1 Monday, 1 July 2013
2 (9.00 am)
3 (Delay in proceedings)
4 (9.17 am)
5 THE CHAIRMAN: Good morning. Mr Wolfe?
6 MR WOLFE: Good morning, sir. Professor Gabriel Scally,
7 please.
8 PROFESSOR GABRIEL SCALLY (called)
9 Questions from MR WOLFE
10 MR WOLFE: Good morning, professor. You have to date
11 provided the inquiry with a report, followed by an
12 addendum report. Let's identify those: your report is
13 251-002-001 and it is dated 25 April 2013 and then,
14 comparatively recently, on 27 June, you provided us with
15 an addendum, which is 251-004-001; is that correct?
16 A. That's correct.
17 Q. We have a copy of your CV, which we can put up on the
18 screen. The first page is 315-030-002.
19 Professor Scally, your current post, what is that?
20 A. The current post is for two days a week and I am
21 professor of public health and planning at the
22 University of the West of England and I direct the World
23 Health Organisation Collaborating Centre on healthy
24 urban environments.
25 Q. So you work in an academic setting presently?

1 A. Indeed. It's an academic post concerned with the broad
2 determinants of health.
3 Q. A brief word about your qualifications. We can see
4 those at the bottom of the page in front of us. You
5 graduated from Queen's University Belfast in 1978 with
6 a medical degree.
7 A. Yes.
8 Q. In 1982, you obtained a Master of Science in community
9 medicine from the University of London and recently
10 a doctorate of science from the University of the West
11 of England.
12 A. That is correct. I should add the DSc was an honorary
13 degree.
14 Q. In terms, professor, of your familiarity with the
15 development of clinical governance in the
16 United Kingdom, can you help us with that? What is your
17 familiarity with that landscape?
18 A. I worked in England, since 1993, as a regional director
19 of public health, and part of that brought me into
20 contact with a number of episodes of serious clinical
21 failure, and regional directors of public health had
22 particular responsibilities in relation to those at that
23 time, initially as members of the regional health
24 authorities. And my engagement with that, in addition
25 to my service as a council member of the General Medical

1 Council, where I was involved in the professional
2 conduct committee and the standards and ethics
3 committee, both of those brought me into very close
4 contact with the key issues, and I worked very closely
5 with Liam Donaldson, who was regional director of public
6 health at that time in another region, and subsequently
7 chief medical officer for England, and we produced,
8 I think, the seminal journal paper on clinical
9 governance, which we saw as the development of a system
10 for trying to improve the standards of clinical care
11 in the country.
12 Q. Yes. Maybe just take a step back: before you went to
13 England, as we can see, I think, just over the page
14 perhaps, you were employed in Northern Ireland as the
15 director of public health as it was to become known
16 in the Eastern Health and Social Services Board?
17 A. That's correct.
18 Q. And you worked in that capacity until 1993; is that
19 right?
20 A. That's correct.
21 Q. Tell us about that role. By 1993, the trusts and the
22 establishment of trusts in Northern Ireland had been
23 signalled; is that correct?
24 A. Indeed. More than signalled, it was being put in place,
25 the structures were being put in place. I think

1 I joined at a seminal moment as chief minister and
2 medical officer in the board because the government's
3 policy for changing the structure of the Health Services
4 and introducing purchaser/provider split was being
5 introduced at that time or it was announced at that
6 time, and we went through the process within the
7 Eastern Board of conversion of directly-managed units
8 into trusts. So it was very much a period of change.
9 Q. And so I take it, professor, you would have familiarity
10 then with that triangular relationship, trust, board and
11 department?
12 A. Indeed. And particularly so, I think, in my job as
13 chief minister and medical officer and director of
14 public health because prior to the creation of trusts it
15 was that role that had the responsibility for all the
16 medical and indeed the professions allied to medicine,
17 all of those staff, and in particular in relation to
18 medical staff whose contracts were actually held by the
19 board centrally and I had to deal with the medical
20 personnel issues at that time.
21 Q. Maybe just stopping there and let's perhaps focus on --
22 I tend to call it the pre-1996 stage. You have
23 indicated, of course, that trusts were developing in
24 shadow form. In terms of the Sperrin Lakeland Trust
25 with which we're specifically concerned, their

1 establishment order was enacted in 1996, that's why
2 I use the phraseology "pre-1996". Just focusing on that
3 period of time for the moment, the picture that has been
4 painted for us, for example by Mr Frawley, who gave
5 evidence from a position as having been general manager
6 of the Western Board at this key time, he told us that
7 before 1996 he had the role of establishing, for
8 example, in the adverse incident context, the process,
9 becoming involved in the arrangements, terms of
10 reference, who would undertake such a review, et cetera.
11 Is that familiar territory for you?
12 A. It is. From the introduction of general management into
13 the health boards, indeed that overall coordinating
14 responsibility rested with the board general manager.
15 Q. He was overseeing and managing what was going on in the
16 individual units of management; is that right? So for
17 example, those working and managing the Erne Hospital
18 would be reporting in to him?
19 A. That is correct.
20 Q. I want to look at how that was to change with the
21 establishment of trusts and I want to focus and
22 concentrate for a short time on the nature of the
23 relationships in the changed environment.
24 THE CHAIRMAN: Before you go there, if I go back to pre-1993
25 in Belfast, pre-1996 in the west. If there was

1 a serious incident and this is then picked up and
2 becomes the responsibility of Mr Frawley in the west or
3 whoever in Belfast -- and this is before the trusts were
4 established -- at what point and why would the
5 department be notified? I presume there's some
6 incidents which would not have been reported to the
7 department because not everything is serious enough to
8 go to the department. So what sort of incidents did go
9 to the department before the establishment of trusts?
10 A. I think, chairman, you've correctly put your finger on
11 that. It's an issue around seriousness and one can
12 define seriousness in several different ways. It could
13 be seriousness in relation to the reputation of the
14 Health Services or the individual organisations, or
15 indeed it could be seriousness in relation to its effect
16 on the care and treatment of patients. So it would be
17 a judgment call by the senior officers of the board as
18 to when they would inform the department.
19 But I, like any of the professional officers, or
20 indeed the general managers, would also have relied upon
21 senior officers in the department for advice and
22 assistance in handling some of these incidents, so
23 it would be a matter of reporting them, certainly, but
24 also a matter of discussing and seeking guidance on how
25 these issues should be correctly handled.

1 THE CHAIRMAN: Does that mean that there would be some of
2 these incidents which the department was notified of but
3 was simply kept informed about, rather than being
4 required to be actively engaged in?
5 A. Indeed.
6 THE CHAIRMAN: Were there any in which the department was
7 expected to become actively engaged? Do you remember
8 any incident pre-1993/1994 in which the department had
9 to intervene beyond the stage of being kept informed
10 about what was going on?
11 A. I don't, Mr Chairman. When I had issues that arose,
12 I would very often discuss those with the chief medical
13 officer and seek his views on how we should be handling
14 them and keep him informed, and I think that would be
15 the way in which I would have co-operated with the
16 department at that time.
17 THE CHAIRMAN: Was that, Dr Henrietta Campbell at that time
18 or was that her predecessor?
19 A. That was Dr James McKenna.
20 THE CHAIRMAN: Thank you.
21 MR WOLFE: So that's the pre-1996 era, if I can describe it
22 thus. Moving into that period then where trusts were
23 signalled, what we want to focus upon, professor, if you
24 can help us, is how relationships and how, in
25 particular, reporting or accountability relationships

1 changed with the creation of trusts. Could I have up on
2 the screen, please, a circular, which is a management
3 executive circular of 1993? It's at 323-001a-002.
4 First of all, professor, the management executive;
5 could you help us with that? What was that
6 organisation?
7 A. The management executive didn't have a separate
8 organisational existence, so it didn't exist in statute;
9 it was in essence a part of the Department of Health, an
10 attempt to separate the issues around the management of
11 the Health Services -- Health and Social Care Services
12 in Northern Ireland -- from the operation of the
13 Department of State as such of the Department of Health
14 and Social Services.
15 Q. So it was part of the Department of Health, but separate
16 in terms of how it did its work?
17 A. Yes, it was meant to deal with the day-to-day business
18 of the operation of Health and Social Care Services in
19 the Province and the same alteration took place in
20 England at the same time. It was, I think, part of the
21 purchaser/provider split mechanism to bring a greater
22 management focus on Health and Social Services at
23 a provincial or national level.
24 Q. So this document, issued on 1 October 1993 by the
25 management executive, issued to:

1 "Chief executives of Health and Social Services
2 trusts and shadow trusts for action, also issued to area
3 general managers, UGMs."
4 Can you help us with that?
5 A. Yes, unit general managers. As we touched on earlier,
6 the directly-managed units of the boards, some had
7 indeed been converting to NHS trusts but some at that
8 stage were still directly-managed units, and they were
9 under the management of the unit general managers, who
10 were directly accountable to the area general manager
11 at the board.
12 Q. Paragraph 1 then:
13 "Accountability framework for trusts."
14 So it tells us that:
15 "This letter sets out the framework of
16 accountability, which will exist between the management
17 executive and HSS trusts in the future. It reflects
18 both the statutory responsibilities of trusts and the
19 role they will be expected to play in the pursuit of the
20 corporate objectives of the HPSS, currently summarised
21 annually in the management plan."
22 So as a document, it's primarily looking at the
23 relationship between the trusts and the department
24 in the form of the management executive?
25 A. Indeed, and I think it's designed to reflect the

1 increasingly complex system that was put in place where
2 instead of having merely the department and four area
3 Health and Social Services boards, you had something
4 much more complex with quite a number of trusts
5 developing and then the boards also staying in place.
6 So it was an attempt to put that on a more structured
7 footing.
8 Q. At paragraph 3, it tells us something of the reforms
9 that were being brought forward in that sector, pursuant
10 to the 1991 order, with which we're familiar. It says:
11 "The separation of the purchasing and providing
12 roles will, in particular, allow the delegation of
13 management responsibility to the local level. Health
14 and Social Services trusts established under the 1991
15 order are independently-managed provider units, which
16 are statutory bodies and remain within the HPSS."
17 So this was, Professor Scally, a sea change in terms
18 of how health provision was being delivered in
19 Northern Ireland?
20 A. Absolutely. It was a move from very large area Health
21 and Social Services boards responsible for the delivery
22 of all services, employing all of the staff, to very
23 much slimmed down area boards and the creation of
24 separate independent provider units as trusts.
25 Q. And then the document sets out, if you like, the

1 accountability relationships. At (i):
2 "Trusts are accountable to the general public and,
3 in particular, local communities."
4 We see how that's described.
5 Could we go over the page, please, to 003? The two
6 significant relationships with which we are concerned:
7 "The trusts are accountable to the purchasers."
8 And in straightforward language, that is the boards,
9 Professor Scally?
10 A. The boards and to GP fundholders, where they exist.
11 Q. So it describes:
12 "The primary accountability of trusts for the
13 quantity, quality, efficiency of the service they
14 provide will be to their purchasers. The contracting
15 mechanism will provide the means for these to be
16 specified and monitored. In the main, therefore, the
17 line of accountability for service delivery issues will
18 be initially to the purchasers and from there to the
19 management executive if there are strategic implications
20 or the matter is the subject of a parliamentary question
21 or minister's query."
22 Could we pause there and unpack that? The reference
23 to the contracting mechanisms, is that the service level
24 agreement that is put in place or was to be put in place
25 between a board and a trust?

1 A. In essence, I think that's correct. At this stage,
2 I think, of the development, the precise mechanisms of
3 the contracting were as yet to be defined, particularly
4 with the development of what was, in organisational
5 terms, a complication of GP fundholding. But in
6 essence, you're correct, it was the agreements between
7 boards and trusts.
8 Q. Just before that, the sentence reads:
9 "The primary accountability of trusts for quantity,
10 quality and efficiency is to the purchasers."
11 It's not to the department?
12 A. In relation to the quantity, quality and efficiency,
13 I think that is correct. Though it does say "primary
14 accountability" and not "the sole accountability". So
15 I think, in strict organisational terms, the trusts were
16 independent bodies, but they were responsible to the
17 Department of State, the Department of Health.
18 Q. Although the paragraph goes on to, if you like, identify
19 the nature of the accountability in that realm to the
20 department, and in particular to the management
21 executive, it refers to "strategic". The strategic
22 implications of a matter is the kind of topic or subject
23 matter that might or would go in the direction of the
24 department.
25 A. Indeed. I think there are a wide number of issues that

1 could be strategic, but I think it was designed to
2 delegate as much responsibility as possible to the
3 boards and the trusts to, in a sense, reach agreement
4 about what one was to do for the other and how that
5 would be monitored in terms of quantity, quality and
6 efficiency so that the department or the management
7 executive did not have to get involved in the detail on
8 a routine basis.
9 Q. Let's stick then with the relationship between the trust
10 and the board in this context. The trust is accountable
11 to the board for the quantity, quality and efficiency of
12 the services that are being purchased by the board?
13 A. Yes.
14 Q. And in that area, professor, what is your understanding
15 of what was changing with the creation of the trust in
16 this context? Because before the creation of the
17 trust -- let's call him Mr Frawley -- the general
18 manager of the board would be very interested to know
19 what was happening in terms of the delivery of services
20 in a hospital. What is changing with the establishment
21 of the trusts?
22 A. I think in essence it's an issue of delegation.
23 Although unit general managers had progressively, over
24 time, been given more autonomy and more responsibility
25 by the boards following their appointment, this changed

1 things quite substantially at the local level in that
2 those unit general managers in the main became the
3 chief executives. But in any case, the chief executive
4 of a newly formed trust has his or her own board to
5 which they personally would account. So there was
6 a chair appointed, non executives and executive
7 directors appointed, so it was a public body in its own
8 right and a public-facing body as well as one that was
9 accountable to the DHSS.
10 Q. Maybe let's think about this in terms then of what has
11 been said to this inquiry about that relationship. Even
12 by the year 2000, when sadly Lucy died,
13 Professor Martin Bradley, who gave evidence to the
14 inquiry, drew a contrast between the relationship of,
15 for example, the Altnagelvin Trust with the board, which
16 was much more business-like, issues were, if you like;
17 "constructively contested" is how he put it. By
18 contrast the Sperrin Lakeland seemed to be in
19 a parent/child relationship, is how he described it, in
20 terms of its interaction with the Western Board. The
21 impression given by that evidence was that as these
22 things began to settle down, different trusts had
23 different kinds of relationships with the commissioning
24 board.
25 A. I think that's absolutely correct and it depended on

1 a wide range of factors. Often to do with the
2 personalities involved and the way in which trusts came
3 into being. For example, was it a simple matter of the
4 former unit general manager stepping into the role of
5 chief executive or was there a new chief executive who
6 came from outside and therefore, wasn't part of
7 a previous pattern of behaviour of operation? And also,
8 the degree to which the chair and the non-executive
9 directors would want to steer the operation of the trust
10 and maybe take it in a slightly different trajectory to
11 that which had gone before when it was
12 a directly-managed unit. And of course, part of the
13 reasoning for the introduction of the purchaser/provider
14 split was to create competition so that the
15 organisations would compete, one with each other, on
16 grounds of quality or price or whatever. So it would
17 depend on the ethos that developed within these
18 newly-formed and independent organisations.
19 Q. Mr Hugh Mills, who is chief executive of the Sperrin
20 Lakeland Trust at the relevant time, 2000, when speaking
21 about the reporting of adverse incidents to the
22 Western Board, he referred to a document, circular 1 of
23 86. It's a document dealing with the notification of
24 untoward events and unusual occurrences to board
25 headquarters. In his view, that was the template that

1 was in place pre-1996 and it was the template that, so
2 far as he was concerned, remained in place after 1996.
3 He was reporting, if you like, to the Western Board
4 in the same way with regard to adverse incidents; the
5 difference, I suppose, was in terms of who had
6 responsibility for investigating those adverse
7 incidents, which of course by 1996 was now resting with
8 the trust itself.
9 A. Yes. I think that's correct. I think one of the
10 difficulties is that the definition of adverse incidents
11 wasn't quite drawn in the same way as we would certainly
12 draw it now or it didn't move very fast in some places.
13 In many places, it appeared to me that almost the more
14 serious the incident was, the less likelihood there was
15 of it being reported through those particular
16 mechanisms. Very often they were designed to deal with,
17 for example, equipment failures and there tended to be
18 well-trod pathways and well-delineated mechanisms for
19 reporting equipment failure all the way up to the
20 department and for circulars to be issued in relation to
21 equipment on a regular basis. But when it came to
22 clinical care, I think those pathways were not well
23 developed and not satisfactorily dealt with in the
24 adverse incident reporting system, rudimentary as it was
25 at that time.

1 Q. We'll come back to that in a moment, but I just want to
2 finish looking at this circular in terms of its
3 implications. You have said in an addendum report that
4 this circular causes you to be strengthened in the view
5 that you expressed about the nature of the relationships
6 between trusts and boards, and you go on to say that:
7 "The circular indicates that there was a clearly
8 spelt-out responsibility on the Western Board
9 in relation to the quality of service being provided
10 under contract for the population. The responsibility
11 did not extend as far as holding managerial
12 responsibility for the actions of the trust, but it did
13 extend to a duty to hold the trust to account for the
14 quality of the service provided."
15 Could you just help us with that? The notion of the
16 purchaser/provider split was to give autonomy and
17 independence on the one part to the trust and separate
18 themselves fully in that sphere from the board. To what
19 extent did there then remain an obligation on the board
20 to oversee and hold to account the actions of an
21 independent trust?
22 A. I think that's dealt with in the circular to which you
23 refer in two regards. Firstly, in the circular,
24 there is a very clear statement in paragraph 3 of it
25 about:

1 "... trusts being expected to maintain good
2 relationships with purchasers based on collaboration and
3 partnership."
4 So I think there is an expectation first of all that
5 they should operate in collaboration and partnership.
6 And the paragraph that you read out some of, in terms of
7 the trusts' accountability to the purchasers around
8 quality, quantity and efficiency of the service, I don't
9 believe one can require trusts to be accountable to
10 boards without also having a parallel expectation of
11 boards having a degree of accountability for maintaining
12 that relationship and operating that relationship in
13 respect of issues such as quality, quantity and
14 efficiency. So I don't think in any way that it's
15 a one-way traffic situation.
16 Q. The issue of the responsibility for the quality of care
17 is an issue which the inquiry has received a variety of
18 evidence on. It wasn't until 2003 that legislation was
19 passed, which gave rise to a duty of quality. That was
20 introduced into the HPSS Quality Improvement and
21 Regulation Order 2003. The duty of quality set out at
22 article 34 stated that:
23 "Each Health and Social Services board and each HSS
24 trust shall put and keep in place arrangements for the
25 purpose of monitoring and improving the quality of the

1 health and personal social services which it provides to
2 individuals in the environment in which it provides
3 them."
4 Can you help us with this: what was your
5 understanding of the practice, prior to the adoption in
6 legislative form, of a duty of quality which rested with
7 the trusts and the board?
8 A. Well, I think the 2003 order and the circular that
9 followed it do perform a useful function in that they
10 place matters around the quality of care on an equal
11 footing with the way of operation in relation to
12 financial matters. For example, it was quite common for
13 the boards of trusts to have very weighty, substantial
14 issues on their board agendas in relation to the
15 financial performance of trusts, in relation to the
16 quantum of service being delivered on waiting times,
17 et cetera. But it was clear that in many cases, trusts
18 rarely, if ever, had any reporting on their boards about
19 the quality of care being delivered to their patients.
20 And I think, across the UK, there was a recognition that
21 we needed to move to a situation where issues around the
22 quality of care of services were dealt with on an equal
23 footing.
24 So that is why it was moved to, I think, being
25 placed on a statutory duty. But it didn't create a new

1 duty in my view; that duty had always been there. One
2 of the things that the development of clinical
3 governance sought to do was to create a framework
4 whereby the various disparate elements of that attention
5 that should have been there to quality of clinical care
6 was brought together in one place.
7 If I could go back perhaps to the 1993 circular that
8 we touched on a minute ago. In the paragraph from which
9 you read an excerpt in relation to the accountability of
10 trusts, it clearly states:
11 "The contracting mechanism will provide the means
12 for these to be specified and monitored."
13 So I think there already existed, as a result of
14 that circular, a requirement for the specification of
15 quality and for the monitoring of quality. So to go
16 back to your 2003 circular, I think what that does is
17 put on to a statutory basis and a much firmer
18 expectation of how that would be reported and
19 particularly reported through the board mechanisms.
20 Q. Yes. I'm particularly interested in your point where
21 you say this wasn't a new duty, it was a new duty in
22 a statutory sense. You have read the evidence of
23 Mr Frawley. He told the inquiry when he gave evidence
24 on 20 June that, before 1996, he considered he, as the
25 general manager of the Western Board, had real

1 responsibility for the quality of care provided and
2 then, once the trusts came into being, the
3 chief executive of the trust would have had a similar
4 responsibility to the responsibility he held pre
5 formation of trusts. He encapsulated it really by
6 saying:
7 "If you recruit and employ a clinician, you have
8 a clear interest and responsibility in the performance
9 of that individual once appointed."
10 And he was saying that in the context of the
11 delivery, obviously, of healthcare to patients. So
12 is that what you're describing yourself, that the
13 responsibility for quality of care was always there but
14 in 2003, so far as you understand it, the legislation
15 was formalising this duty?
16 A. Indeed. I think that's correct. Even if one goes back
17 to the period prior to the pre-1996 period before the
18 trust was created, the unit general manager would
19 of course have a great deal of delegated managerial
20 responsibility for the operations in the particular unit
21 of management, directly managed though it was, and would
22 of course be expected to have an interest in the quality
23 of services. I think intrinsic to the provision of any
24 Health Service has to be a concern about the quality of
25 that service. And I think the change in relationship to

1 the pre and post 1996 in respect of the general manager
2 of the health board is a matter of mechanism rather than
3 duty. By that, I mean prior to it, the relationship,
4 being a purchaser and provider, it was directly managed.
5 So the board still had a responsibility for the quality
6 of healthcare provided for its population, but the
7 mechanism by which that duty could and was exercised,
8 was expected to be exercised, altered from being
9 a direct managerial responsibility to being exercised
10 via, as it was stated in the 1993 circular, the
11 contracting mechanism, via the purchaser and provider
12 split. But the responsibility, I feel, was unchanged in
13 principle.
14 THE CHAIRMAN: While that sounds as if it makes sense,
15 professor, that's directly contrary to the view
16 expressed by Mr McKee, who became the chief executive of
17 the Royal Trust when it was formed. In that he was
18 supported to some degree by Dr Carson, who was the
19 medical director and was, I think, the deputy
20 chief executive. Dr Carson's view was, while the trust
21 took over responsibility for quality of care in 2003 on
22 the statutory footing, when I asked him who that had
23 been taken from, he said they just didn't really have it
24 before then. It doesn't sound right to me and what
25 you're saying is you don't think that is right. You

1 think it may not have been expressed as precisely or
2 concisely as it was in the 2003 legislation, but there
3 was a responsibility for a quality of care before the
4 2003 order?
5 A. I think that is absolutely correct. You can draw this
6 really very widely. For example, every doctor and nurse
7 operating, for example, within the Royal Group of
8 Hospitals has a professional duty in relation to their
9 treatment of patients and they are employees of that
10 hospital. The big change, I think, in relation to the
11 acquisition of trust status was that the employment
12 responsibilities for the senior medical staff
13 transferred to the trust from the board, and that was
14 something that was quite new.
15 I think, by the time we got to 2003 and the creation
16 of that statutory duty, there was sufficient concern
17 that in some places those leading trusts were not taking
18 on board their responsibilities to concern themselves
19 with the quality of care being afforded to patients, and
20 in the governance of trusts issues around the quality of
21 care being provided to patients were not being given due
22 weight in the proceedings of the trusts, for example
23 appearing within meetings of the board and being brought
24 to the attention of chairs and non-execs as part of
25 that.

1 So when statutory duties came in, I don't believe
2 that it was a statutory duty in respect of quality of
3 care; I believe it was a statutory duty into how quality
4 of care should be accounted for within the structures of
5 the organisation.
6 THE CHAIRMAN: Can I ask you: is there a British equivalent
7 of the 2003 order? So what we know was introduced here
8 in 2003, had it been necessary to produce that in
9 Britain some years earlier?
10 A. Yes, I think there was indeed, and it was quite
11 contested at that time because there were some
12 chief executives and senior managers who objected to
13 that duty being placed upon them. Those objections,
14 I think, didn't get very far.
15 THE CHAIRMAN: What was the basis of a chief executive of
16 a trust objecting to being responsible for the quality
17 of care provided by a hospital?
18 A. I think because it introduced a very clear duty for them
19 to intervene when there were problems of quality of care
20 and that could at some times mean they could have to
21 tackle vested interests within the hospital,
22 particularly clinical vested interests. Some
23 chief executives found that a difficult thing to do.
24 The issue arose very prominently in the proceedings
25 around Bristol and particularly, I think, in the GMC

1 hearings in relation to the then chief executive of
2 Bristol, who was a doctor, which was why he was brought
3 before the GMC. The argument played out at that point
4 that the chief executive had no responsibility in regard
5 to the operation of consultants within the Bristol Royal
6 Infirmary, and that argument was rejected by the GMC and
7 that view, I think, was a game-changing view and it made
8 it clear that chief executives were accountable and,
9 of course, the proceedings around Bristol were
10 well-known across the entire clinical and management
11 community in the UK.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: Just a question directed to me by one of my
14 learned friends. In the context of this responsibility
15 among, as you described it, a chief executive of
16 a trust, could that in how it was played out in
17 Great Britain have led to a potential for criminal
18 responsibility if the facts allowed it?
19 A. Indeed. It didn't arise at that time, but that was
20 indeed one of their concerns. I think they were right
21 to be concerned. They were right to be concerned
22 because of the power relationships that existed at that
23 time and the difficulties there were in some places and
24 often related to the culture of the organisation in
25 tackling issues of poor performance amongst senior

1 clinicians, particularly in well-established large
2 hospitals where the medical staff held great sway and,
3 in many instances, were very much listened to by
4 chairmen of trusts in terms of making appointments or
5 continuing people's contracts.
6 THE CHAIRMAN: To put it in very crude terms, was this an
7 objection by some doctors that "I'm not accountable to
8 a pen-pusher"?
9 A. Indeed. Indeed, Mr Chairman.
10 THE CHAIRMAN: But the follow-on from that is if they're not
11 accountable to a manager, or a pen-pusher in their
12 terms, then they would only accept accountability to the
13 GMC.
14 A. That's correct. Of course, it played both ways. There
15 were some chief executives who were very happy not to
16 have the responsibility.
17 THE CHAIRMAN: Yes.
18 A. And very often -- in fact one of the major problems was
19 that when clinical issues arose within the hospital
20 context, one of the inadequate coping mechanisms that
21 was often adopted was simply to bundle up the issue and
22 pass it to the GMC for them to look after. In fact,
23 that was entirely an appropriate way of handling them
24 because the doctors were duly accountable, they were
25 accountable certainly to the GMC, but they were also

1 accountable to their employer and there were very
2 clearly laid-down mechanisms for the exercising of that
3 accountability to employers. So it's not that the
4 mechanisms for dealing with these issues were not in
5 place within the structure, but there was a real
6 reluctance -- because, I think, of the power
7 relationships in some places -- to operate those
8 mechanisms.
9 THE CHAIRMAN: Thank you.
10 MR WOLFE: Let me move back to the more specific point,
11 which we were dealing with in the 1993 circular, and
12 that is the nature of the accountability relationship
13 between the trust on the one part and the board on the
14 other. Could I have your observations on this?
15 Mr Mills, in describing that relationship in general
16 terms, before we descend to the specifics of adverse
17 incidents, talked in terms of having extensive monthly
18 meetings with, if you like, his equivalent in the board,
19 the chief executive of the board, with various agenda
20 items. He would use such meetings to update the board
21 on matters of importance and he expected that the board,
22 either in the person of Mr Frawley or in the person of
23 the director of public health, Dr McConnell, he would
24 expect them to suggest anything that the trust should be
25 doing pursuant to the provider/commissioner

1 relationship, and indeed to correct and suggest
2 corrections if the trust was perceived as not doing its
3 job properly. Could you help us with that? Is that how
4 you would expect the relationship to have been working?
5 A. I think there is a substantial range in the nature of
6 the relationship that operated and it very much depended
7 on the cultural dimension to the organisations involved.
8 I think you alluded to there being a different nature of
9 relationship, for example between Altnagelvin and the
10 board, and the relationship would be determined over
11 a period of time and factors such as whether the
12 chief executive of the trust was the former unit general
13 manager. You had mentioned an adult/child relationship
14 in relation to how the trust and board might have
15 operated in the past. Had that relationship changed
16 substantially or was it still an adult/child
17 relationship? And I think there are a whole range of
18 ways in which that operated. So I couldn't say
19 definitively what took place in those meetings, but
20 certainly they were the prime opportunity for the
21 exercising of the sort of relationship, both the
22 collaboration and partnership aspect of the
23 relationship, but also the accountability aspect of the
24 relationship.
25 Q. I'm interested in your view on this because in your

1 first report to the inquiry, I suppose it's fair to say
2 that you emphasised the absence of a direct managerial
3 accountability type relationship --
4 A. Yes.
5 Q. -- whereas I think if there is a strengthening in your
6 view in terms of the nature of that relationship, it
7 comes from your understanding of the 1993 circular,
8 where, as you say in your addendum, you now perceive, if
9 you like, a greater role for the board in terms of
10 holding the trust to account.
11 A. Indeed. I apologise for only coming to the 1993
12 circular late, but it does indeed strengthen my view.
13 It's very clearly laid out in some of the words you read
14 out earlier that there is a direct relationship.
15 I particularly note the contracting mechanism being
16 specified as the way in which quantity, quality and
17 efficiency would be specified and monitored. I think
18 that probably also would strengthen the view in my
19 earlier advice in relation to the contract that was in
20 place, the service agreement which was in place, which
21 I didn't find to be particularly adequate and I think
22 that view is very strongly reinforced by a circular
23 which states that the contracting mechanism will really
24 play such an important role in relation to these issues.
25 Q. Moving on to the specific area of adverse incidents, it

1 seems, Professor Scally, that there's a degree of
2 consensus between the witnesses who gave evidence on
3 behalf of the trust and the witnesses who gave evidence
4 on behalf of the Western Board that the requirement to
5 report, if I put it in those terms, or the understanding
6 that a report of an adverse incident would be made
7 derived in significant part from the fact that the board
8 was the commissioner of services and had
9 a responsibility for the health of the local population.
10 That was the reason why the trust was reporting serious
11 adverse incidents into the board; is that your
12 understanding of the rationale?
13 A. Yes. I can see no other rationale for it because, if
14 I'm recalling the documentation correctly, what had been
15 the incident-reporting mechanism prior to the trust
16 coming into being, in a sense that was truncated and
17 there was nothing in that mechanism under the trust that
18 indicated reports would be made as a matter of course to
19 the board. So therefore, adverse incidents, if they're
20 of sufficient seriousness, I would have now expected to
21 be done in the context of the accountability for quality
22 that existed between the purchaser and provider and via
23 the contracting mechanism.
24 Q. There were a number of nuances to the rationale as it
25 was explained by various witnesses. So for example --

1 and maybe this touches upon the cultural factors that
2 you alluded to earlier -- Mr Mills understood that he
3 had to report to the board because of the fact that the
4 board were the commissioners, but he also saw a second
5 feature of the reporting arrangements, and that is that
6 the Western Board, as he said when he gave evidence on
7 17 June, was a key source of advice which they, that is
8 the trust, relied upon. And again, your observations on
9 that, that is an understandable cultural development,
10 perhaps tapping into the resources that were available?
11 A. Indeed. I think there are various forms of authority
12 and the positional authority that the general manager
13 would have had in relation to a directly-managed unit
14 and a unit general manager, that positional authority
15 ended with the creation of a trust, so that the
16 chief executive of that trust was accountable to the
17 chair and the board of the trust. But there is also
18 a physical authority or a sapiental authority, either of
19 which might operate, and I can absolutely see how the
20 board general manager would continue to be a source of
21 expertise and a source of advice to chief executives of
22 trusts, and for many of them I'm sure it was extremely
23 valuable because being the chief executive of
24 particularly a small trust could be a very lonely place
25 to be.

1 Q. Dr McConnell, the director of public health, he put
2 another layer on this when he gave evidence on 19 June.
3 He talked about, if you like, the potential for
4 unhelpful media reportage of incidents and there was, in
5 a sense, in that context, a need for the board to
6 receive first-hand from the trust an understanding of
7 what had happened so that the board could take on its
8 responsibility of explaining to its constituency just
9 what had happened. Is that, in your experience, an
10 understandable concern?
11 A. I think that's a very important concern. A part of the
12 relationship that would be built up between purchasers
13 and providers would have a strong element of -- it's
14 sometimes expressed as a "no surprises" approach. One
15 would not expect to read about a serious problem
16 occurring in a trust in the newspapers if you were the
17 chief executive of their major purchaser of services.
18 That's certainly one element of it, and I think the
19 other element of it is around what we would now describe
20 as reputation management, that those serious issues,
21 particularly in the context of those times where there
22 had been a huge amount of media attention devoted to
23 avoidable deaths, that the issue of managing the
24 relationships with the media were extremely important in
25 order to preserve the reputation of the Health Service.

1 Q. Another layer, professor, explaining the rationale, if
2 you like, for the trust reporting to the board came from
3 Mr Frawley when he gave evidence on 20 June. He
4 explained that fundamentally, if an adverse incident
5 occurred, if there's learning to be achieved, we need to
6 identify it very quickly, he said, and implement it very
7 quickly because the protection and the quality and the
8 safety of the service can become part of that process.
9 So he was explaining, if you like, a need to get to
10 grips with matters early and in that sense there was
11 a need for an exercise of judgment on the part of the
12 trust as to whether a particular incident should be
13 referred to the board and, if that judgment was
14 exercised positively, then a need arose for the board to
15 understand quickly the direction of travel. Is that
16 again, in your experience and understanding, an
17 understandable rationale?
18 A. It is an understandable rationale. When serious
19 clinical incidents occur -- in my experience they occur
20 against a background where there are deficiencies in the
21 organisation or deficiencies in relation to the practice
22 of an individual. The most important feature is to try
23 and prevent the occurrence of further such incidents,
24 whether that be by intervening in relation to an
25 individual or an organisation or in relation to an issue

1 around equipment or drugs or whatever. So it's entirely
2 reasonable to think that learning would be one component
3 of the response.
4 Q. I want then to move on to receive your views, if we can,
5 on, given the norms of that time -- and here we're
6 talking about the year 2000 -- what would be expected of
7 a board in circumstances where the trust had, as in
8 Lucy Crawford's case, reported an adverse incident in
9 and indicated to the board that it intended to
10 investigate that death via a process, if you like, of
11 internal review, using an external expert to provide
12 some assistance. So from the starting point of a report
13 coming in to the board in those terms, what is your
14 understanding, applying the norms of the time, of what
15 would be expected from the board and its officers?
16 A. At that time, I think -- and one would hope that it
17 still holds -- serious clinical incidents involving
18 avoidable deaths are rare events, particularly in
19 relatively small healthcare organisations. And the
20 conducting of a review into such events is not something
21 to be undertaken lightly because, if it is not done well
22 initially, it's unlikely to be possible to recover some
23 of the quality of the review. And setting up a review
24 is not a particularly easy thing to do. Therefore,
25 it would be good practice to discuss how that would be

1 carried out and who would be carrying it out and under
2 what circumstances it would be carried out. If a report
3 had reached me, my view would be that I would want to
4 have a discussion with the trust involved and understand
5 how exactly they were intending to conduct that review
6 and to satisfy myself that I found those arrangements
7 acceptable so that I could therefore reassure my board
8 that, as an organisation purchasing services for our
9 population, we were fulfilling our responsibility
10 correctly.
11 Q. Could I ask you just a number of supplementary questions
12 arising out of that? An issue arose certainly on the
13 papers about -- let's put it in these terms -- whether
14 in terms of using a Dr Quinn to carry out a review of
15 the clinical notes was an appropriate way to go because
16 of a perception that he may not be regarded as
17 independent. I don't wish to descend into the fine
18 detail of that, that's a matter for the chairman to
19 reach conclusions upon, but are you saying that as the
20 commissioner of services you would expect either the
21 chief executive or the director of public health to
22 analyse the appropriateness, whether in terms of skills
23 or independence or such factors, of the persons who are
24 carrying out the review?
25 A. I would certainly expect them to ascertain who the trust

1 was suggesting should carry out the review and then make
2 a judgment as to whether, in their view, that person was
3 sufficiently divorced from the field of play to be able
4 to provide an objective analysis of what had happened.
5 Q. What about the terms of reference? The board was told
6 that a review was being carried out, it was provided
7 with an update which indicated who would be carrying out
8 the review and the nature of the issues that would be
9 examined. Are you saying, professor, that having been
10 informed that a review is to be carried out, the
11 officers of the Western Board should be rolling up their
12 sleeves and seeking to influence the direction of travel
13 in terms of the terms of reference?
14 A. I think the terms of reference of any review are
15 absolutely crucial. They define not just the matters to
16 be reviewed but they should also go on and define to
17 whom the review reports. I think that is another
18 crucial issue.
19 Q. The perspective that, if you like, came back from the
20 board witnesses when addressing this kind of area
21 is that plainly, under the post-1996 arrangements, the
22 trust was independent, it was autonomous, so it wasn't
23 for the board and its officers to be second-guessing the
24 fine detail, if you like, of the trust's approach, at
25 least not at the stage when the review was setting out

1 on its journey. There was certainly a role for their
2 input when the review report was received, but could you
3 help us with that? Is that fair that the board officers
4 could, in fact should, stand back at the start and not
5 get too deeply involved?
6 A. Well, I think the expression "second-guessing" is
7 a loaded expression, and it seems to me to cut across
8 the relationship that should properly be established
9 between a purchaser and a provider. In fact, in the
10 1993 circular -- I mentioned it earlier -- the
11 collaboration and partnership relationship doesn't seem
12 to me to be compatible with someone suggesting that it
13 might be second-guessing. Collaboration and partnership
14 should mean bringing the full expertise of all those
15 involved to bear on a problem in order to solve that
16 problem in the interests of the population they're both
17 trying to help.
18 Q. One of the issues that both the trust and the board
19 witnesses were asked about was, if you like, the
20 narrowness of the terms of reference which didn't permit
21 those reviewing the case, on the face of it, to ask for
22 seek views from those in the royal Children's Hospital
23 who had the care of Lucy. So in no sense were they
24 asking those clinicians to contribute to the review.
25 Is that the kind of thing that a board could become

1 involved in in terms of seeking to influence the terms
2 of reference?
3 A. Indeed, and that is one of the areas I think I picked up
4 in my original statement. I think everyone who is faced
5 with an unexplained death, particularly one where there
6 may be queries of the quality of care, it would be wise
7 to review the entire care pathway in relation to that
8 incident, which would include -- and could even extend
9 back as far as the general practitioner care made
10 available, but certainly from time of admission all the
11 way through to time of death, and in fact beyond that
12 in relation to how that death was dealt with within the
13 hospital where it occurred in relation to post-mortem or
14 to whom it was reported. And I think it is really
15 difficult to see a review being adequate when it's
16 restricted to only one part of that particular patient
17 journey.
18 THE CHAIRMAN: Particularly when the information which comes
19 from the review is still unclear about why Lucy died?
20 A. Indeed.
21 THE CHAIRMAN: So if you had a review which had answered
22 those questions, then the need to go to the Royal for
23 further information might have been more questionable,
24 but when you have a review which ends up still without
25 anybody knowing why Lucy died, that can't possibly be

1 going far enough?
2 A. I agree. That would direct one's attention to not just
3 the GP care, the hospital care, but also the
4 transportation of the child to Belfast, plus the care
5 that was delivered in Belfast.
6 THE CHAIRMAN: And the other serious omission was the direct
7 involvement of the family in the review.
8 A. It would be absolutely good practice to keep the family
9 informed.
10 THE CHAIRMAN: And to seek their input or not? I hope that
11 happens now, but in 2000 would that still have been good
12 practice in 2000 if you were doing a review?
13 A. I think it would have been absolutely good practice.
14 I think it would be carried out much more often now than
15 then, but it would still have been good practice.
16 THE CHAIRMAN: Thank you.
17 MR WOLFE: In your original report, professor, you
18 identified a number of, if you like, micro steps that
19 you would have expected a board at that time to be
20 taking. They were to advise the trusts to report to the
21 coroner and advise the trusts to report to the
22 department and thereafter to take steps to ascertain
23 that those reports had been made.
24 So advise them to make the report and then check to
25 make sure that had been done. Are you saying that that

1 would have been, if you like, a norm or are you saying
2 that would be more in the realms of good practice in
3 2000 for a commissioning organisation?
4 A. I think it would have been in the realm of good
5 practice, but it strikes me as self-evident if it's
6 an important issue and you, in discussion with other
7 parties, are helping to produce a pathway forward around
8 something really serious, then I would expect someone to
9 check what had actually happened. That doesn't need to
10 be desperately formal; it could be an enquiry, a request
11 for an update. That certainly personally would be my
12 way of doing it. I would have asked: could you provide
13 me with a briefing on progress within a few days?
14 THE CHAIRMAN: In fairness, Mr Frawley did ask at one point
15 for an update on progress and he seems to have got an
16 update. So quite a lot of this started, but a lot of it
17 also ended up in a rather unsatisfactory form. There
18 was a review of sorts, there was information to the
19 board of sorts, but too many things seem to have been
20 allowed to drift away without any meaningful conclusion
21 or lessons being learned.
22 A. I think, chairman, I agree. I think reading the papers,
23 I was interested to note the number of informal
24 communications that seemed to take place around
25 something that was really very serious, and it seemed to

1 be conversations on the side of meetings or what are
2 sometimes referred to as corridor conversations about
3 issues, with no note keeping and --
4 THE CHAIRMAN: That's fine up to a point if there's an
5 outcome. But what seems to be missing here in Lucy's
6 case is an outcome because there's a review finished,
7 but Dr McConnell in any event seems to be saying, "Look,
8 the review was over and I may have received a draft of
9 the review, maybe not the final version, but by then
10 I knew that the hospital was involving the Royal
11 College, so I waited for that". So time is moving on,
12 but if this was more serious than a one-off, major
13 medical failing, if there was a systems failure, the
14 fact that it was being allowed to drift on would be
15 inconsistent with the obligation to put things right
16 sooner rather than later?
17 A. I interpreted that -- and I agree with your analysis --
18 as a shift in concern, a shift in concern from the death
19 of one child into a concern about the overall clinical
20 performance of one consultant. The main objective being
21 to identify, "Was there an issue in overall
22 performance?", and a desire to deal with that particular
23 issue to ensure that there weren't further patients
24 damaged in the future. So these are very complex
25 matters to handle and I do think that there was that

1 shift and in some ways that shift was understandable.
2 THE CHAIRMAN: Provided that you don't overlook the most
3 catastrophic incident of all, which is the death of
4 a child?
5 A. Indeed, and the judgments about overall performance are
6 absolutely dependent upon reaching good judgments about
7 each individual episode of clinical care that's under
8 consideration.
9 THE CHAIRMAN: Thank you.
10 MR WOLFE: I think it was Mr Bradley who suggested quite
11 candidly that he became, in a sense -- "distracted" was
12 his word -- by the influence or the importance that was
13 given to this next stage of looking at Dr O'Donohoe's
14 competence and performance. And he recognised before
15 this inquiry that one of the, if you like, ways of
16 testing competence and performance would have been to
17 maintain a focus on how that particular child had been
18 treated and, in that sense, I think being fair to him,
19 he regretted that that distraction had affected him and
20 perhaps he was speaking widely for his board colleagues.
21 We'll come to the specifics of what should have happened
22 after a report was produced, but could I, in fairness to
23 Mr Frawley and perhaps to Dr McConnell as well, put
24 their perspective on what you said about the board's
25 need to assure itself about reportage to the coroner and

1 reportage to the department?
2 I think, to put their perspective fairly, they're
3 saying that there was a little bit of looking at this
4 with the benefit of hindsight, that they can recognise
5 that given the catastrophic events, if you like, that
6 unfolded of course it would have been good to ensure
7 that the coroner had been properly informed, that
8 it would have been good to ensure that the department
9 was apprised of these events.
10 But their main point seemed to be this: that given
11 the autonomous nature of the trust's status, they should
12 not be expected to be looking over the shoulder of the
13 trust and checking up whether these kinds of reports had
14 been made. If you like, the trust was big enough and
15 expert enough and experienced enough to do that for
16 themselves.
17 A. I don't think it was a matter of looking over their
18 shoulder. This is about the collaboration and
19 partnership arrangements that should have existed.
20 Collaboration isn't just for the good times and
21 partnership is not just for the good times, but for the
22 tough times as well, and that means an engagement in the
23 issues.
24 Q. Could I move on to that stage then and, as the chairman
25 noted -- and in fairness to the board and indeed to the

1 trust -- there was a process of updating informally and
2 formally at meetings, updating the board about various
3 steps that were being taken pursuant to this review.
4 But at the stage where a review report is available, can
5 you help us with this: would it have been your
6 expectation that that should have been delivered, in
7 a sense, formally to the board for its comment and
8 observations?
9 A. I think it should have been shared with the board, given
10 the board knew something of the circumstances, knew of
11 the existence of a review, and it's part of the
12 assurance of quality that should exist in terms of the
13 board's duty. I think, knowing the background of the
14 unexplained death of a child, one would want to know
15 that the review that had been carried out had been
16 a satisfactory review in terms of answering the terms of
17 reference and reaching some conclusions that could be
18 acted upon or not acted upon if everything was found to
19 be fine.
20 Q. It was Mr Frawley's perspective that he personally, as
21 general manager of the Western Board, would have
22 expected to receive the trust review under cover of
23 a letter and, if he had received it, he would have gone
24 on to speak to the professional leads and engaged in
25 a process of working out whether the review report was

1 an appropriate and proportionate response to, if you
2 like, the problem. And at that stage then bring it
3 forward to the healthcare committee within the
4 Western Board to, if you like, report and decide on what
5 steps should be taken vis-a-vis the trust in terms of
6 going back to the trust with recommendations or
7 suggestions. Is that, in your experience, an
8 appropriate description of the expected pathway?
9 A. I think it's slightly more than I would have expected.
10 If there was a serious incident and if the review had
11 taken place and been discussed with officers of the
12 board and there were concerns about it or even if the
13 incident was now closed, it's certainly entirely
14 reasonable that the officers would report to the
15 committee. I wouldn't expect the committee to
16 necessarily see the review or have an opportunity to
17 discuss the review. I think those are likely to be
18 professional issues. But one would reasonably expect
19 the officers, including the general manager,
20 chief executive, to make a report to the committee.
21 Q. And then the next stage, as Mr Frawley described it on
22 20 June, was this: in circumstances where, if you like,
23 there was an inconclusive report in the sense that it
24 didn't achieve the objective or one of the objectives of
25 accurately describing the cause of death, that he saw

1 for the Western Board a responsibility to advise the
2 trust of the need for a further and broader review.
3 A. I think, having taken appropriate professional advice,
4 that would be an entirely reasonable thing for him to
5 expect.
6 Q. And he saw this in the context of the board as the
7 commissioner of services needing to understand whether
8 there were lessons to be learned which might be of
9 perhaps broader application.?
10 A. Yes, but also concern perhaps that they hadn't got to
11 the bottom of the incident properly. That concern might
12 have been heightened by not having had any real
13 involvement in defining the terms of reference of the
14 review in the first place. And to receive an
15 inconclusive review that not only doesn't answer the
16 questions but doesn't convince you that the mechanisms
17 set up to deliver answers to the questions were
18 adequate, that that mechanism was adequate, I think
19 those are matters of concern and one would certainly
20 want to go back to the trust firmly about those issues.
21 Q. Yes. And as I, and indeed the chairman, characterised
22 it a few moments ago, the report on the care provided to
23 Lucy didn't arrive formally with the board. It seems to
24 have been discussed, if we understand Dr Kelly's
25 evidence correctly, on the fringes or as part of another

1 agenda at a meeting in September, which discussed, for
2 example, the wider hospital debate in the south-west.
3 Is that satisfactory in your view that it wasn't
4 discussed as, if you like, a central item on an agenda
5 between the two parties?
6 A. I think the review should have been discussed formally
7 in the sense of it being recorded and documented and
8 a serious discussion having taken place about it within
9 the board itself, with the chief executive and
10 professional officers, as appropriate, and then it
11 should have been part of a formalised interaction with
12 the trust. I don't necessarily mean it has to be
13 a separate meeting about that, but it should be
14 a meeting at which the appropriate people to deal with
15 the issue are present on both sides.
16 Q. The explanation perhaps for not addressing it, that is
17 the review report, specifically within the board seemed
18 to be from Dr McConnell, or at least his understanding
19 was that, if you like, they hadn't reached the end of
20 the story, that they were moving into this new phase via
21 the Royal College and the appointment of
22 Dr Moira Stewart to, if you like, continue the
23 investigation. Is that a reasonable explanation in your
24 view, applying the standards of the time, for not
25 examining formally the review report?

1 A. Well, at that point they had what was clearly a review
2 that was inconclusive and they had decided, at the trust
3 level, I think, to ask the Royal College to nominate
4 someone to look further into the matters. Within the
5 health board context, I would have expected that matter
6 to be part of a discussion at a fairly serious level
7 between the chief executive and one or more of the
8 professional officers and it to be drawn to the
9 attention perhaps of the chair and/or the non-executives
10 perhaps via their committee, but it should certainly be
11 entered in some way into the formal business of the
12 organisation.
13 Q. Of the board?
14 A. Of the board.
15 Q. Again, the tenor of Dr McConnell's evidence, in fairness
16 to him, was that he found himself satisfied that this
17 pathway of having the issues examined via Dr Stewart was
18 satisfactory. He took some reassurance from that. Your
19 point is that if what is his position, his
20 understanding, that that should be, if you like,
21 reported back to the board and formally noted?
22 A. Indeed. I can understand how he would be reassured by
23 that and in a sense he was, to some extent, right to be
24 reassured by that in at least that there was going to be
25 another clinician looking at the evidence. At that

1 point in particular, perhaps it does -- and with time
2 moving on, it becomes an important matter to have it
3 dealt with properly within the board systems.
4 Q. One of the concerns expressed by Dr MacFaul, another
5 expert retained by the inquiry, was that these matters
6 around why Lucy died ought to have been addressed, if
7 you like, more urgently than the process or using the
8 vehicle of a Royal College-type review would allow for,
9 in that it wasn't until, if you like, a full year after
10 Lucy's death that the Royal College report or
11 Dr Stewart's report was available. Is that just how
12 things were done in 2000 or is that a valid concern?
13 A. I think the timescale is a valid concern. There is no
14 reason why it should take that length of time at all.
15 If there was a judgment that the initial review was
16 inadequate in any way -- and that could be inadequate
17 through its performance or merely inadequate in that it
18 didn't reach a firm view -- then it should be possible
19 to get another clinician to review it within a matter of
20 weeks and certainly within a month or so. Although the
21 review is described as a Royal College of Physicians
22 review, I think what happens under these circumstances
23 is that the appropriate people in the trust will
24 approach an officer of the Royal College of Physicians
25 and ask them to suggest a clinician from outside who

1 might undertake this review. So it is merely
2 a mechanism for identifying what might be felt to be
3 a suitable external person. One can absolutely see why
4 it would be done in that way as in a small trust they
5 might have no other way of identifying a suitable
6 clinician.
7 Q. The output from the Dr Stewart intervention was a report
8 that examined a number of cases, including Lucy's death.
9 She would describe her work within the remit of
10 a competence and performance review rather than
11 a medical report looking at these four incidents, and
12 that is, if you like, a nuance which the chairman has
13 heard evidence on. But could I ask you this: the report
14 was sent to Dr McConnell and he wrote to Dr Kelly in
15 response to it and met with him, but his correspondence
16 with Dr Kelly of the trust didn't touch upon the
17 conclusions reached in Dr Stewart's report in relation
18 to Lucy Crawford. Can you help us with this: where
19 Dr McConnell was viewing the Royal College intervention
20 as being part of the further investigation of Lucy's
21 death, should he have been commenting formally in
22 response to that report by reference to the specific
23 case of Lucy Crawford?
24 A. I think that is a difficult question. Certainly there
25 was unfinished business in relation to Lucy's death and

1 the reasons for it. But as I said earlier, the shift
2 was towards broader competence issues. I do feel that
3 it is problematic to leave a death of a child
4 unexplained. That's an inadequacy and I would hope that
5 it would have been picked up and further effort put into
6 reaching a conclusion in relation to that individual
7 case.
8 Q. Could we move then to the department and seek to
9 identify, if we can, the nature of the relationship
10 between the trust and the department in the post-1996
11 period? Could we take as our starting position again
12 the circular that we looked to at the start?
13 323-001a-002.
14 I should add, professor, before looking at this
15 document again, that the department has advised the
16 inquiry, in correspondence dated March of this year,
17 that the circular that we are looking at sets out the
18 accountability framework which was in place in 2000
19 between the management executive and the trusts.
20 Going over the page to 003, and the continuation of
21 this paragraph 4. We've looked at the accountability of
22 trusts to purchasers. Then at (iii) we have the
23 accountability of trusts to the management executive and
24 the description is that they are:
25 "... accountable for the performance of their

1 functions, including the delivery of objectives and
2 targets set out in the strategic direction and annual
3 business plans. They will also be required to meet
4 their statutory financial obligations and conform with
5 any other specific requirements placed upon them,
6 including those in the management plan."
7 So the narrative set out here is in terms of an
8 accountability, the trusts to the department, in terms
9 of these financial and, if you like, strategic issues,
10 but is it your understanding that there is any
11 operational accountability?
12 A. Operational in terms of the full range of services
13 provided by the trust. Where it says there in that
14 paragraph:
15 "Accountable to the management executive for the
16 performance of their functions."
17 I would draw that very widely in that the entire
18 organisation is responsible to the management executive.
19 You cannot divide off any one particular component of
20 it. For example, the clinical care issues and issues
21 around quality of care. Although there is a laid down
22 accountability to the purchasers of that care, I don't
23 believe that the management executive could be entirely
24 blind to issues surrounding quality of care, though
25 their focus would be substantially upon issues of

1 finance and issues of productivity -- in a crude sense,
2 numbers of patients dealt with, waiting lists,
3 et cetera.
4 THE CHAIRMAN: Yes, but it doesn't help for the Sperrin
5 Lakeland Trust or any other trust, for that matter, to
6 be able to report back to the management executive,
7 "We've kept within the budget this year, we've provided
8 a very wide range of services, obs and gynae,
9 cardiology, paediatric and so on so on", and then stop
10 without saying, "Some of the services weren't very good
11 at all, but at least we provided them". That just
12 doesn't make any sense.
13 A. I agree with you, chairman.
14 THE CHAIRMAN: That's why you have to interpret that widely
15 for the system to work?
16 A. Exactly.
17 MR WOLFE: Could we look at paragraph 18 of this document?
18 I think it's three pages further on. 007. Again, this
19 is a description, at paragraph 18, of the circumstances
20 in which the department, through the management
21 executive, might intervene in the affairs of a trust:
22 "Intervention by the management executive in the
23 affairs of a trust should be exceptional, in line with
24 the principles of maximum delegation. It may be judged
25 necessary in certain circumstances, eg items of concern

1 relating to patient or client care; failure to discharge
2 statutory functions; breach of statutory obligations;
3 unacceptable financial performance."
4 Et cetera:
5 "Any such intervention will not preclude relevant
6 actions by the appropriate board ..."
7 That is in this case the Western Board:
8 "... whether acting in its role as purchaser or
9 fulfilling its statutory residual responsibility in
10 respect of the statutory functions delegated to the
11 trust."
12 So this circular envisages certain limited or
13 exceptional reasons or circumstances in which the
14 department can intervene either with or in addition to
15 the board's intervention with the trust.
16 A. Indeed, I think it's an important paragraph to simplify
17 matters. I think what it says is the management
18 executive will allow you to get on with the day-to-day
19 business, but if you're not doing the business properly,
20 we reserve to ourselves the right to intervene in any
21 part of your business. And I think it is notable that
22 the first item in that list is regarding patient or
23 client care. That, of course, seems also to me to place
24 an obligation on the management executive to have some
25 mechanism of knowing when it is appropriate for them to

1 intervene in relation to these matters.
2 Q. Just on this paragraph 18, are you reading that as
3 implying an obligation to report individual incidents or
4 are you reading it in terms of keeping the department
5 informed of, if you like, general trends in the work,
6 that is the delivery of healthcare to patients, so that
7 the department might be in a position to understand when
8 it might have to intervene?
9 A. If an incident is serious enough, it should most
10 certainly be reported to the department. After all, the
11 duty of the Civil Service is to operate in support of
12 ministers, and ministers are accountable for the entire
13 performance of Health and Social Care and they would be
14 failing in their duty, I think, if they didn't have an
15 expectation to learn about serious incidents across the
16 Health and Social Care system.
17 THE CHAIRMAN: Let's take a couple of examples. The Sperrin
18 Lakeland Trust and, for that matter, the Western Board
19 could have been lobbying the department regularly to
20 say, "Please make a decision urgently on where the new
21 hospital's going to be located because, until that
22 hospital is built, we're going to struggle to provide
23 good services in the west".
24 A. Yes.
25 THE CHAIRMAN: They could lobby the board and the department

1 to say, "Look, we're having trouble recruiting
2 consultants in the west, it's been a problem for years
3 and we need your support and we need ideas about how we
4 are going to recruit these people".
5 A. Yes.
6 THE CHAIRMAN: So those are two areas in which they can go
7 directly to the department where they have concerns with
8 the department which they need dealt with in the
9 interests of the people who live in the west.
10 A. Yes.
11 THE CHAIRMAN: By the same token, if there's a problem with
12 a major incident which has happened in which a child has
13 died, it's their obligation to go to the department to
14 keep the department informed?
15 A. I think that's in keeping with their duty.
16 THE CHAIRMAN: Right. But the other issue you add to this
17 is to say it's then incumbent on the department to have
18 some way of knowing what's going on?
19 A. Indeed.
20 THE CHAIRMAN: If there is an obligation on the trust to
21 report major issues, can the department not say, "Well,
22 in the same way as they come to us about making a
23 decision about where to build a hospital or how to get
24 doctors, we except them to come to us if there's a major
25 incident"?

1 A. I think the department should be saying that. I think,
2 first of all, they need to ensure that they are informed
3 about major incidents and then they need to have also an
4 ability to judge when their intervention is necessary
5 and when it is not.
6 THE CHAIRMAN: So as we said at the start of your evidence,
7 it's a judgment issue about how you don't go to the
8 department about everything, but you go to them about
9 the important issues?
10 A. Yes.
11 MR WOLFE: In many ways, what you have just said echoes what
12 Mr Frawley, the Western Board's general
13 manager/chief executive, said when he gave evidence on
14 20 June. He said:
15 "Given the nature of the accountability
16 relationships, he believed that the trust had an
17 obligation to report adverse incidents to the
18 department."
19 Although he added the caveat:
20 "Whether a trust would report would depend upon the
21 exercise of a judgment call, if you like."
22 And he seemed to emphasise that clearly you
23 wouldn't, as a trust, go running to the department for
24 every difficulty or every incident, but you would report
25 the more serious incidents.

1 Some of the other witnesses then -- and in
2 particular Mr Mills and Dr Kelly on behalf of the
3 trust -- put a completely different perspective. Could
4 I have your observations on that? Mr Mills said, when
5 he gave evidence on 17 June, that at that particular
6 point in time -- we're talking about the year 2000:
7 "[He] or the trust wouldn't have viewed the
8 reporting of an untoward incident as something that
9 we would have reported to the department."
10 Indeed, he went on to say that there were no
11 reporting arrangements in place, as he understood the
12 position, and that position was echoed by Dr Kelly. Can
13 that be correct?
14 A. There may not have been specific reporting relationships
15 or mechanisms in terms of reporting serious adverse
16 incidents to the department, but there was certainly
17 a reporting mechanism to the department and there was
18 nothing to preclude that reporting mechanism and those
19 contacts between the department and the trust
20 encompassing serious clinical issues. Indeed, given the
21 atmosphere of that time, particularly with the problems
22 in Bristol and several other really high profile
23 incidents of clinical failure, I would have expected
24 there to be a very ... You know, a sense amongst
25 people, both in the service end of the system and in the

1 department of the importance of serious clinical failure
2 to the whole system and therefore that they would indeed
3 be reporting issues where there were doubts about the
4 quality of care provided, resulting in potential death,
5 death or potential death.
6 THE CHAIRMAN: Professor, when had Bristol started?
7 A. It really broke into the public understanding in 1995
8 and received its maximal publicity during the GMC
9 inquiry, which I think reported in 1998 --
10 THE CHAIRMAN: Right.
11 A. -- but the Kennedy report, Sir Ian Kennedy's report
12 wasn't until 2002, I think.
13 THE CHAIRMAN: That led into Alder Hey, didn't it, about the
14 retention of organs?
15 A. Yes.
16 THE CHAIRMAN: So Bristol was the cardiac failures?
17 A. Paediatric cardiac surgery, but there were a number of
18 other significant failures at that time as well,
19 particularly in relation to the screening services,
20 cervical screening in Kent and Canterbury, breast
21 screening in Exeter and others.
22 MR WOLFE: Let me push Mr Mills' perspective just
23 that little bit further. You're saying that it was, if
24 you like, the feeling of the time emerging out of some
25 of these scandals, if you like, in the health

1 environment in England that people were or ought to have
2 been more sensitive about the need to report out of the
3 local into the regional and perhaps into the national,
4 whereas from Mr Mills' perspective they're dealing with,
5 obviously, a significant tragedy, but one that was not
6 immediately discernable as a case, he would say, of
7 wider ramifications. And indeed, building on that, he
8 would say the absence of a mechanism identified for him
9 for reporting in. Taking those two points together, but
10 perhaps emphasising the second point, should the
11 department have been constructing and, if you like,
12 disseminating to the trusts a specific rulebook, if
13 that's not to put it too far, in terms of when and how
14 to report adverse incidents if that indeed was the
15 obligation?
16 A. I think it is reasonable to have had an expectation that
17 the department would have done something in relation to
18 the reporting of these arrangements. In a sense,
19 I think the situation in Northern Ireland is an
20 interesting one because clearly all of the players
21 involved know each other very well at a senior level
22 within the Health and Social Care. They meet on a very
23 regular basis and no doubt they are involved in
24 telephone communication on a regular basis as well. And
25 I wouldn't like to reach a judgment on how far the

1 senior people involved place reliance on those informal
2 mechanisms of communication and the passage of
3 information as a substitute for codifying a process for
4 reporting and investigating and dealing with and
5 accumulating the information around serious incidents.
6 Q. Just to be absolutely clear, Mr Mills and indeed the
7 department in its recent correspondence to us emphasised
8 that there were accountability meetings, trust to the
9 department, and they tended to occur twice per annum.
10 But in Mr Mills' eyes, they were designed to address the
11 bigger structural and policy issues and perhaps be
12 a situation where he might have to explain the need,
13 particularly at that time, for new hospital
14 accommodation or what have you, capital expenditure,
15 those kinds of issues, but not descending into a single
16 adverse incident, no matter how serious. Again, putting
17 that in the balance, is that an understandable
18 explanation for the trust's behaviour at that time in
19 not reporting it to the department?
20 A. I think it's understandable in terms of the history of
21 the relationship and the dominance of financial and
22 strategic issues on the agendas of the communication.
23 But it does strike me very forcibly that serious
24 clinical failure has such an effect, not only on the
25 patients who may fall victim to incompetence or

1 malpractice, but indeed for the whole credibility of the
2 service. It strikes me that serious clinical issues are
3 of the utmost strategic importance and should indeed be
4 on the agenda of such meetings if there are particular
5 concerns in play at that time.
6 THE CHAIRMAN: In fact, if you take that analysis, it's even
7 harder to understand if it is the case that Lucy wasn't
8 raised with the department because it wasn't just about
9 Lucy's death. We had the death of a child combined with
10 some crisis about the competence and conduct of
11 a paediatrician in an area in which there were very,
12 very few paediatricians, so to a degree this could be
13 interpreted as threatening the whole delivery of
14 paediatric services in County Fermanagh.
15 A. A very important strategic issue, chairman.
16 THE CHAIRMAN: So not to mention that or not to raise that
17 with the department is rather hard to explain?
18 A. It is. It is, except that these are extraordinarily
19 difficult issues that go to some of the very
20 fundamentals of how the Health Service had at that time
21 traditionally operated in regarding consultants as
22 autonomous professionals capable of reaching their own
23 judgments and accounting for those judgments to the
24 profession as a whole via the General Medical Council or
25 whatever mechanism. The introduction of general

1 management some time before and of chief executives and
2 of trusts -- I'm not sure those two worlds had really
3 been brought together in a structured and ordered way
4 that would have given a great deal of confidence to the
5 senior managers in their skills, ability and standing in
6 dealing with some of those issues. So I think it is
7 very much a cultural issue.
8 THE CHAIRMAN: Thank you.
9 MR WOLFE: Could you help us perhaps, professor, just in
10 terms of what, comparably speaking, the department in
11 England and Wales would have been doing at that time
12 after the creation of trusts to, if you like, train,
13 inform and explain to chief executives their
14 responsibilities for reporting adverse incidents out?
15 A. At that time, the department in England had issued its
16 guidance about the introduction of clinical governance
17 and there was a substantial programme in place to help
18 with the introduction of clinical governance across the
19 piece. Every region of the country would have people
20 charged with assisting in the implementation of clinical
21 governance and a process was set in train, which in due
22 course led to the creation of the National Patient
23 Safety Agency, et cetera. And one would have had an
24 expectation at that time that not only would clinical
25 governance leads be in place, but that medical directors

1 would be fully aware of their duties and
2 responsibilities.
3 The General Medical Council, particularly
4 post-Bristol, had reviewed its guidance to the medical
5 profession and been very explicit about the duties of
6 doctors and what they needed to be doing if they felt
7 a colleague was putting patient lives at risk. So
8 I think the culture had already shifted quite
9 considerably in the five years between 1995 when the
10 Bristol scandal broke and the year 2000.
11 Q. Just again to put the trust perspective, I think it was
12 Dr Kelly's point that this cultural change in terms of
13 understanding the need to report to the department such
14 matters didn't really arrive in Northern Ireland until
15 2004, so after the 2003 legislation then it became, via
16 a circular, quite prescriptive in terms of what the
17 trusts should be reporting to the department, whereas
18 that had not been the case hitherto. Your observations?
19 A. I can't speak without further work about the precise
20 dates on which reporting mechanisms were put in place.
21 Certainly as someone at that time responsible for,
22 geographically, the largest English region of 5 million
23 people, I met regularly with the medical directors of
24 every trust in that region, in which we discussed issues
25 relating to clinical governance. I dealt with an

1 enormous number of reports of serious clinical issues
2 from those medical directors in regard to their trusts
3 and I think we have seen the benefit of that in that the
4 number of such serious clinical incidents directly in
5 respect of the competence of doctors declined very
6 steadily.
7 Q. Again, just going through the circular, Mr Frawley in
8 his evidence saw in particular the death, unexpected
9 death, of an infant in the hospital setting as
10 pre-eminently, if you like, an issue that would go to
11 the department. Just to add a further layer to that,
12 his sense of it was that it would be important to go to
13 the department because, if there were to be lessons
14 learned, the department was perhaps the best vehicle,
15 the better vehicle to disseminate those through the HPSS
16 in Northern Ireland. That's Mr Frawley's perspective.
17 Is that a fair analysis?
18 A. I think that is fair analysis. Certainly the department
19 would be the key mechanism for the dissemination of
20 lessons, though I do believe that the focus at that time
21 was very much around competence, the issues of
22 individual clinical competence, but nonetheless the
23 department of course has a role in relation to those
24 issues because it sets the framework within which they
25 are dealt with.

1 Q. Yes. Just one further area to touch upon -- I'm
2 conscious of the time; it won't very take very long,
3 chairman -- and it concerns your observations in your
4 initial report about the role of the Royal Belfast
5 Hospital.
6 Perhaps it would assist you and others to put it up
7 on the screen. 251-002-017. It's under the heading
8 "Additional observations", it's the first point. You
9 say:
10 "There is value in exploring the role of the
11 RBHSC ... If there was any significant suspicion that
12 this was a death that arose out of inadequate treatment
13 then those in the Royal should have exploited their
14 internal mechanisms to address that."
15 And in addition to that, you would see, if you like,
16 an obligation to report in a formal manner their
17 concerns to the Sperrin Lakeland Trust. The whole area
18 of audit, Professor Scally, is something that the
19 inquiry has examined through certain witnesses, and
20 certainly there was a paediatric mortality arrangement
21 or meeting which was supposed to examine children's
22 deaths and there's an uncertainty -- I think it's best
23 to characterise the evidence as being uncertain -- as to
24 whether Lucy's case was discussed in any great detail.
25 Could you help us then in terms of 2000? Would your

1 expectation have been to use one internal mechanism, the
2 whole audit arrangements that should have been in play?
3 A. There should indeed have been in play within the
4 Children's Hospital routine audit including routine
5 mortality meetings and there should be no question as to
6 whether an individual case was discussed or not because
7 those meetings should have been carefully minuted and
8 the records should have been available. Audit is, in my
9 view, the key mechanism for raising concerns and
10 deciding on how those concerns should be dealt with.
11 One talks of an audit cycle where a topic is decided
12 upon for audit, audit is carried out, conclusions and
13 recommendations, if necessary, are reached, and then the
14 audit cycle starts again as one audits against those as
15 to whether conclusions and those recommendations have
16 been put in place.
17 Q. How useful is audit in the sense that you've described
18 it when what the clinicians in the Royal would be
19 looking at is something, as we now know and might have
20 been known at the time, that had happened elsewhere in
21 another hospital prior to the child's transfer in
22 a moribund state? What assistance is audit in that
23 context?
24 A. I think potentially enormously helpful in that it is
25 possible, through audit, particularly one that might

1 perhaps capture cases from across a large geographical
2 area, to potentially discern a pattern to those cases
3 and a common mechanism for those cases. Certainly not
4 useful in all circumstances, but I think culturally we
5 attach an enormous amount of concern to the deaths of
6 children and they receive particular attention within
7 audit processes.
8 I should add that things have moved on quite
9 considerably in relation to those duties as a result of
10 the Shipman inquiry and the recommendations around the
11 creation of a medical examiner role, who would in
12 a sense conduct an audit of all cases within
13 a geographical area. But the fundamental building block
14 of good clinical audit operating at a local level is, in
15 my view, the basic foundation stone of good quality
16 care.
17 THE CHAIRMAN: There has been a bit of an issue here about
18 audit meetings not being minuted or recorded. It's been
19 suggested that this was done perhaps with the input of
20 insurers to make sure that if there was the sort of open
21 discussion that you would want to take place, that that
22 would not then become a discoverable document in the
23 event of medical negligence litigation. You've just
24 said that routine audit meetings should be minuted and
25 should have records available. Was that what was going

1 on in England at the time in 2000?
2 A. Indeed, and I would have expected it to be going on in
3 Northern Ireland at that time. I'm certainly aware of
4 that argument and I remember it in the context of when
5 I was at the Eastern Board. Those discussions were very
6 live about the potential for audit records to be used in
7 litigation, but I think by that time we should have been
8 well past that position and what would in these days be
9 known as a duty of candour --
10 THE CHAIRMAN: Was that emerging or had it emerged?
11 A. Not in those terms, but certainly we had reached the
12 point where it was recognised that our duty to patient
13 care far outweighed our position or the position that
14 some clinicians took with regard to protecting their
15 personal or organisational position around potential
16 litigation. And it was no longer acceptable by that
17 time, I think, to use that as an excuse for not engaging
18 in audit or producing good records of audit.
19 THE CHAIRMAN: Would you expect those records to be
20 anonymised so that the identity of, in this case, Lucy
21 would not emerge from the records?
22 A. One would have hoped at that stage that the patient's
23 name was being anonymised, but I fear anonymisation of
24 patient details within the Health Service -- and that's
25 across the UK -- is still not absolute and it is still

1 sometimes an issue.
2 THE CHAIRMAN: But if you have a record and that anonymises
3 a patient's name, the discussion which takes place
4 should still lead to -- in fact, I've been told that if
5 there had been an audit meeting about Lucy, the death
6 certificate would not have been before the meeting, but
7 the contents of the death certificate would have been
8 read out and, according to one paediatric anaesthetist,
9 those present at the meeting would have been jumping up
10 and down and saying, "This can't be right". So if there
11 was a record of the meeting, even if you take Lucy's
12 name out of it, that fact would emerge from the record.
13 A. Well, it should do and one would expect there to have
14 been some background detail given of the case as part of
15 the introduction of the case, the presentation of the
16 case, and although names might not have been used,
17 I would have thought the characteristics of the case
18 would be sufficiently distinctive to enable the case to
19 be identified in retrospect if someone had a mind to do
20 so.
21 THE CHAIRMAN: Thank you.
22 MR WOLFE: Just one very final point in this context. You
23 refer to the concern that if the Royal had suspicions of
24 inadequate treatment, then that should be reported to
25 the Sperrin Lakeland Trust in a formal manner. The

1 evidence that the inquiry has received to date on the
2 communication between the Royal and the Sperrin Lakeland
3 Trust seems to suggest -- and obviously Dr Crean did
4 have a conversation with Dr O'Donohoe about fluids, but
5 leaving that to one side. The lead clinician at the
6 Royal, Dr Hanrahan, was advising the parents of Lucy to
7 take up with the Erne Hospital their questions about
8 what had happened to their child rather than, if you
9 like, facilitating that discussion or advising the
10 parents of what might have been the problem here. So
11 there wasn't a communication between the Erne and the
12 Royal in the sense that I think you intended. Is that
13 a problem or a difficulty that was otherwise widespread
14 in your experience at that time, or had communications
15 between transferring hospitals and the receiving
16 hospitals improved?
17 A. I can't answer that definitively, but I think, in terms
18 of individual clinician responsibility, if one found
19 a problem of a question of medical performance, of
20 competence perhaps, or an issue of malpractice, it would
21 not have been judged reasonable merely to raise that
22 issue with the individual clinician concerned. There
23 would, to my mind -- and I think it's laid out in
24 "Duties of a Doctor", the GMC guidance, that there's an
25 expectation of the doctor to do considerably more than

1 that.
2 Q. And put it on a formal footing so that it can be
3 investigated; is that the point?
4 A. Well, to draw it firmly to the attention of the
5 appropriate people who can take the matter forward, yes.
6 Q. Very well, professor. The duty that you've just alluded
7 to, the duty to do more than simply report it to the
8 doctor causing the problem or suspected of causing the
9 problem, privately the duty to bring it on to, if you
10 like, a higher level, is that a duty that was in
11 existence then or are you referring to now?
12 A. No, I'm referring to then. I think I referred to it in
13 my original statement in relation to the expectation of
14 a doctor when I was discussing it, I think, in respect
15 of Dr McConnell. And it absolutely was very clear in
16 what was expected of a doctor by the GMC at that time.
17 THE CHAIRMAN: That could be a formal report either to the
18 medical director, Dr Kelly, or to the chief executive,
19 Mr Mills?
20 A. I think that is the way one would exercise it, yes.
21 THE CHAIRMAN: Either/or?
22 A. Either/or, yes.
23 THE CHAIRMAN: Thank you.
24 A. I think, because one was talking about consultant-level
25 clinicians in the Royal, the likelihood would be that

1 it would have been to the medical director of the trust.
2 Certainly medical directors at that time were very
3 clearly seen as having a responsibility in relation to
4 clinical standards of practice within their trust.
5 THE CHAIRMAN: Thank you.
6 MR WOLFE: Just for reference purposes, sir, this was
7 251-002-010. You refer to the Good Medical Practice
8 that was written in the aftermath of Bristol and the
9 principle I think you allude to is that:
10 "Doctors must protect patients when you believe that
11 a doctor or other colleague's health, conduct or
12 performance is a threat to them."
13 THE CHAIRMAN: Just to tease this out a bit more, we were
14 told last week that at one point the GMC advice to
15 doctors was not to report colleagues. When you refer in
16 this page, this page 10 in your first report to us, to
17 the Good Medical Practice published in 1998, which says
18 about protecting patients when you believe that a doctor
19 or other colleague's health is a threat to them, do you
20 remember that as being a change in approach from the
21 GMC? Do you remember a time when it had suggested to
22 doctors that they should not report incidents or report
23 each other?
24 A. This was a long time ago. Yes, chairman, I should say
25 that I think I was on the GMC at that time and I believe

1 I was on the standards and conduct committee that
2 drafted that wording. But there was a time long before
3 I was involved when it was possible for doctors to be
4 arraigned before the GMC on a charge of disparagement of
5 colleagues or of another medical practitioner, and it
6 was seen as unprofessional conduct to cast aspersions on
7 the competence of another. But that situation had
8 changed dramatically.
9 THE CHAIRMAN: Yes. This 1998 publication, is that when
10 that change occurred or had it occurred before that?
11 A. I'd need to go back and look. It may have been that
12 that was the first substantial change, but I suspect
13 that the disparagement element had dropped out some time
14 before it. I was concerning myself with the GMC rules
15 that were in place at the time, 2000 --
16 THE CHAIRMAN: I understand. It's just that somebody had --
17 I think Dr MacFaul had suggested last week, as you've
18 confirmed, that there was previously a different
19 approach from the GMC, and the prospect of being charged
20 with disparagement of a colleague would bring about
21 a real chill factor in reporting a colleague for
22 inadequate performance, wouldn't it?
23 A. Indeed, and that's why the GMC dropped it.
24 THE CHAIRMAN: Thank you. Any questions from the floor?
25 No? No questions?

1 Professor, thank you very much. I'm grateful to you
2 for giving us your time and coming over today. That's
3 all. I think we might try to drag you back in the
4 autumn, but unless there's anything else you want to
5 add, that's your evidence complete.
6 A. Thank you, chairman.
7 (The witness withdrew)
8 THE CHAIRMAN: I see Mr Stitt here. I want to deal with
9 some Altnagelvin issues. We'll break for 10 minutes, do
10 that, and then adjourn until tomorrow.
11 (11.35 am)
12 (A short break)
13 (12.04 pm)
14 THE CHAIRMAN: Mr Stitt, we've got more documents.
15 MR STITT: Yes. In fact, Mr Chairman, the lady who found
16 the documents has come to Banbridge this morning.
17 That is Mrs McKenna, and she's the head of paediatric
18 and neonatal services. Subject to what you suggest,
19 sir, might I respectfully suggest that perhaps if she
20 were to tell you how she came upon these documents, that
21 at least would be a starting point to any observations
22 which you might have in relation to any observations
23 you have in relation to the document issue.
24 THE CHAIRMAN: We've been given an explanation in
25 correspondence which is that Mrs Doherty, who no longer

1 works for the Trust, received a request from us for
2 a witness statement in respect of governance. Was it
3 through Mrs Doherty that this trail was uncovered?
4 MR STITT: Yes. I'll tell you what Mrs McKenna has told me
5 this morning. She was approached by Mrs Doherty who
6 told her that she had received a witness statement
7 request and asked if Mrs McKenna had any old documents
8 relating to training or anything else. Mrs McKenna
9 wasn't aware that she had, but she said she would see if
10 she could pull up anything. Mrs McKenna will say that
11 she has a few ring binders -- her own ring binders,
12 which she keeps not in the Trust's custody -- and she
13 opened one, not knowing what was in it, and came across
14 letters which actually were written by her -- which are
15 one of the three sets of documents -- in or around
16 2000/2001 to Mrs Doherty. Those are the three letters
17 which you have.
18 THE CHAIRMAN: Pausing there, those are, broadly speaking,
19 letters about staffing issues?
20 MR STITT: They are.
21 THE CHAIRMAN: Concerns being raised by the nursing staff
22 in the children's ward about the adequacy of staffing
23 levels.
24 MR STITT: That's correct.
25 THE CHAIRMAN: But these are Mrs McKenna's own letters?

1 MR STITT: These are copies of Mrs McKenna's letters that
2 she wrote in her capacity as a staff nurse. It was her
3 responsibility to answer the query and she did so in
4 2000 and 2001. She happened to keep three copies, which
5 she didn't know she had. She thought: well, I'll
6 obviously give them to Mrs Doherty. She didn't discuss,
7 by the way, Mrs Doherty's evidence, but she gave them to
8 her and at the same time she handed them to
9 a Mrs Teresa Mc Guinness a couple of weeks ago, whatever
10 the date was, who was the inquiry's support officer who
11 was handling these matters instead of Mrs Brown, who had
12 been served with a statement. So she immediately handed
13 those and thought these might be relevant and of course
14 they were then handed to the inquiry.
15 THE CHAIRMAN: Okay. That's one set of documents.
16 MR STITT: Linked to that is the second set, which is, on
17 the front page, "Audit of dependency levels". It looks
18 like that, sir (indicating).
19 THE CHAIRMAN: Yes, thank you.
20 MR STITT: Once Mrs McKenna came across these letters, she
21 thought to herself, she tells me, "I think as a result
22 of the requests and complaints to which [she] had
23 responded", there had been an audit carried out, so she
24 then searched again in her own personal files and found
25 this document, which she gave to Mrs Doherty and she

1 handed to the support officer.
2 THE CHAIRMAN: Right.
3 MR STITT: So having discovered in fact -- and she will say
4 she felt quite shocked. "Shocked" is probably too
5 strong a term, but she was very surprised to have found
6 these documents which she didn't know existed and she
7 thought, "I had better have another search". She
8 literally got down on her hands and knees and, in the
9 bottom of her office, obscured from view, she found
10 a brown cardboard folder, which she pulled out, and it
11 had the name Raychel Ferguson on it, and that did shock
12 her.
13 What she then discovered was that this actually, she
14 believes, is Margaret Doherty's Raychel Ferguson file,
15 which she put together, Margaret Doherty, who was the
16 clinical services manager with the Trust and who retired
17 in 2003. So Mrs McKenna supposes that this brown folder
18 had been lying in this position, undiscovered by anyone,
19 for ten years. They are essentially -- this is the
20 document comprising approximately 15 pages, which ...
21 They speak for themselves. Some of them are direct
22 photocopies of the clinical notes and some are
23 summaries --
24 THE CHAIRMAN: Do you have them to hand, Mr Stitt?
25 MR STITT: I do.

1 THE CHAIRMAN: If you go -- I'm not sure how many pages in,
2 but there's a document headed "Report re
3 Raychel Ferguson, Ward 6" and, in handwriting in the top
4 right, "MD copy", which I presume is Margaret Doherty.
5 Maybe you'll confirm that.
6 MR STITT: That presumably is a logical conclusion, yes.
7 THE CHAIRMAN: And that is prepared by Mrs Doherty?
8 MR STITT: Yes, on the second page.
9 THE CHAIRMAN: Then there's a second version of it, I think,
10 which is the following page; right?
11 MR STITT: The following page is a handwritten page in my
12 set.
13 THE CHAIRMAN: Show me the first page. The first page is
14 headed?
15 MR STITT: Of the handwritten? It's headed "Ann Noble ".
16 THE CHAIRMAN: And then we have pages 1, 2, 3 and my next
17 one has two lines on it; is that right?
18 MR STITT: Yes, the fourth page has two lines and the fifth
19 page is headed "Staff Nurse Daphne Patterson". The
20 sixth page is headed "Raychel Ferguson".
21 THE CHAIRMAN: And that's a different writing, is it?
22 MR STITT: Whether it's the copying that makes it look
23 different or not, I wouldn't profess to ...
24 THE CHAIRMAN: Do we know who wrote these? On the index
25 which we received with these documents, they were

1 described as:
2 "Handwritten notes which I believe to be written by
3 Sister Catherine Little."
4 And then:
5 "Handwritten notes I believe to have been written by
6 Margaret Doherty."
7 MR STITT: I'm just taking instructions. The more faint of
8 the two is Margaret Doherty.
9 THE CHAIRMAN: Okay.
10 MR STITT: The bolder of the two is Sister Little.
11 THE CHAIRMAN: Okay.
12 MR STITT: So the first five or six pages are Sister Little,
13 then we have what looks like two pages plus a line,
14 which all seem to come together in the same sort of
15 handwriting, which I'm instructed is that of
16 Margaret Doherty.
17 THE CHAIRMAN: Let's take Mrs Doherty's first. Are they
18 made from her speaking to the staff or are they made by
19 her going through the notes, or can you help me?
20 MR STITT: I don't know, and it would be wrong of me to
21 speculate.
22 THE CHAIRMAN: Okay.
23 MR STITT: It is possible, if the inquiry were minded to, to
24 ask Mrs Doherty, who's obviously doing her statement,
25 which we'll come to in a moment, a further question

1 perhaps and then she could clarify that.
2 THE CHAIRMAN: Yes.
3 MR STITT: I haven't spoken to Margaret Doherty.
4 THE CHAIRMAN: The disappointment about this is we thought
5 we'd finished the clinical aspect of Raychel's case and
6 the query is whether any of the contents of these notes
7 re-open any issues. Sister Little's five-page note, can
8 you tell me offhand how Sister Little came to write that
9 document?
10 MR STITT: I'm sorry, I can't help you on that --
11 THE CHAIRMAN: Okay.
12 MR STITT: -- but I can make enquiries and have an answer
13 for tomorrow.
14 THE CHAIRMAN: Well, I would like in particular to know how
15 it came about that these handwritten notes were made by
16 Sister Little on the one hand and Mrs Doherty on the
17 other. You'll confirm if this is right, but Mrs Doherty
18 at the time was a clinical services manager?
19 MR STITT: Yes, she was.
20 THE CHAIRMAN: So she may have been gathering information
21 from members of staff or whoever. Do you know if
22 Sister Little had any managerial or supervisory role?
23 MR STITT: I'll just take instructions on that point.
24 THE CHAIRMAN: Yes. (Pause).
25 MR STITT: She was really a nursing sister. I'm told she

1 was gathering information for the clinical services
2 manager, Margaret Doherty.
3 THE CHAIRMAN: It would be helpful if that could be
4 confirmed over the next day or two in writing,
5 Mr Stitt --
6 MR STITT: Yes.
7 THE CHAIRMAN: -- so we understand how these notes came
8 about, and then, if necessary, we'll raise further
9 requests for witness statements from anybody who it
10 touches on. Obviously, the fact that these documents
11 have been provided to us means that this isn't
12 a cover-up, but it's frustrating beyond words that they
13 have emerged after we had understood that we'd finished
14 the hearing into the clinical aspects of Raychel's care.
15 MR STITT: Nobody could possibly argue against that, sir.
16 What I'm simply saying is that the circumstances round
17 this possibly give some explanation as to why they had
18 not been found before.
19 THE CHAIRMAN: Okay. Can we go on? I will hear from
20 Mr Quinn if he needs to say anything in a few moments.
21 Can we go on to the outstanding governance witness
22 statements? I think there are now 13 which are
23 outstanding. I think there were 15 and two have been
24 received this morning from Dr Fulton and Ms Brown, and
25 there was a request made on Friday for an extension

1 until this Friday for a number of statements. Let me
2 make two points about that.
3 A request on the last day for an extension of a week
4 isn't likely to get a sympathetic response. So if there
5 were issues about people needing another few days, then
6 they should have been raised before Friday. What I will
7 say now is this: it's Monday coming up to lunchtime.
8 I expect to have all of the outstanding statements
9 together with all of the appendices and attached
10 documents by Wednesday afternoon.
11 MR STITT: Yes. If I may just update. At this point, there
12 are three statements which are with the inquiry. There
13 are two where an extension has been given on medical
14 grounds.
15 THE CHAIRMAN: Yes.
16 MR STITT: There are nine which we will have -- I would be
17 confident will be with the inquiry by Wednesday
18 afternoon. There are four that we don't have
19 a statement -- I just can't say what the position is.
20 What I can say is this: that first of all the request
21 was made on 30 May --
22 THE CHAIRMAN: Yes.
23 MR STITT: -- which was four weeks ago. An e-mail was sent
24 to everyone last Monday, reminding them that the
25 statements were to be in with the inquiry by Friday,

1 last Friday. A second e-mail was sent to those who had
2 not responded last Friday morning and, at my direction,
3 a further e-mail was sent this morning to the four from
4 which we've not heard.
5 THE CHAIRMAN: Are these people from whom you haven't heard
6 anything at all?
7 MR STITT: Yes.
8 THE CHAIRMAN: Can you give me the names of those four
9 people, please?
10 MR STITT: Yes. I have only put surnames down. Martin,
11 a Dr Martin.
12 THE CHAIRMAN: There's a Dr Dennis Martin; is that him?
13 MR STITT: I'm told it is. Mr Gilliland.
14 THE CHAIRMAN: Does he now work in the Ulster?
15 MR STITT: Yes.
16 THE CHAIRMAN: You haven't heard anything from Mr Gilliland?
17 MR STITT: Those are my instructions.
18 THE CHAIRMAN: He's already given evidence here, hasn't he?
19 MR STITT: Yes. I think Dr Dunn.
20 THE CHAIRMAN: Marie Dunn?
21 MR STITT: It's the only Dunn that I'm aware of.
22 THE CHAIRMAN: I should have asked you about Dr Martin: do
23 you know where Dr Martin works now? He's retired?
24 Thank you. And Dr Dunn? (Pause).
25 MR STITT: Marie Dunn is an administrative manager.

1 THE CHAIRMAN: In?
2 MR STITT: Retired.
3 THE CHAIRMAN: She was working in Altnagelvin; did she work
4 in Altnagelvin until her retirement?
5 MR STITT: Yes.
6 THE CHAIRMAN: Roughly how recently did she retire? Two
7 years? Thank you.
8 Can anybody help me, is Dr Martin still working?
9 No? And when he retired, did he work in Altnagelvin
10 until his retirement? He did? And approximately how
11 long ago did he retire?
12 SPEAKER: Five years. He has been in contact with the Trust
13 in preparing his statement for the last ten(?) days.
14 THE CHAIRMAN: He has been?
15 SPEAKER: Yes.
16 THE CHAIRMAN: Right, thank you. So Dr Martin is
17 outstanding, Mr Gilliland is outstanding, Marie Dunn is
18 outstanding.
19 MR STITT: I said four, but on review it looks like three.
20 THE CHAIRMAN: Right. We could do two things. If we could
21 have the outstanding witness statements together with
22 whatever documents are also going to be relied on or
23 referred to, if we could have those by Wednesday
24 afternoon, Mr Stitt, that would help. In terms of the
25 outstanding statements then, do I take it from what

1 you've just said you have e-mail addresses for those
2 people?
3 MR STITT: Yes.
4 THE CHAIRMAN: If they could be sent an e-mail to say I have
5 required all the witnesses to provide their witness
6 statements by Wednesday afternoon and if any of these
7 three people do not respond, then the inquiry will take
8 the matter up directly with them.
9 MR STITT: We will do that. I will ask that we try to
10 telephone each of them today also.
11 THE CHAIRMAN: Thank you very much. I can understand it
12 perhaps being a bit more difficult in relation to two
13 retired people who have not previously been involved in
14 the inquiry, but I'm at a bit of a loss in Mr Gilliland
15 not engaging.
16 MR STITT: If there's a rational explanation for it, I will
17 put it forward on his behalf.
18 THE CHAIRMAN: The point is we've had a number of people who
19 have asked for extensions because they're unwell for
20 different reasons, but there hasn't been an equivalent
21 response from Mr Gilliland?
22 MR STITT: My instructions do not include such a response.
23 THE CHAIRMAN: Thank you, Mr Stitt.
24 Mr Quinn, have you anything apart from frustration?
25 MR QUINN: Frustration. I should say that, from our point

1 of view, it's a relief that these notes have been
2 brought forward, and we certainly can see the position
3 that the Trust have been in and certainly notes have
4 been found in cases that I've been in in the past.
5 Therefore, I'm not raising any issues about that.
6 I'm raising issues about some of the notes, some of
7 the content. For example, on page 013 on the reference,
8 where the handwritten note says, "Raychel was feeling
9 funny, query confused". I'm therefore confused about
10 that particular entry -- it's only one that I'm picking
11 out -- because that wasn't the thrust, to the best of my
12 recall, of the nurses' evidence when they gave evidence
13 here a number of weeks ago.
14 Therefore what we have --
15 THE CHAIRMAN: That's why I want to find out where
16 Sister Little made those notes from. Because if we find
17 out who those notes are from, then we can follow up on
18 what actually the note is. It wasn't entirely clear to
19 me at the bottom of that page what the writing was.
20 MR QUINN: "Raychel was feeling funny query confused. Fiona
21 and Sandra went to see child."
22 So there's one particular note that causes me
23 concern. The other note is on page --
24 MR STITT: If I may, I understand your difficulty, sir, in
25 terms of interpreting the -- I thought the word was

1 "behaving funny", rather than "feeling funny".
2 MR QUINN: It may well be.
3 MR STITT: It may be a distinction without a difference.
4 MR QUINN: Therefore the first point I make is we would like
5 some typed transcripts of the notes so there is no
6 confusion, as has just been pointed out by Mr Stitt very
7 usefully.
8 Again, on page 18 there's reference to vomiting,
9 about tucking in her pyjama top, tucking in the sheets.
10 To the best of my recollection -- once again, I haven't
11 checked the transcript -- that evidence wasn't given by
12 the nurses at the time. This is about 10.30 when the
13 parents were leaving. There was evidence about putting
14 pillow cases around Raychel to prevent further bed
15 changing after vomiting, but the reason here seems to be
16 different. So for a number of reasons we respectfully
17 say those nurses mentioned in this, where their evidence
18 doesn't fit with the transcript, that they should be
19 recalled. It's a handwritten note, middle paragraph:
20 "Parents left at query 10.30 pm. Raychel was
21 settled. Routine obs taken. Felt cold. Didn't want
22 pyjama top on, so tucked it around her and tucked sheets
23 [something] around her."
24 THE CHAIRMAN: Okay.
25 MR QUINN: So there's a number of references that I don't

1 have to go into detail. I think it's very important
2 that the fluids are mentioned twice so far as I can see.
3 "Solution No. 18 fluids, 80 ml per hour" is on the page
4 you're looking at, sir, and it's also mentioned in
5 handwriting on the page I first referred to, page 13,
6 fluids are again mentioned:
7 "Friday 8th, Solution No. 18, 80 ml an hour."
8 So it's a very important issue in relation to the --
9 at that stage already they're putting in the fluid
10 record and looking at the fluid record.
11 THE CHAIRMAN: Okay. We'll get on to that. If we could
12 have that explanation. What we would like to have is
13 some more information tomorrow about these notes,
14 Mr Stitt, and we'll follow it up as quickly as we can,
15 because the final segment in Raychel's case is starting
16 on 27 August, and if it means having to recall one or
17 two of the people who have already given evidence, we'll
18 do that. I don't particularly want to do it, but we'll
19 do it if we have to.
20 MR STITT: I understand that.
21 THE CHAIRMAN: Thank you, Mr Stitt, for coming and Ms Beggs.
22 We'll resume tomorrow morning with Dr Gannon and
23 Professor Lucas. There will be some discussion -- again
24 that's expected to be a half-day session.
25 Unfortunately, Professor Scally wasn't available on the

1 same day as the pathologists and vice versa so we're
2 having two half-days to finish this segment.
3 We'll have some discussion tomorrow about the autumn
4 schedule. Raychel governance will be starting on
5 27 August and will continue for the next two weeks and,
6 if needs be, into a third. But in light of some contact
7 we've had from the Mitchell family, we might rejig
8 the September-into-October bit, and we'll discuss that
9 tomorrow. Thank you very much.
10 MR QUINN: Sir, tomorrow at 10 o'clock?
11 THE CHAIRMAN: 10 o'clock tomorrow.
12 (12.28 pm)
13 (The hearing adjourned until 10.00 am the following day)
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1 I N D E X
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PROFESSOR GABRIEL SCALLY (called) 1
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Questions from MR WOLFE 1
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