, indeed, who was still alive, a medical practitioner was perfectly safe in acknowledging any damage or harm done to that patient and their role in it in that informal sense, even if litigation was pending, because that's not the same as an admission of liability. And the two processes -- that is of dealing with patients and dealing with the court -- are really two quite different things and you really do need to distinguish them.

If I think back to 2000/2001, many people found it very difficult to distinguish those processes and responsibilities and the argument I'm advancing was probably quite unusual and would often be challenged. But I have never seen any adverse outcome arising from that and I think the tide of opinion has changed very much towards that now, in 2013, such that those sort of defensive measures I think would now be quite unusual.

THE CHAIRMAN: Thank you very much.

Any questions from the floor? Mr Coyle?

Questions from MR COYLE

MR COYLE: If I could ask Professor Swainson to perhaps expand on matters he's touched upon. One is the numbers of people attending the sort of meeting that occurred on 3 September.

What would you consider to be good practice from a trust's or board's point of view in placing the number of people at a meeting with the family?

A. Yes, the difficulty you face is having enough people there who understand what happened balanced against the fact that you've got a small family group who could be easily intimidated by just the sheer number of people in the room, let alone how many it is. I guess the ideal for me is probably an equal balance of family and professionals, with maybe a chair, so that's slightly weighted towards the organisation, but that's difficult to achieve in complex investigations and requires that the people attending have been very well briefed and thoroughly understand all the aspects in which the family might have an interest. But I think if you go to the opposite extreme and -- I don't know how many were at that meeting, I can't recall now from the minute, but if you have 10 or 12 people and only two or three family members, that's quite intimidating to a family.

Q. On that point, have you ever seen it deployed that people who can speak specifically to an issue are in

a side room or an anteroom and are invited to attend regarding a precise issue which they're on top of or au fait with to assist the whole group. Is that something you have seen deployed?

A. Yes, I'm aware of people using that so you have a core group of people who are in the room most of the time and then you have experts, like I'm doing here, coming in to offer their particular bit. And I think that's probably better, but that's quite difficult to take in, still, even if you're a family member, people might have an additional five or six people popping in and out. It's difficult to remember then who they were, what they said, and if you think of something later you want to go back and ask them, it's quite difficult. So I think the preference is to have a smaller number of people who are very well briefed, hence the importance of the preparation meeting.

Q. In terms then of the positioning of people at a meeting, would it be the patient's advocate -- what would you see as good practice in that regard, paragraph?

A. How do you mean?

Q. The logistics of the meeting. Where ideally should the patient's advocate have been positioned to give the correct designation of her role?

A. I think probably right next to the family in the sense

of seating arrangements.

Q. And a point you made there in terms of an issue arising, and people may wish to return to it, was that dealt with in your evidence in respect of a series of meetings where the family might absorb a point or an issue occur, but then be able to return to it on a later occasion.

A. Yes, I think there are a number of ways of doing that. One other technique is to have the first part of the meeting for 30 or 40 minutes and then take a break.

Q. Yes.

A. And the particular role of the patient advocate then would be to withdraw with the family, review what has been said and what has been heard, discuss whether there are any things you want to return to or review again: these are the things we want to hear about next. So you get the chance to assimilate what you've heard and then go back to it and reconvene the meeting. I have seen that work very successfully.

Q. Lastly, professor, if you could assist. As we know here, there was an offer to make available to the family the notes and records pertaining to Raychel. How adequate a discharge of the duty of candour or frankness do you see that as being? In other words, providing laypeople with dense medical notes and records?

A. I think it's very helpful to give them the notes, but

it's even more helpful if you couple that with the opportunity to discuss them. So one of the -- I'm not clear about the law in Ireland, but certainly in Scotland there's an Access to Health Records Act, where people can require to see their own records; they just have to write in and ask to see them. The code of practice that goes with that is not that you hand them the record and here's a room you can read them in or you can take away a photocopy, but to offer to sit down with the person and go through the record at the pace that they require in order that they can understand it. And if it's complicated, you probably would have to do that -- well, I know you do have to do that more than witness.

Q. It may require writing paper, people being allowed the opportunity to make notes and perhaps take away with them the definitions of medical terms?

A. Yes, absolutely, of course.

MR COYLE: Professor, thank you for answering my questions.

THE CHAIRMAN: Mr Lavery, do you have anything?

Questions from MR LAVERY

MR LAVERY: Perhaps one brief point through you, Mr Chairman. Can I preface it by saying that the trust believe that Professor Swainson has provided a very balanced report for the inquiry. Indeed, he says at the

end of the report:

"Many of the actions taken by individuals, such as Dr Nesbitt, led by Dr Fulton and supported by the trust and driven nationally by the CMO, ensured that accurate and considered fluid management of ill children is better now than in 2001."

And the question that I wanted really to ask through you, Mr Chairman -- and it might provide some comfort for the family -- is does Professor Swainson believe that the actions taken by those individuals perhaps saved lives that perhaps wouldn't have been saved?

A. It's hard to answer that precisely, but probably yes. Bearing in mind that these deaths from hyponatraemia are relatively infrequent and rare, it might be a few years before you could be certain of that. But yes, the intention to deliver safer guidelines for the administration of fluid and particularly the requirement to check the blood electrolytes when people are on fluid, yes, that would certainly improve the situation.

MR LAVERY: Thank you.

THE CHAIRMAN: Nothing further?

Professor, thank you very much for your written report and for coming today. Unless there's anything further that you want to add, you're now free to leave.

A. No, I don't think so.

THE CHAIRMAN: Thank you very much. You can step back.

(The witness withdrew)

Timetabling discussion

THE CHAIRMAN: Let me just finish, ladies and gentlemen, by saying that, with the professor's evidence, that brings to an end all of the three elements of Raychel's case that we have been looking at, starting with the aftermath of the death of Lucy Crawford, then the clinical aspects of Raychel's case and the governance aspects. That being the case, I will write formally to all the parties next week, but if any party wants to make written submissions on any or all of those aspects, I'd invite you to start working on them now if you haven't already started and I will lay down some timelines next week for that to be done.

We will adjourn in a few minutes and we will resume four weeks yesterday on 16 October to deal with the aspects of the treatment and death of Conor Mitchell that we're looking at. All of the parties, I think, have the original files from what was the Craigavon Trust, what was the Royal Trust, and from the coroner. At our end, as I announced previously, we've engaged Dr Scott-Jupp to do a report. We will have that report available to circulate to the parties on Monday, perhaps tomorrow, but more likely Monday.

That report is based on the files to which I've just referred. He hasn't yet seen any witness statements which the inquiry has sought, and in terms of those witness statements we've asked 12 individuals for statements. They're due tomorrow with the exception of two people for whom we've given an extension until next Wednesday, and a third person, who I think has suffered a recent bereavement, and we're not entirely clear when that person will be able to report to provide a statement.

We also have some outstanding information requests. The reason I'm going through that is twofold. One is to emphasise to the Southern Trust through DLS that we absolutely need these witness statements now. Okay? Secondly, to say that Dr Scott-Jupp will, if he thinks it's appropriate, do a supplementary report based on any fresh information which comes in in the witness statements. So if some points are clarified for him or any fresh issues arise, he will deal with that in a supplementary report.

I said when we last dealt with this issue that the Southern Trust as successor to Craigavon can take a line in relation to Dr Scott-Jupp by either engaging its own expert or relying on its witness statements, or a third line might be for the doctors involved to do a position

paper together.

Mr McAlinden, can you help me on this? Are you engaged in this element?

MR McALINDEN: I am, I recently received instructions in relation to this element.

THE CHAIRMAN: I understand why you will want a few days to look at Dr Scott-Jupp's report in order for the trust to see how critical or otherwise it is or what areas he's critical of or not. But I would like to know at the earliest possible opportunity whether the trust is going to respond through the witness statements it already has, it's making, through engaging its own expert or through the third option I have just suggested of putting together a position paper to which there will be a heavy contribution from those involved.

MR McALINDEN: I will hope to be able to give you an answer to that issue by the end of next week.

THE CHAIRMAN: Thank you very much. The reason I'm going through this is partly to explain the next stage of the inquiry, starting almost four weeks from now, but also to emphasise that we need this information, in particular we need the witness statements because we have to define interested parties, we have to issue Salmon letters and so on. That will be the next stage.

The stage after that, as you know, begins on

20 October. That involves the departmental end. We've circulated and agreed in the absence of contrary suggestions the limited issues on which this part of the inquiry will proceed. We have sought 11 witness statements for which the -- I think the deadline is 30 September. We have received three, but one of the concerns, I think, Ms Rodgers, if I can raise this with you, in least one of the statements we've received to date, the witness has answered as best he can, but he's said, "I've been retired for a number of years and I don't have access to the department's documents". With all due respect, that's of limited value to us, and I wonder if for him -- and we'll deal with this in correspondence -- but for him and for other witnesses who have retired, could there be some engagement between your office and the department and those people to ensure we do have access to the documents?

MS RODGERS: Mr Chairman, a response has been issued to Ms Dillon this morning. The department's position has been in receiving each of the witness statements to go through it and identify any relevant documentation that it holds and it has served that through the witness statement request. All documents that we hold of relevance have been served with the witness request and no other documents can be found to assist the witnesses.

THE CHAIRMAN: Okay. I'll look at this morning's exchanges and, if needs be, we'll come back to that. Thank you very much.

That leaves the week of 11 November, when we will be dealing with the current positions, primarily to deal with what has been raised yet again this morning as the family's main concern to see the extent to which things are better now than they were between 1995 and 2001, to see the extent to which the families can be reassured that these same events won't happen again.

There's one further issue in Claire's case, Mr Quinn. We have provided Dr Giles's report. It only went out yesterday. I will write to the interested parties, obviously including Mr and Mrs Roberts, through your solicitors at the start of next week, but that, I think, is the only outstanding issue in Claire's case.

MR QUINN: I'm obliged, sir. It strikes me that Mr Green should be included in that correspondence.

THE CHAIRMAN: Particularly Mr Green and his solicitor, but all of the interested parties will be sent Dr Giles's report.

MR QUINN: And I will consult with Mr and Mrs Roberts and their solicitor and prepare a response in due course.

THE CHAIRMAN: You'll understand that I'm anxious to sort that issue out fairly quickly over the next week or so.

MR QUINN: Mr Chairman, you did mention timetabling, written submissions in relation to Raychel's case. There hasn't been much of a mention of timetabling in relation to submissions in relation to Claire's case.

THE CHAIRMAN: That's because we haven't quite ended Claire's case.

MR QUINN: Yes, of course. I understand.

THE CHAIRMAN: I can make that decision once we decide what we're doing on foot of Dr Giles's report.

MR QUINN: Yes, sir. I understood that was the delay, but I just wanted to clarify that.

THE CHAIRMAN: I think one two people might have sent in submissions already in anticipation, but we'll come to that.

That's everything for today. Ladies and gentlemen, thank you for your co-operation over the last four weeks, and we'll meet again on the morning of Wednesday, 16 October. I'm not sure it will necessarily be a 10 o'clock start, but we'll let you know in due course. Thank you very much.

(2.40 pm)

(The hearing adjourned until Wednesday, 16 October)

I N D E X