1 Wednesday, 6 November 2013
2 (10.00 am)
3 (Delay in proceedings)
4 (10.13 am)
5 THE CHAIRMAN: Good morning.
6 MS ANYADIKE-DANES: Good morning. Could I call, please,
7 Mr Gowdy?
8 MR CLIVE GOWDY (called)
9 Questions from MS ANYADIKE-DANES
10 MS ANYADIKE-DANES: Good morning, Mr Gowdy.
11 A. Good morning.
12 Q. Mr Gowdy, you have provided two witness statements for
13 the inquiry; they both bear the series 062. The first
14 is dated 6 July 2005, and the second is dated
15 30 August 2013. Subject to anything that you tell the
16 chairman here today, do you adopt those witness
17 statements as your evidence?
18 A. Yes, I do.
19 Q. Thank you. Have you made any other statements
20 in relation to the work of the inquiry?
21 A. No.
22 Q. And do you have those two witness statements there?
23 A. I do, yes.
24 Q. Thank you. Then if we go to your experience, which can
25 best be seen actually from your second witness

1 statement, witness statement 062/2, page 2, we can see
2 from it that you entered, I think, the Department of
3 Health first in September 1990.
4 A. Yes.
5 Q. And you did that as undersecretary and you had a period
6 when you were acting Permanent Secretary, another period
7 of undersecretary, and then there was a period of about
8 two years when you were out of the department and came
9 back in again for a brief period, January to March 1997,
10 when you were the chief executive of the Management
11 Executive. So that would have been between Mr Hunter
12 and Mr Simpson; is that correct?
13 A. That's correct.
14 Q. Then you became Permanent Secretary in March 1997 and
15 you stayed in that position until July 2005.
16 A. That's correct.
17 Q. So for the purposes of this inquiry, you pick up from
18 Mr Elliott, and the deaths that would have occurred
19 after your appointment as Permanent Secretary are really
20 Lucy, Raychel and Conor.
21 A. Yes.
22 Q. And also you would have had the start of this inquiry.
23 A. Yes.
24 Q. I just want to ask you a little bit about the structure
25 of the department so that we're clear on that because it

1 changed at some point. If we can pull up 323-027e-003.
2 Am I right in saying that this is the structure
3 after the Management Executive had been reabsorbed into
4 the department?
5 A. Yes, that's right.
6 Q. If one sees to the right there, the HPSS management
7 group, with Mr Simpson as the deputy secretary, was that
8 group in the main doing the kind of work that the
9 Management Executive had been doing?
10 A. Yes.
11 Q. And then the planning and resources group; is that more
12 the policy side of matters?
13 A. To some extent it was. They were involved in a lot of
14 strategic planning. It also had a lot of the financial
15 responsibilities, which would have got it into areas of
16 planning and policy formulation as well.
17 Q. Yes. When the structure looked like this, which side of
18 the house would have been mainly concerned with the
19 developments in clinical governance?
20 A. It would have been the management group under
21 Paul Simpson.
22 Q. Okay. And then if one sees, under "Planning and
23 resources group", go down to the second tier, there's
24 a title there, "Health Service audit".
25 A. Yes.

1 Q. There's "Internal audit", which I presume is the work of
2 the department itself.
3 A. Yes, that's right.
4 Q. What is the Health Service audit dealing with?
5 A. It's dealing with the financial responsibilities
6 exercised by the Health Service bodies, making sure that
7 they were doing things in a proper way financially.
8 Q. And does that mean there was some liaison between them
9 and the management group?
10 A. Not really. Their role was pretty much an independent
11 one. They were checking the probity of the way in which
12 public money was being spent. That was their primary
13 function.
14 Q. Okay. When you were undersecretary for those reasonably
15 brief periods, apart from when I think you had
16 a slightly longer stint between 1991 and 1993 as
17 undersecretary, what was your primary role?
18 A. In that role I was what was known as the Principal
19 Establishment and Finance Officer. I also had
20 a responsibility on the social security, the social
21 welfare benefits side of the house, as it then was. So
22 I was dealing with all the funding issues, securing
23 resources, allocating resources, dealing with personnel
24 issues within the department.
25 Q. And does that mean that when you were acting as

1 undersecretary you wouldn't necessarily have been aware
2 of the department's proposals and initiatives
3 in relation to the improvement of the quality of
4 healthcare, or would you have been aware of that?
5 A. No, not unless there was a direct financial implication
6 or they were seeking resources to do something. I might
7 have been involved at that stage, but I can't recall any
8 particular issues that came up in that sense in my time.
9 Q. When you were dealing with the resources, would you have
10 been dealing with resources that were going to be
11 available to the purchasing bodies? Would that come
12 into it?
13 A. It would have been the gross amount of money coming into
14 the department for all its purposes, which would then
15 have been allocated out and I would have been doing that
16 in concert with the Permanent Secretary of the day where
17 we were dividing the money amongst the various areas of
18 the department at that stage. So some of it would have
19 gone to the Health Service side, which would then have
20 been allocated by them out to the boards.
21 Q. When you were doing that, would you have had any
22 dealings at all with the management plans for those
23 purchasing bodies?
24 A. No.
25 Q. That would have been somewhere else who looked at that?

1 A. That would have been dealt with on the then Management
2 Executive side of the house.
3 Q. So your job was part and parcel of allocating the
4 resources, not how those resources were to be spent?
5 A. That's right.
6 Q. Is the first time that you would become concerned with
7 the quality of care when, for that period of about three
8 months, I think, in 1997, you became chief executive of
9 the Management Executive?
10 A. Yes. Well, I was acting Permanent Secretary for
11 a while, while Alan Elliott was out ill during that
12 period in -- from October 1990 to February 1991. So
13 I did at that stage have an involvement with issues
14 across the range of responsibilities of the department.
15 Q. I see. Would that mean that you would have been aware
16 of developments in relation to quality of care at that
17 early stage when you were the acting Permanent Secretary
18 and then picked up again in 1997 when you were
19 chief executive of the Management Executive?
20 A. Yes. Although in that short period when I was the
21 acting Permanent Secretary, I don't recall any issues or
22 any policy requirements that got me into that area of
23 the department's business.
24 Q. Would you have received any reports as to what was
25 happening in the rest of the UK in relation to quality

1 of care?
2 A. To some extent, yes. Yes.
3 Q. So you would have been aware of it to that extent?
4 A. Yes.
5 Q. And even more aware of it in a way because you would be
6 directly involved with it when you became
7 chief executive, albeit for a relatively brief period of
8 time?
9 A. Yes.
10 Q. Were you aware of what the state of play in the rest of
11 the UK was in relation to the development of clinical
12 governance when you were chief executive?
13 A. Yes, although it was probably when I became
14 Permanent Secretary that I first had an involvement with
15 those sorts of issues. Not long after my appointment,
16 I went -- a few months after my appointment, I went
17 across to meet my counterpart in London in the
18 Department of Health, and it was around the time that
19 the White Paper on "The new NHS: modern and dependable"
20 was being put together. So I had a good discussion with
21 my counterpart over those sorts of issues at that point.
22 That was my first real introduction into that territory.
23 Q. So you knew what was being intended in that White Paper
24 and the reasons for it?
25 A. Yes.

1 Q. And did you also know what the position was in relation
2 to those sorts of issues in Northern Ireland?
3 A. Yes.
4 Q. Before we move completely into that area, I wonder if
5 you could help us with what your role was as
6 Permanent Secretary? Maybe I can ask you this,
7 Mr Gowdy: were you aware of the evidence that Mr Elliott
8 gave yesterday, who was your predecessor?
9 A. I have seen some of it, yes.
10 Q. The transcripts?
11 A. Yes, I have seen a bit of it. I haven't read it all.
12 Q. So from your point of view, what did you regard your
13 role as as Permanent Secretary?
14 A. First and foremost, it was to act as the principal
15 adviser to the minister, to make sure that ministers'
16 wishes were being carried out in respect of policies
17 across the department's remit, which in those days
18 included social security as well as health.
19 Q. One of the ministers' wishes was the development of the
20 internal market, a by-product of which, it was hoped,
21 would be an increase in the quality of care as well as
22 more efficient use of resources.
23 A. Well, I was there for only a short period of the
24 Conservative government because the election
25 of May 1997, which was just shortly after I took over as

1 Permanent Secretary, brought the Labour government in,
2 who had a different approach to the way in which the
3 Health Service should operate. So the internal market
4 was very much a Conservative government approach.
5 Q. Was increase in the quality of care very much
6 a Conservative government approach?
7 A. Oh, undoubtedly one of the driving forces behind it was
8 to make sure that the quality of care provided by the
9 system was of a standard that was appropriate and
10 acceptable to the population.
11 Q. So that was a ministerial wish when you came in a
12 Permanent Secretary?
13 A. Yes.
14 Q. Part of your responsibility was doing what you could do
15 to give effect to that?
16 A. Yes, very much so.
17 Q. And when the Management Executive was reabsorbed or
18 absorbed into the department in 2000, what was your
19 relationship with the management group who are now,
20 perhaps, a more separate unit than the Management
21 Executive had been? What was your relationship?
22 A. When it was reabsorbed, the whole tenor of the business
23 had changed from one of leaving trusts to operate as
24 sort of free-standing enterprise units, who would
25 operate in a very commercial private sector way, into

1 something that was considered to be more appropriate,
2 a more cooperative way of doing the business. I worked
3 very closely with Paul Simpson then, we were part of
4 a team, there was no longer the separation that there
5 had been before when the Management Executive was set up
6 as a free-standing unit within the department.
7 Q. So if anything, that brought you closer to some of the
8 issues that are of concern to this inquiry?
9 A. Oh, yes.
10 Q. If I can just put up -- and maybe you can see if you
11 agree with it -- part of Mr Simpson's witness statement,
12 WS084/2, page 3. Then you can see right at the top
13 a series of questions that preceded this about the
14 Management Executive. The answer he gives is as to why
15 it ceased to exist, you see it there, but then he talks
16 about what happened to its role. He says:
17 "The reduced scope of the department meant that the
18 Permanent Secretary could take on the responsibilities
19 formerly those of the chief executive, including those
20 of accounting officer."
21 Would you agree with that statement?
22 A. Yes, I would. I am not sure that that was the driving
23 force behind absorbing the Management Executive back
24 into the department. It was more because it was no
25 longer felt that we needed to have a separate unit

1 managing the Health Service or operating in a way which
2 was directly involved in the business of the Health
3 Service. And we were operating then in a much more
4 cohesive, cooperative way. I certainly had a view that
5 we needed to be working closely with all the Health
6 Service bodies and Paul Simpson and I were the people
7 who were probably in the best position to make sure that
8 that was happening.
9 THE CHAIRMAN: Was that a politically driven change?
10 A. Yes, it was.
11 THE CHAIRMAN: But it meant that there was more oversight of
12 what the trusts were doing from then on or not?
13 A. I'd certainly like to think we were giving more
14 oversight to the trusts rather than letting them go off
15 and do their own thing, which was the previous policy.
16 But they were still operating in a way which kept them
17 a little bit distant from the department because their
18 first port of call was the board to which they were
19 responsible because that was the relationship in
20 commissioning and providing terms.
21 MS ANYADIKE-DANES: Two things: although you might not agree
22 with how he has characterised the motivation behind it,
23 I'm not sure you've disagreed with the end result that
24 the Permanent Secretary took on the responsibilities
25 that were formerly those of the chief executive,

1 including the accounting officer responsibility?
2 A. Yes, I entirely agree with that.
3 Q. And although I think, when you answered the chairman,
4 you said there was still some sort of distance, but you
5 do accept that in the change that happened the result --
6 and even the intention -- was that you could have
7 a greater scrutiny over what the trusts were doing and
8 they were not so distant from you in the way that
9 Mr Hunter perhaps and Mr Elliott have described?
10 A. Yes. Ministers were very concerned at that stage with
11 a number of large-scale issues -- the waiting lists
12 issue is probably the most prominent one that people
13 would be aware of -- and they wanted to see the trusts
14 put a greater emphasis into those sorts of things. So
15 the role that we were playing was very much one of: this
16 is what the minister wants you to do, now let's see you
17 carry that out.
18 Q. Yes.
19 A. Whereas before, they would have been left rather more to
20 their own devices under the previous government's
21 philosophy to carry out business themselves in a way
22 they thought fit.
23 Q. Although I think Mr Hunter would say still that he had
24 a responsibility for monitoring what they were doing and
25 making sure they were adhering to it.

1 A. I entirely agree with that.
2 Q. But in that, I think, you accepted that quality was
3 an issue and that some of these initiatives, I presume,
4 on the health side, went towards that and it was your
5 responsibility to ensure that the trusts met those
6 wishes of the minister. Who, in your view, had the
7 overall responsibility for making sure that quality was
8 in fact being improved? At the departmental level,
9 I mean.
10 A. Well, the buck always stops with the Permanent Secretary
11 because the Permanent Secretary's role is to be in
12 overall charge of the department and what the department
13 does and what ministers want to see happen. Obviously,
14 that's carried out by people within the organisation.
15 Q. Of course.
16 A. So it was very much part of what the department did and
17 I'd like to think that at every level within the
18 department there was an awareness of what it was
19 ministers were asking us to do and people were playing
20 their role in the way in which they co-operated with the
21 various Health Service bodies.
22 Q. Understood. But ultimately, the responsibility is
23 yours?
24 A. Yes.
25 Q. And then if I ask you to explore a little bit how you

1 got the information so you could ensure you were
2 discharging that responsibility. Mr Elliott, when I was
3 asking him something similar to that yesterday, said
4 that the departmental board was actually, in his time,
5 more concerned with administrative matters and, for him,
6 the important meeting was a meeting of what he called
7 the top of the group meeting. And certain senior people
8 attended that meeting and that was one of his principal
9 sources of information to find out what was going on.
10 Was it like that for you or did you have a slightly
11 different structure?
12 A. I changed the structure and I had all of the heads of
13 the various bits of the business of the department round
14 the management table. We met as the departmental board
15 on a monthly basis and that was certainly one of the
16 means of gathering the information needed to understand
17 what was happening in the Health Service.
18 I should say that we weren't in direct drive on the
19 delivery of services. The role of the department was an
20 enabling one, a strategic one, a policy one. The aim
21 was very much to let the Health Service bodies carry out
22 their functions within a framework of support from us.
23 Q. At that meeting that you've just described, did that
24 mean that you had the chief officers of the professional
25 group attend?

1 A. Yes.
2 Q. All of them?
3 A. All of them, yes.
4 Q. That's a monthly meeting?
5 A. Yes.
6 Q. How did matters get on the agenda for that meeting?
7 A. There was a secretariat, which drew up some of the
8 standing issues or some of the issues that I had asked
9 to have flagged up. Other members of the group could
10 ask for things to be put on the agenda.
11 Q. And is that a forum, a place where issues to do with the
12 quality of care and introducing initiatives that were
13 being discussed perhaps in the rest of the UK? Is that
14 a place where that might arise?
15 A. Yes. If, for example, some of the chief professional
16 officers had met their counterparts and had learned that
17 something was happening, they would have come back to
18 the departmental board and said, "This is what's
19 happening elsewhere".
20 Q. So that was another way of you being kept in touch with
21 what was happening in the rest of the UK other than your
22 own meetings with your counterparts in London?
23 A. Yes.
24 Q. Aside from that meeting, which sounds like quite
25 a structured meeting, what were the more direct

1 meetings, liaisons, that you might have with, let's say,
2 Mr Simpson at that time when he was no longer the
3 chief executive of the management group and any of the
4 chiefs of the professional groups? With what sort of
5 frequency did you meet them?
6 A. Virtually daily. Our offices were very close together,
7 we would bump into each other in the corridor or I would
8 call into their offices if I had an issue that I wanted
9 to explore with them. And they would do the same if
10 they had something they wanted to raise with me. We
11 worked very closely together.
12 Q. I appreciate that this was at that time a very, very
13 large department, spanning a large number of areas, and
14 we've heard what the budget was, or just one part of it,
15 from Mr Elliott, but I'm going to focus on the medical
16 aspect of it for obvious reasons. If one's talking
17 about that and thinking about policy, whether it's that
18 which is emanating from the minister or something that
19 you're trying to formulate to put to the minister, how
20 significant was the Chief Medical Officer as a resource
21 for you?
22 A. A very valuable resource, a very important colleague.
23 I would have regarded her expertise as being very
24 important in the formulation of advice to the minister
25 or indeed on the formulation of policy initiatives.

1 Q. And perhaps some of the difficulties arising in its
2 implementation, would you expect to hear that from her
3 also?
4 A. Yes, I would.
5 Q. Because when she describes it -- we don't need to pull
6 it up -- in her witness statement, 075/2, page 2, she
7 describes input or facilitating policy development
8 in that way, so that's her input to the department, but
9 also bringing to you some of the issues that she hears
10 from her own network, as she is directly connected
11 through meetings with the consultants and the senior
12 administrators in the hospitals and trusts. Would
13 you have valued that as a way of gaining insight into
14 how these policies are actually playing out in the
15 hospitals and trusts?
16 A. Yes.
17 Q. To the extent that she perceived any difficulty with the
18 implementation of policy, would you expect her to be
19 telling you that?
20 A. Yes.
21 Q. From your point of view, was it important that she not
22 only had participated in the special advisory
23 committees, that were really her committees, but also
24 that she sat very often by invitation on the committees
25 of the Directors of Public Health of the boards and also

1 at the CEMACH? Would you have regarded that as
2 an important source of information for you?
3 A. Yes. As she considered it important to raise with me --
4 I wouldn't expect her to give me an account of every
5 meeting she had, but if there were issues that were
6 important, either in the context of the work we were
7 doing to formulate policies or in terms of me providing
8 advice and updating the minister.
9 Q. Yes. There were some significant developments, or at
10 least they appear to have been significant from the
11 point of view of the inquiry, before you became
12 a Permanent Secretary in 1997, in the whole development
13 of clinical governance. I'm just going to ask you to
14 what extent you were aware of them either from the
15 chief executive of the Management Executive, from your
16 own resources or from any of the professional chiefs.
17 The circular in 1993 -- I'm sure you've seen it --
18 it was issued on 1 October 1993 with its reference for
19 the framework of accountability.
20 A. Mm-hm.
21 Q. That was when you were in the old dispensation of
22 Management Executive and so forth. Were you aware of
23 that circular?
24 A. Yes.
25 Q. And the publication of improving clinical effectiveness

1 that the NHS issued, might you be aware of something
2 like that?
3 A. Um ...
4 Q. Maybe not the detail.
5 A. Well, when I came back into the department in early
6 1997, I read up on some of the significant things that
7 had been happening just to bring myself up to speed.
8 I'm pretty sure I've read some of that material then.
9 Q. Mr Hunter, from his point of view, so if he was going to
10 be a source for you, says he was aware of what was going
11 on. And Professor Hill, who was the Chief Nursing
12 Officer, she was aware as well, and of course she had
13 worked in England before she came to Northern Ireland.
14 But were you aware of the Clothier report that came out
15 of the Allitt inquiry?
16 A. No, only having read the newspaper reports before I came
17 into the department.
18 Q. Yes. That was a significant report in the rest of the
19 UK and, to the extent that it was known about by any of
20 the officials in your department, would you have
21 expected to have been alerted to it? Maybe not taken
22 down to the very detail of it, but at least alerted to
23 its general direction?
24 A. I don't recall anyone ever raising that subject with me.
25 Q. Well, let me help you a little bit.

1 THE CHAIRMAN: Let's just be careful here. The Clothier
2 report came out in 1994; Mr Gowdy comes in in 1997. So
3 it may be that if there is movement in Northern Ireland
4 or there is prospective movement in Northern Ireland to
5 match what has been recommended in the Clothier report,
6 it doesn't come to you in terms of what has been said
7 in the Clothier report, it comes to you in terms of this
8 is the way things are moving and it doesn't have to be
9 attributed to Clothier.
10 A. Again, I didn't have anything raised with me on either
11 of those fronts.
12 MS ANYADIKE-DANES: Sorry, that's really what I meant, not
13 really the detail of it, but the direction of travel of
14 it, that we're now even more concerned with accuracy of
15 reporting of adverse incidents, that sort of thing.
16 A. Yes.
17 Q. Then if we come to when you do come in and you say you
18 recall that government White Paper in 1997, "The new
19 NHS: modern and dependable". When you had your
20 discussion about that in London, and you came back to
21 Northern Ireland, what intentions did you have in terms
22 of where Northern Ireland might go with that kind of
23 initiative?
24 A. There were a few things. The first would have been,
25 I needed to have a discussion with our then minister,

1 who I think at that stage was Tony Worthington, as to
2 the extent to which he wanted to take on board the
3 principles that were in that White Paper and obviously
4 being a minister within that government I expected him
5 to want to follow more or less. But it's not a given
6 that they'll adopt everything that's in those papers, so
7 we have to have an iterative(?) discussion with them.
8 So he was keen that we followed most of the principles
9 in it and we then produced a paper called "Fit for the
10 future".
11 Q. Yes, that was in April of 1998.
12 A. Yes, April 1998. I'd also picked up from the
13 discussions I'd had with my counterpart that this
14 concept of clinical governance was emerging out as
15 something new. I was quite interested in that. The
16 discussions I had with my counterpart led me rather more
17 to the emphasis on risk management. I'd become quite
18 a -- after that discussion and subsequently, I'd become
19 quite a firm adherent of pursuing risk management as
20 a way of looking at the patient safety issues, and I was
21 quite keen that we should try and follow on that track.
22 I wasn't at that stage aware of the adverse incidents
23 dimension, which features, I think, within that paper --
24 Q. Yes, it does.
25 A. -- in a small-ish way.

1 Q. Well, in the "Fit for the future" paper you've just
2 raised, as you are probably aware, it had six themes --
3 A. Yes.
4 Q. -- to that paper. One of them was to place an emphasis
5 on improving the quality of the services. I'm sure
6 that's probably a given theme in just about anything
7 that the Health Service puts out. But to develop that:
8 "To ensure the development of a system which
9 delivers fair access to high-quality services for
10 everyone."
11 So it's how you ensure that you're delivering that
12 which brings, you are right, I think, a bit of
13 a monitoring role or some way of knowing where you were
14 in relation to the development of quality services. So
15 did you have any idea as to how you would actually give
16 effect to that? Because that's part of your role to
17 support the minister.
18 A. Mm. Quality in this sense, in a policy paper of this
19 nature, had more to do at that time with ensuring that
20 we were getting the quantity of service and the quality
21 of service meshed together. So if you took the waiting
22 lists again as the obvious issue, we needed to make sure
23 we were getting a proper throughput of patients, that it
24 was timely, that they were not having to wait long
25 periods, that the priorities were properly set and so

1 on.
2 Having done that -- and getting things moving on
3 that front was the first priority for us. Having done
4 that, it's a question then of following it up and
5 getting material back to point to how effectively they
6 were introducing the policy. So statistics on how many
7 people were going through the system and so on were the
8 way we would measure that sort of thing.
9 Q. Sorry, are you saying that was the way you were
10 measuring quality at that stage?
11 A. What I -- maybe I should step back a bit. "Quality"
12 means a number of different things.
13 Q. Yes.
14 A. Quality in terms of ministers trying to deliver
15 a service to so many people within Northern Ireland
16 requires them to make sure that they're providing equal
17 access, requires them to ensure that the volume of
18 patients requiring treatment is matched by the provision
19 of the service, that we get a timely service, that
20 people aren't having to wait years for operations.
21 Those were touchstones of quality at that stage.
22 Equally, of course -- and what this inquiry is
23 focusing on -- is the clinical quality of service.
24 Q. Yes.
25 A. How well were the surgeons doing their operations and so

1 on. And that's a different issue from the ones which
2 were being flagged up in papers like "Fit for the
3 future".
4 Q. Yes. Maybe I can help you a little bit with that.
5 There was a report of the controller and Auditor General
6 in England, which is called clinical audit, which was
7 looking at exactly that: what clinical audit was and
8 what you could use it for. That report came out in
9 1995, so just two years before you came into office.
10 A. Mm-hm.
11 Q. The reference for it is 338-011-001, and what it was
12 looking at was the progress of the audit of clinical
13 care between 1989 and 1990, taking one year, and 1994
14 and 1995. So a comparative.
15 There, they make it quite clear -- and this is the
16 page I would like pulled up, 338-011-007 and 008 with
17 it, please. So a major study like this coming out of
18 the Audit Office is something at some point you might
19 expect to see, particularly if you're dealing with
20 quality?
21 A. Yes.
22 Q. And you can see, right at the beginning, under the first
23 paragraph, it describes what clinical audit is all
24 about, and one of the reasons I wanted to highlight this
25 is because Mr Hunter was unsure -- and I think in that

1 he was supported by Mr Elliott -- that there actually
2 was a way of measuring quality and didn't think that
3 that was happening at that stage. There you see:
4 "Clinical audit is a process by which doctors,
5 nurses and other healthcare professionals systematically
6 review and, where necessary, make changes to the care
7 and treatment they provide to patients. Its primary
8 objective is to improve the quality and outcome of
9 patient care. The NHS Executive [which was the
10 counterpart to Management Executive in Northern Ireland]
11 intends it to be an important component of continuing
12 professional development and education."
13 Then they refer to the White Paper, "Working for
14 patients".
15 So the Audit Office regards the clinical audit as
16 an important tool of working out where you are in the
17 delivery of quality of services. And if you look, I'm
18 not going to take you through all of it, but just to
19 highlight perhaps the relevant passages over at
20 paragraph 7 where they go in and do samples of the
21 clinical audit activity.
22 Then if we pull up the next pages, 009 and 010
23 together. You can see that right at the top, under
24 paragraph 9:
25 "[At that time] 83 per cent of hospital and

1 community health consultants were attending most, if not
2 all, clinical audit meetings."
3 So that would appear to be reasonably
4 well-established in the rest of the United Kingdom at
5 that stage. Then they go on to talk about the benefits
6 of it and that there have been benefits which have -- if
7 you look at paragraph 11 -- led to changes in clinical
8 care. And that, of course, is one of the reasons why
9 it's being done, so you can keep track.
10 Just a little bit further down in paragraph 11:
11 "Some of the changes have led and others may lead to
12 improved quality of patient care and outcomes."
13 And that was its significance.
14 So when you came in as Permanent Secretary, to what
15 extent were you looking at clinical audit to assist any
16 developments towards improvement in clinical care?
17 A. I was well aware that clinical audit was an important
18 tool. My understanding was that it was being used by
19 clinicians, that this was something that they would
20 regularly do. We didn't -- I didn't get any direct
21 feedback on the results of those clinical audits because
22 they were conducted, as I understood it, at local level.
23 My expectation would have been that if those clinical
24 audits were throwing up issues of concern then they
25 would have been raised on the medical line, they would

1 have involved clinical issues and that those would have
2 been raised with the Chief Medical Officer or her staff.
3 Q. So if they disclosed difficulties in terms of delivering
4 a high-quality service, ultimately you would expect to
5 receive that problem, if it was significant enough as
6 opposed to just a local difficulty, to you through the
7 CMO?
8 A. Yes.
9 Q. And if there was any difficulty about the audit process
10 for some reason not being sufficiently well embraced or
11 being implemented properly, you would expect to receive
12 that information either depending on when it happened,
13 through somebody in the Management Executive or through
14 somebody in the management group or perhaps also the
15 CMO?
16 A. Again, I would have thought through the CMO. Clinical
17 audit is a matter for the clinicians in the sense that
18 they're the ones who are looking at the way in which the
19 service is delivered, the standards that are being used,
20 the competence of the people who are delivering the
21 particular specialty that is concerned. Those issues
22 would then be the sort of things that they would raise
23 internally within the organisation with the medical
24 director or clinical director, who in turn, if he or she
25 thought it of wider significance, would address that

1 through the Chief Medical Officer's staff. If she or
2 her staff thought that this was an issue that the
3 department generally needed to be aware of or to address
4 in some way, then I would expect it to be raised with me
5 or with other colleagues on the management side.
6 Q. Yes. And if there were thought to be any financial
7 difficulties in terms of sufficient budgetary allowance
8 being made for that activity, that might come to you in
9 a different route?
10 A. That might because that -- if that was the problem that
11 the clinicians in a trust saw, my expectation would be
12 that they would raise that with their chief executive
13 and the board of the trust. And if they felt this is
14 something that needed more financing beyond what was
15 available within their own budget, they would then raise
16 that with the department.
17 Q. Thank you very much. Then I want to move on then to the
18 department, just the year after --
19 A. Might I just make one point, chairman? This issue of
20 quality is quite an important one to address in terms of
21 the definition. We see the word used quite extensively,
22 as you say, in government papers. That to ministers
23 means the totality of the quality of the service that's
24 being provided, not just the clinical quality. So it is
25 important for us just to focus on what we really mean

1 when we're looking at some of these points because for
2 a minister it's how the public perceive the totality of
3 what's being delivered. That's the touchstone of
4 quality for them. The clinical issues obviously are
5 a subset of that and are very important in terms of the
6 patient safety issues, but those tend to be ones within
7 the medical line in the first instance.
8 THE CHAIRMAN: So on a general overview if waiting lists are
9 too long, that's a quality issue for the public?
10 A. Yes.
11 THE CHAIRMAN: If waiting times are too long, that's
12 a quality issue?
13 A. Yes, they're getting a poor service.
14 THE CHAIRMAN: And if for instance there's a unit in Tyrone,
15 to take a practical example, which is struggling, then
16 you have decisions to make -- and they were made in this
17 era -- about whether different units could stay open?
18 A. Yes.
19 THE CHAIRMAN: Those are all quality issues to ensure
20 there's a service?
21 A. Yes.
22 THE CHAIRMAN: And what I understand you to be saying
23 is that the way in which any individual patient is
24 treated is also a quality issue.
25 A. Yes.

1 THE CHAIRMAN: But while you can deal with the overarching
2 aspects, you need to have any identified specific
3 problems about patient care brought to you, and what
4 we're looking at is whether there was a method in which
5 that was done, because I think your statements to the
6 inquiry have acknowledged that the deaths of each of
7 these children should have been raised with the
8 department.
9 A. Yes.
10 THE CHAIRMAN: So while you're making progress and trying to
11 make progress on waiting times and waiting lists and
12 where somebody in Tyrone or Fermanagh will get treated,
13 you have your eye on that ball, there's another ball
14 about how individual patients are treated?
15 A. Yes, absolutely, yes.
16 THE CHAIRMAN: I think we'll come to that, but I think you
17 believed there was a system in place whereby any serious
18 issues would be brought to your attention but, as it
19 turned out, that didn't happen?
20 A. That's true, yes.
21 MS ANYADIKE-DANES: And just as the chairman has left it
22 there, we'll come on to it in a minute, but now that
23 you're talking about what words mean, whether you have
24 a system which is sufficiently robust and reliable to
25 alert you to the sorts of issues to do with, let's call

1 it patient safety --
2 A. Yes.
3 Q. -- whether a patient's going to receive adequate
4 treatment. Whether you have that kind of system, do you
5 regard that as a quality issue or a tool to ensuring
6 that you can deliver on your quality issues?
7 A. Sorry, could you just give me the gist of that again?
8 Q. Whether you have a system that can alert you to the
9 patient safety issues, so whether you have that system
10 in place, is that system just part of monitoring whether
11 you're delivering an adequate quality service or do you
12 regard that as part of this larger definition of how the
13 minister would regard quality, that system itself is
14 part of quality?
15 A. The system itself must be part of quality, yes.
16 Q. Thank you. Then if we look at where I was just going to
17 take you to, about a year after you came into post as
18 Permanent Secretary, 1998, the department commissioned
19 a risk survey -- well, a survey of risk management,
20 really, by Healthcare Risk Resources.
21 A. Yes.
22 Q. You've already told the chairman that risk management
23 was a concept that you embraced and would like to see
24 instituted here in Northern Ireland --
25 A. Yes.

1 Q. -- or perhaps improved upon, if it was already here in
2 Northern Ireland.
3 A. Yes.
4 Q. And this survey was being carried out to see where
5 matters stood to provide some baseline information, as
6 I understand it, on the dimensions of risk management
7 across all the trusts, and that included the reporting
8 of adverse incidents, and that would then guide you as
9 to what further needed to be done. Does that capture
10 it?
11 A. Yes, it does.
12 Q. That report is referred to in a 2002 report from the
13 Auditor General here, NIAO office here. That's where
14 we have it, I'm afraid. We don't have it as
15 a free-standing report, and even then we have, if you
16 like, a summary of it. But can we go to 338-006-106 and
17 if you could pull alongside that 107? So they were
18 commissioned in 1998 and they reported in February 1999;
19 do you recall this?
20 A. Oh, very clearly. I was instrumental in having this
21 carried out.
22 Q. Well, you can see the first issue is "risk management".
23 A. Yes.
24 Q. There it says:
25 "Almost all trusts have introduced a strategy, but

1 they are limited in their contents and the variety of
2 models that they have developed and greater efforts need
3 to be made in order to ensure that the risk management
4 strategy is endorsed fully by the board and the trust
5 concerned and that all managers, clinicians and other
6 professionals are fully aware of its contents."
7 So some work still to be done on the risk management
8 side, and you'd accept that?
9 A. Yes, mm-hm.
10 Q. Then if we look at 107, on incident reporting, which is
11 an issue of significance for the inquiry, you can see
12 that they conclude:
13 "There is generally a good level of reporting of
14 incidents of the slips, trips and falls variety."
15 But they then highlight that:
16 "The major deficiency relates to the very limited
17 and therefore probably significant under-reporting of
18 clinical incidents and near misses, which can be as
19 important as a learning tool, and a major effort is
20 needed in almost all trusts to improve in this area."
21 And you accept that as well?
22 A. Yes, indeed.
23 Q. Then patient records is another area of concern. They
24 say:
25 "There was a low level of compliance with this issue

1 amongst the majority of trusts. There is no doubt that
2 inadequately prepared patient records ... contribute to
3 unsafe clinical care."
4 That must have been a concern to you because that's
5 a fairly basic thing to have deficient in a hospital.
6 A. Yes, it is.
7 Q. Just before we get to this coming to you by way of
8 a report from the consultants: had that been brought to
9 your attention by the CMO or, for that matter, anyone in
10 your department that there could be a low level
11 compliance with good patient record keeping?
12 A. No, not that I recall.
13 Q. Would you have expected that to come to you before you
14 saw it in a report like this?
15 THE CHAIRMAN: If she was aware of it. She has to be aware
16 of it for it to come to the Permanent Secretary.
17 MS ANYADIKE-DANES: Yes. Well, if there was the kind of
18 concern that these consultants have reported, if that
19 did exist, would you have expected, through the meetings
20 that she has, that she would be aware of it?
21 A. I would have expected any of the folk in the department
22 who had an interaction with these various bodies and had
23 been told that there was a problem to have let me know,
24 yes.
25 Q. I'll put the question a slightly different way.

1 THE CHAIRMAN: Sorry, surely the way to look at it is
2 this: surely sometimes you need an external body to come
3 in to point out what the failings are in order for the
4 people working in the system to realise that.
5 A. Yes.
6 THE CHAIRMAN: Very often when you're working in a system
7 you don't internally recognise what the problems are
8 until someone comes in from outside and points out what
9 the problems are.
10 A. Absolutely.
11 THE CHAIRMAN: So this result in 1998 would have helped to
12 highlight problems which were there, which may or may
13 not have been evident to those who were working in the
14 system?
15 A. Yes. In fact, the intention behind this survey was very
16 much to get a feel for how risk management was being
17 addressed within the HPSS. I was very concerned about
18 how effectively we were dealing with risk management.
19 MS ANYADIKE-DANES: I understand. And when these sorts of
20 concerns were being identified in this report, if your
21 professional group were not already aware of them, would
22 you have expected them to now have them on their radar,
23 as it were, and to be following up those sorts of themes
24 in the meetings they had with the clinicians?
25 A. Yes. If this was --

1 THE CHAIRMAN: It must follow, mustn't it?
2 A. It does.
3 THE CHAIRMAN: Because if you bring in external consultants
4 to provide this report to cast their light on the
5 service, and they identify failings, what you then
6 expect to follow next is that those failings will be
7 worked on --
8 A. Yes.
9 THE CHAIRMAN: -- at whatever speed can be achieved to
10 ensure that there's an improvement in the service?
11 A. Yes. Otherwise it's a waste of money --
12 THE CHAIRMAN: Exactly.
13 A. -- doing a survey in the first place. Yes, very much
14 so.
15 What I was hesitating over was I can't remember any
16 actual discussion I had with any of the chief
17 professional officers on this issue, on the report. I'm
18 sure they must have got it, but ...
19 MS ANYADIKE-DANES: When it came to you, is it the kind of
20 report that you would have wanted to have tabled at
21 these regular meetings, monthly meetings, that you have
22 described to the chairman before?
23 A. Yes.
24 Q. And would you not have been wanting to decide: what are
25 we going to do as a result of this report?

1 A. Yes.
2 Q. Here are some criticisms helpfully highlighted to us by
3 an independent body, we need to take some action
4 in relation to some of them?
5 A. Yes, and we did have within the department, within
6 Paul Simpson's side of the department, a group of people
7 who were charged with the responsibility of looking at
8 these sorts of issues. They were the ones who would
9 have been taking the information that was in this report
10 and following up on some of these points. The
11 discussion I do remember having was around how we
12 embraced the issues that were coming out of this report
13 within this wider concept of clinical governance.
14 One of the problems for us was that although in
15 England they could run straightaway with clinical
16 governance on the medical line, we also have social
17 care, that was an integral part of the Health and Social
18 Services system, so whatever we did had to embrace both
19 the clinical aspects and the social care aspects, you
20 know homes, children's homes, childcare, day care,
21 domiciliary care. Those sorts of issues, which raised
22 a number of different concerns to the ones of addressing
23 patients in hospitals.
24 So we needed to have a system which covered both
25 aspects of the Health and Social Services system. So

1 for us it was clinical and social care governance, and
2 this was a complicating factor in how we were able to
3 put some of these issues into effect.
4 Q. Do you say that it might, as a complicating factor, have
5 meant that you were a little slower in delivering some
6 of this?
7 A. Undoubtedly, yes. Yes, we were. We certainly were
8 slower than in England, but there are reasons why that
9 was the case.
10 THE CHAIRMAN: I'm just not quite clear: you have this
11 report, this report is focusing on hospitals, isn't it?
12 A. It was all the bodies, it was all the Health and Social
13 Services bodies.
14 THE CHAIRMAN: Right, all the trusts. So in
15 Northern Ireland, unlike England, social workers are
16 employed by trusts rather than by local authorities as
17 they are in England.
18 A. That's right.
19 THE CHAIRMAN: But in terms of under-reporting of clinical
20 incidents, why would progress on that be delayed because
21 you also had responsibility for children's homes,
22 children in care and so on?
23 A. Because what we saw in this was a need to have a proper
24 system of clinical and social care governance, that
25 there wasn't one aspect of this that should be pulled

1 out and addressed separately. This was the starting
2 point for the development of a totality of a concept,
3 which embraced both clinical and social care governance.
4 THE CHAIRMAN: Okay.
5 MS ANYADIKE-DANES: We can see it also has comments to do
6 with clinical audit, which we were looking at, but
7 I would like to pull up one particular --
8 THE CHAIRMAN: Sorry, before we move on from that page. On
9 the top right of the screen, Mr Gowdy, issue 3, the
10 significant under-reporting of clinical incidents. What
11 has emerged from the evidence in this inquiry is that
12 there was significant under-reporting in the deaths that
13 I'm looking at. Okay? And I've understood from the
14 evidence that this relates to a culture among doctors,
15 which was defensive and which led to matters which
16 should have been reported not being reported. For
17 instance, Dr Carson as medical director in the Royal was
18 unaware of some events, which he clearly should have
19 been aware of.
20 A. Mm-hm.
21 THE CHAIRMAN: Were you aware of the view which was taken by
22 at least some doctors, if not a significant number of
23 doctors, towards reporting of incidents and towards
24 reporting either themselves or their colleagues within
25 the hospital?

1 A. No, I wasn't. I was getting information from the
2 system. Chief executives, chairmen, would ring me up
3 with issues which they regarded as significant ones
4 which we needed to know in the department, but they
5 weren't clinical issues, I realise. I was getting
6 information on a death of a child in care, there were
7 a couple of incidents, violent incidents in hospital A&E
8 departments. Those sorts of issues were coming to me.
9 I also understood that this --
10 THE CHAIRMAN: And that's perfectly legitimate and --
11 A. Those were things that I would expect to have heard of.
12 THE CHAIRMAN: But that shows that the senior managers
13 in the trusts knew that they had access to you.
14 A. Yes.
15 THE CHAIRMAN: You weren't some remote figure who couldn't
16 be contacted and who wouldn't engage with them if they
17 had problems.
18 A. Yes.
19 THE CHAIRMAN: Right. But not on clinical issues?
20 A. Well, when I was looking at risk management and we were
21 developing out the way in which we should be putting
22 together the various aspects of it, of which incident
23 reporting was one, it had become rather more clear to me
24 that there was an under-reporting of clinical incidents.
25 At the time I didn't think that was the case.

1 THE CHAIRMAN: Right, thank you.
2 MS ANYADIKE-DANES: Can I just pull up 108, that's the next
3 page? You can see, under issue 9, "The supervision of
4 junior staff" -- if I pause there for a moment.
5 These concerns that are raised here, you've already
6 told the chairman, obviously, you took them seriously
7 and you would have had a discussion as to what was to
8 happen in relation to them. So this is 1999, you're
9 receiving the report. If we look at "The supervision of
10 junior staff". The second sentence starts:
11 "However, consultants found few examples [the
12 consultants doing the report, not the medical
13 consultants] of formal written procedures for ensuring
14 that clinical staff have ready access to advice and
15 support from their seniors."
16 That doesn't mean that there aren't such processes
17 in place, but in their view these do need to be made
18 more explicit:
19 "This is a particularly vulnerable arena in the
20 context of clinical risk and needs more focused
21 attention."
22 One of the reasons I have highlighted that is
23 because that was a concern in Raychel's case about the
24 extent to which junior doctors had ready access to --
25 knew who to contact when, if you like, things were

1 perhaps getting above the knowledge that they had. And
2 that was obviously a case that happens in 2001.
3 A. Mm-hm.
4 Q. So how, in your view, was this to be taken forward, what
5 had been highlighted here?
6 A. I don't remember any discussion on that. I just can't
7 recall that that was particularly highlighted as an area
8 of concern.
9 Q. But it's the kind of report that should have led to
10 something?
11 A. All of these points were points that were drawn out from
12 that survey, giving us information about flaws in the
13 system and, yes, I would have wanted all of those to be
14 addressed. I have no recollection of any discussion
15 about how that would be addressed.
16 Q. You were about to give some reasons to the chairman
17 about why you thought the pace was slower here in
18 developing some of these clinical governance issues than
19 in the UK and I'm going to ask you to express your view
20 on that. But before that, if it is taking time before
21 you can institute a total system that encompasses both
22 medical and social services, when you receive a report
23 like this, is there not some suggestion you might at
24 least share this report with the trusts and the boards
25 to see what they can be doing in the meantime, given

1 that some of these concerns would appear to be quite
2 serious? Did this report go to the trusts?
3 A. I don't recall. I don't know what happened in terms of
4 the wider dissemination of this. It was seen as
5 a document for the department, pulling together a policy
6 on clinical and social care governance, and giving us
7 base information on the areas which we needed to
8 address.
9 Q. But it did not also assess the trusts? In order to
10 reach these views, it received responses from trusts and
11 assessed them, did it not?
12 A. It wasn't done in terms of a sort of league table or it
13 wasn't intended as a tool to go out and speak to
14 individual trusts. It was information to us in the
15 department to develop the policy, which we would then
16 deliver to the trusts. So I have no recollection of
17 whether or not this was circulated more widely.
18 Q. Would it not have been more helpful for it at least to
19 have gone to the chief executives of the trusts and
20 maybe the directors of the boards so that they can see
21 the concerns that the department now has about their
22 activities? Would that not have been a step?
23 A. The difficulty with this is I haven't seen this report
24 since 1999.
25 Q. But you said --

1 A. I remember the thrust of it and, as you bring this up,
2 a lot of these points are certainly very familiar.
3 I can't remember to what extent it gave valuable
4 information at a trust level.
5 THE CHAIRMAN: Yes, sorry, Mr Gowdy, the problem we have
6 at the inquiry is that we don't actually have a copy of
7 this report. We're fiddling around with extracts from
8 it in a later document.
9 A. Yes.
10 THE CHAIRMAN: To the extent that this report is
11 commissioned for the important purpose and well
12 commissioned for the important purpose of seeing where
13 you stand with a view to developing governance and risk
14 management, it's rather hard to identify what specific
15 actions flowed from the findings made by the
16 consultants.
17 A. Other than they gave us the information on what we
18 needed to be doing in terms of putting the policy
19 together. It gave us a very clear indication that there
20 were issues around incident reporting and so on, which
21 would have to be built into a clinical and social care
22 governance policy.
23 THE CHAIRMAN: Right. Then let's see how that moved
24 forward.
25 MS ANYADIKE-DANES: I have just been handed, Mr Chairman,

1 the actual terms of reference of the study and a summary
2 of it. I think we perhaps ought to get it paginated
3 because it most definitely does refer to individual
4 hospitals and does appear to give them a scoring across
5 the sorts of things that are at issue.
6 A. It was certainly being done on a trust level. They were
7 going -- the consultants were going out to obtain
8 information from each of them. What I don't know,
9 because I haven't got the report, is whether the
10 information that they brought back in their report on
11 each individual trust was sufficiently robust or useful
12 for us to have disseminated it to the trusts to say,
13 "Look, you're not shaping up here". It was more to give
14 us an overall feel for how the system as a whole was
15 operating.
16 Q. Perhaps we'll get it copied and paginated and look at it
17 in a break.
18 That was the 1999 report. We can see, just for
19 comparison purposes, if we look at the NIAO report in
20 2002, which looks at what happened in relation to that
21 report, the 1999 report is at appendix 5 of the 2002
22 NIAO report, and there are some aspects which bear
23 scrutiny in the NIAO report. Perhaps we can pull up
24 338-006-062.
25 So they are going through some of the items --

1 medical notes and records was an item -- and they are
2 working through this. We can see that at paragraph 3.28
3 they talk about:
4 "A subsidiary group of the Medical Protection
5 Society was commissioned by the HPSS to carry out an
6 audit of medical records and case notes."
7 What they talk about there is a lack of consistency
8 in the filing and format and "difficult to access
9 relevant clinical information". And their conclusion
10 is:
11 "These deficiencies cannot only prejudice the
12 successful defence of a claim [which is one of the main
13 reasons this report was looking at it was it was looking
14 at compensation payments] but may also jeopardise
15 appropriate clinical management."
16 This is now looking back from 2002, so whatever was
17 happening in the intervening period in terms improving
18 medical notes and records, there still seems to be
19 a concern insofar as the NIAO are concerned. And then
20 one sees at 338-006-089 -- and if we pull up 090
21 alongside it -- this is where they are directly
22 referring to the summary we were just looking at of the
23 consultants' report. So they summarise what was
24 happening, and in that first paragraph at the end of 5.4
25 they say:

1 "In particular, it was hoped that there would be
2 changes."
3 And they identify what the changes might be. And
4 then, in 5.5, you see that they refer to summarising
5 what is said in that report.
6 Then if you look at their comments and
7 recommendations, which you can see at 090 in that text
8 box:
9 "Nevertheless, the survey's findings suggest that
10 there remains scope for further improvements and, given
11 that DFP had issued general guidance in 1994, we would
12 have expected further progress on this front."
13 And then if we go to 091, which is the continuation
14 of that text box --
15 THE CHAIRMAN: Just before you go there, let's look at the
16 end of 5.8:
17 "The consultants' report [which is a reference to
18 the 1998/99 report] reinforces in many places the
19 findings of the Audit Office during our examination."
20 This examination is coming in 2002.
21 MS ANYADIKE-DANES: Yes.
22 THE CHAIRMAN: And what the Audit Office seems to be saying
23 is that, in terms, they seem to be saying there really
24 hasn't been very much progress in two to three years.
25 Would that be a fair reading of it?

1 A. Yes. Yes, it would. But can I say that this obviously
2 is a period when we had quite tumultuous political
3 change in Northern Ireland, which actually had an impact
4 on our ability to deliver some of the issues and some of
5 the policies that were being developed? This was the
6 period in which -- from 1998 we had the Assembly
7 elections. We then had a year or more while a lot of
8 the preparatory work was being done and devolution then
9 came into effect at the end of 1999. We then had
10 a number of periods when devolution was suspended over
11 the next couple of years.
12 To an outside observer, that just sounds like
13 a series of facts, but in terms of its impact on the
14 ability of the system, the government system, to move
15 things forward, there were difficulties for us. I well
16 remember one of these papers, "Fit for the future",
17 being taken to the Assembly by the then minister,
18 John MacFaul, he actually went on the floor of the
19 Assembly and was setting out the agenda. But the
20 Assembly were obviously concerned that their pitch
21 shouldn't be queered, as it were, because if devolution
22 was coming along pretty soon after they wanted to take
23 control of it and set the agenda rather than simply take
24 a preordained agenda from another minister and another
25 government. So a lot of the things that we were doing

1 were actually being delayed and put on hold because
2 ministers didn't want to present policies and changes
3 that the assembly might themselves want to take control
4 over.
5 THE CHAIRMAN: It's important evidence, Mr Gowdy, because it
6 seems curious to, I think, everybody here as outsiders
7 that the fact that there's some toing and froing and
8 some delay in the establishment of the Assembly and
9 in the ending of direct rule and the coming into power
10 of local ministers, that that somehow has an effect on
11 making progress in terms of patient care. I think
12 you have just acknowledged that, for us, that might be
13 difficult to understand.
14 A. Yes. There are limited number of people within the
15 department who are taking these things forward, and
16 during the period from the election of the Assembly in
17 1998 until devolution came into effect, there were a lot
18 of preparations going on, there were a lot of seminars
19 being held for Assembly members. We were having to
20 prepare papers and explain how the system worked and
21 what sort of policies there had been in the past. And
22 those were very extensive over the period between the
23 election and devolution coming into effect. But the
24 major impact was -- it's a bit like the purdah period
25 that happens when there's an election throughout the UK

1 and government will not release new policies because
2 that would pre-empt what the incoming government might
3 want to do.
4 This was a very similar period for us, but much
5 longer, so it had an impact on the ability to move the
6 agenda forward as quickly as we would have wanted.
7 There were also, as I say, resource issues because the
8 people who would have been taking some of these things
9 forward were doing a lot of the preparatory work.
10 We also had some issues around the way in which the
11 departments were going to be reconfigured because, if
12 you remember, pre the election we had only six
13 departments. Those were then divided up and there were
14 13 departments created. That in itself was an issue
15 because at one stage I can remember discussions around
16 whether social services, social care, should be taken
17 away from the Health and Social Services system and
18 moved to another department. It didn't happen for
19 reasons of the tightness of the integration we already
20 had. But those sorts of issues were really striking
21 at the heart of the ability to move a big agenda
22 forward.
23 MS ANYADIKE-DANES: Maybe if I can ask you to reflect on two
24 things. Firstly, Professor Scally addressed that in
25 a supplemental report that he provided, dated

1 3 November 2013. It may be that you disagree with him.
2 We can pull up 341-003-005. It starts at paragraph 10
3 where, in his view, there was massive organisational
4 upheaval taking place in the English NHS and the
5 Department of Health in London over this particular
6 period. So to the extent that there were changes, there
7 were changes being experienced perhaps throughout the
8 United Kingdom. But in any event, in terms of
9 Northern Ireland, he says:
10 "The changes over time within Northern Ireland were
11 concentrated at the level of government structures and
12 the department, boards and trusts remained remarkably
13 stable and should therefore, in my view, have been able
14 to match, if not exceed, the pace of development of
15 initiatives around quality seen elsewhere in the UK."
16 And then he refers to something that was said in the
17 department's opening and endorses it:
18 "It's one of the functions of a smaller population
19 and a smaller geographical area that we can perhaps act
20 slightly more rapidly and close the gap."
21 A. I don't accept --
22 Q. You don't accept that?
23 A. No.
24 THE CHAIRMAN: Do you think that's a bit naive to look at it
25 from the outside like that?

1 A. I wouldn't want to say naive as such, but I think the
2 level of understanding of the extent to which we were
3 disrupted from the usual business within the department,
4 I think that would be my concern. There was a need for
5 the incoming government, the incoming devolved
6 administration, to be serviced properly, to be prepared
7 properly, to take on its role. There hadn't been
8 a local devolved administration since the beginning of
9 the 1970s, so there wasn't much experience within the
10 cadre of politicians, who obviously wanted to bring
11 themselves up to speed. So a lot of work was going into
12 that preparation, which obviously had an impact on the
13 ability to do other things at the same time.
14 MS ANYADIKE-DANES: But just so that we're clear, at that
15 higher level of assisting in the setting up and initial
16 implementation of a devolved department, are you saying
17 though that sufficient of the staff were consumed with
18 that activity that they couldn't find ways of addressing
19 some of these concerns, which go to patient safety, as
20 you've acknowledged?
21 A. I'm saying that there were priorities that had to be
22 struck at that stage. A number of those priorities were
23 in the political field, making sure that we supported
24 the incoming administration. Other issues around
25 patient safety obviously went on. We would have

1 certainly expected that the trusts would be delivering
2 their services in the same way, so they wouldn't have
3 experienced the disruption. So there was no diminution
4 of the level of quality that was being provided by the
5 system. What was an issue for us was the ability to
6 develop the agenda forward to do the new things that we
7 wanted to do.
8 Q. Then let's pull up the final part of that box, which is
9 338-006-091. As I understand you, you disagree with
10 Professor Scally's characterisation of matters and
11 therefore the scope for introducing change. But this is
12 the Northern Ireland Audit Office, which I hope you'll
13 agree has considerable experience in dealing with the
14 various departments, including health matters, and what
15 they say at the top there is:
16 "We would therefore expect the department to be able
17 to provide positive assurance of substantial progress in
18 risk management within HPSS bodies by 2003 at the
19 latest."
20 Presumably, they were aware, because apart from
21 anything else, representations would have been made to
22 them, about the political context within which these
23 things were happening. But that was their expectation.
24 Were you aware of that?
25 A. Again, I wouldn't quite interpret it that way. I have

1 no argument at all on the fact -- the fact of the matter
2 is that we were slower than in England. I think that we
3 need to acknowledge that there were factors that
4 affected the ability of our system to deliver.
5 Professor Scally and the Audit Office are looking at
6 this in terms of the achievement. That's the role of
7 the NIAO, what was achieved and so on. They've made no
8 reference to any other factors. I would want to put to
9 the inquiry that if there is a suggestion that we were
10 slow, it wasn't that we were sitting on our hands; there
11 was, in fact, a great deal of work being done on
12 a different issue.
13 Q. Yes. Then in paragraph 5.10 they go on to say what they
14 would like the department to do as a matter of priority.
15 Very often when the NIAO issues a report like this,
16 there's then an opportunity for evidence to be given by
17 the Public Accounts Committee in relation to these, and
18 that's an opportunity where the Permanent Secretary, as
19 I'm sure you know only too well, gives evidence and
20 addresses these sorts of concerns. It happened only
21 last -- in fact, earlier this year in relation to
22 a report last year to do with the quality of care. And
23 that's an opportunity where the Permanent Secretary
24 explains the constraints around what the Health Service
25 or the department can deliver in terms of the Health

1 Service and to what extent these things might be
2 unrealistic targets and so forth. The points that
3 you're making now to the chairman, were they made then?
4 A. This was the?
5 Q. 2002.
6 A. Which audit report was this?
7 Q. This is the audit report for compensation payments for
8 clinical negligence.
9 A. Oh yes.
10 Q. I think it was published by the Northern Ireland
11 Assembly on 3 July 2002.
12 A. Yes, and I appeared in front of them.
13 Q. Sorry?
14 A. I appeared in front of them.
15 Q. Yes.
16 A. No, I didn't make these points.
17 Q. But that would have been relevant to the expectations
18 that are being put here as to what can be done and when
19 it can be done.
20 A. I have a slight hesitation here because I'm getting into
21 a field of politics, which I really, I suppose,
22 shouldn't do. I say these things because I'm not in the
23 system anymore, so I have a little bit more freedom in
24 the sort of remarks I can make. It would not have been
25 a judicious comment to make in front of politicians that

1 somehow the political process was slowing up work on
2 other things. Sorry, I'm accepting, as I did then, that
3 it was preferable, desirable, it should have been
4 something that had happened faster. I have no argument
5 with that at all. The fact of the matter is we were not
6 moving at the pace that we would have wanted to.
7 Q. And then if one leaves some of the higher-level
8 initiatives that might have been able to be instituted
9 in relation to clinical governance as a whole and goes
10 to some of the ingredients of that that could perhaps
11 have been worked on and improved whilst you're waiting
12 for the guidance to ultimately be delivered in relation
13 to clinical governance, this report also deals with some
14 of those ingredient issues, if I can use that
15 expression. If we go to 093 and maybe pull up 094
16 alongside it.
17 This really goes to how one might exert control.
18 I put to Mr Hunter whether or not, given that he saw the
19 purchasing agreements between the purchasers and the
20 trusts, whether he could have advised, required, that
21 certain standards or means of monitoring standards be
22 instituted in there so that that's something that he can
23 hold the board accountable to. He said he didn't do
24 that, but he recognised that that was a possibility,
25 that could have happened. And this is a little bit of

1 what is being discussed here.
2 Here, it's being said that whilst it's for the
3 boards to stipulate key initiatives and that the
4 department doesn't see the service and budget
5 arrangements --
6 A. Sorry, which paragraph is this?
7 Q. I beg your pardon, 5.17. The preface to it is 5.16,
8 which is the steps that the boards in their role as
9 major health commissioners could have taken to
10 contribute to standards of care. Okay?
11 A. Mm-hm.
12 Q. Then it goes into 5.17 to see what could be done in
13 terms of the agreements they have with the trusts. The
14 Audit Office is accepting that there's a role for boards
15 to stipulate key initiatives and the department does not
16 see service and budget arrangements between the boards
17 and trusts as the vehicle for comprehensive
18 documentation of all standards or for delivering the
19 improvements necessary, and it goes through the
20 framework for setting standards and so forth. So it
21 accepts that that's the department's position, but
22 in the box is the recommendation:
23 "We recognise and accept the department's view that
24 quality and standards must be driven by a more
25 comprehensive, constructive and focused emphasis on all

1 of the key issues which are part of this concept. We
2 agree that it would not be appropriate to use the
3 contracting/commissioning process solely for this
4 purpose, but we feel that it has an important role to
5 play in ensuring that the commissioning of healthcare is
6 linked to accepted quality standards."
7 That goes to what I was asking before. Whilst
8 you're waiting for this overall approach, which is going
9 to link it all together in a drive towards clinical
10 governance, would you not have been instituting some of
11 these suggestions, which may have had an impact on
12 quality along the way?
13 A. Yes. I think if there was anything that could have
14 helped improve the way in which the system was
15 operating, yes --
16 Q. Thank you.
17 A. -- I would accept that.
18 Q. So you've had your 1999 report, you've had the NIAO
19 report on achievements of improvements, to a certain
20 extent, following up what's happened as a result of that
21 report. And if we look at what happens after that --
22 THE CHAIRMAN: Before we do that, Mr Gowdy, we'll take
23 a break for a few minutes.
24 (11.40 am)
25 (A short break)

1 (11.55 am)
2 MS ANYADIKE-DANES: Mr Gowdy, just before the break we had
3 discussed the extent to which the report might have
4 raised issues which would have been helpful if it had
5 been shared with the other trusts. You weren't entirely
6 sure to what extent the report included matters at that
7 level of detail.
8 We still don't have the report, but we're a little
9 bit further on than just the summary conclusions. And
10 that's this document, the reference for which is
11 338-013-001. If we go to 003 first of all and pull up
12 alongside it 004, and we can do this, I think, quite
13 quickly.
14 This is the scoring scheme or the -- well, it was
15 the scoring system that was applied to the areas of
16 assessment. And the areas of assessment, as we were
17 going through the conclusion, they were done in that
18 order. So 1 was "risk management", 3 was "incident
19 reporting", 4 was "patient and client records". You see
20 5 there, "clinical audit", and so on. And those were
21 the areas of assessment, and then they applied this
22 scoring system to those.
23 They produced, as you can see on the right-hand
24 side, averages for the trusts, but if I just pick out
25 one particular bit of the score, 3, you'll see in

1 a moment why I pick that out:
2 "Partial: in terms of compliance, documents are
3 available, but they are over three years old and there
4 is evidence of dissemination."
5 And it goes all the way up to 10, which is,
6 of course, full compliance.
7 If I then pull up 005 to sit alongside 004. So that
8 was the averages in that first table and it gives you an
9 overall, so the overall average was only 6 out of
10 a possible 10 on all those areas, and then you see the
11 organisations, Altnagelvin is one, and then across you
12 can see Craigavon and so on, including Newry & Mourne.
13 Newry & Mourne has a score of 3, which is pretty low.
14 What I'm wondering is, when you saw that, whether
15 you weren't concerned about maybe not just
16 Newry & Mourne, but all those who had only just got to
17 the halfway stage or were below it and thought that it
18 might be appropriate to communicate with them that an
19 independent consultant had carried out this sort of
20 survey and that was how that trust had been assessed.
21 It may be that they've got explanations for it or
22 maybe more work needs to be done, but would you not have
23 thought that appropriate?
24 A. Could I refer you to paragraph 9? The key sentence to
25 me is the first sentence there, that it was not

1 a detailed audit.
2 Q. Yes.
3 A. So the basis for the information there was something
4 that would need to be explored in more detail before one
5 could be satisfied that there was a great failing there.
6 But I take the point that this threw up information
7 which demonstrated quite clearly that the system as
8 a whole was not performing to the level that we would
9 want to see.
10 The response that we had was: this needs to be
11 embraced within the development of this wider policy on
12 clinical and social care governance, and that that was
13 the way to take it forward. But I accept that there is
14 an argument for disseminating the information to the
15 trusts, and I don't think that was done at the time.
16 I'm sorry about this because I have not had access to
17 this for so long and I can't recall what actually
18 happened to it.
19 Q. If you look at paragraph 11, though, this may be the
20 answer:
21 "The department subsequently advised each
22 organisation of their own scores against the average."
23 So Newry & Mourne would have seen that they got 3
24 against the average of 6, as they related to each of the
25 12 risk management issues surveyed. So there was some

1 thought of what ought to be done. Where my question was
2 going was: what was the result of it? So let's say for
3 the sake of argument you've told Newry & Mourne: this is
4 a bit of a concern, you've scored 3. What is the result
5 of that? I'm only picking out Newry & Mourne because it
6 had a particularly low score, but you could have done it
7 with any of the ones who are 5 or 4 or whatever. What
8 happens as a result of that?
9 A. Well, I think that this would have been taken, given the
10 comment that it wasn't a detailed audit, that this would
11 have been indicative information rather than absolute
12 information.
13 Q. Yes.
14 A. And it would have been an indicator to them that they
15 needed to shape up a bit. But it certainly wouldn't
16 have been detailed enough to give them specific guidance
17 on what they should be doing, which was why a policy
18 needed to be put in place.
19 Q. But would you not want them to either explain to you
20 that this is actually not particularly helpful to you,
21 Mr Permanent Secretary, because whatever is their
22 explanation and on that your advisers can form a view,
23 and if you're not satisfied with that, would you not be
24 seeking, perhaps through your professional advisers, to
25 see what they're going to do to address that kind of

1 concern whilst you're waiting for the overall policy?
2 A. I don't want to appear unhelpful because that's
3 certainly not my intention. I don't recall too much of
4 the detail of what actually transpired in that
5 paragraph 11 action, advising the various bodies,
6 whether there was any qualitative comment made in giving
7 them the information. I'm sorry, I don't know. But the
8 intention behind this survey had been the general one of
9 getting a picture in very broad terms of where we stood
10 on the approach to risk management on all those
11 dimensions by all of the Health Service bodies. It was
12 to give us a starting point --
13 Q. I understand --
14 A. -- for moving forward in the development of something
15 wider.
16 Q. I understand. But before you issue -- in fact, the
17 interim guidance comes out in January 2003, which we'll
18 come to in a minute, which is telling them to start
19 getting their systems in order. In fact, that wasn't
20 the interim guidance; that was to tell them to get their
21 systems in order and the interim guidance, in fact,
22 comes out in, I think, July 2004. So before that --
23 A. That's on the incident reporting side.
24 Q. I understand that.
25 A. There was information on the clinical --

1 Q. I understand that.
2 A. -- and social care governance issues before that.
3 Q. Before that, when would the trust appreciate the
4 information that you had that was driving, if you like,
5 the policy, the overall policy, that you're going to
6 issue? When would they have known that?
7 A. This specific information? Any information?
8 Q. You have said this was a baseline and this was part of
9 what you were using as your starting point for
10 developing your overall policy.
11 A. Yes.
12 Q. What I'm asking you is: this appears to indicate some
13 concerns, so when in that continuum until when the
14 policy is actually published would you be engaging with
15 the trusts about these sorts of things that are going to
16 be reflected to be addressed by your policy?
17 A. Well, you can see that they were given their scores, so
18 that was an initial indication --
19 Q. Right.
20 A. -- of what was found in this particular survey.
21 Q. And then what?
22 A. But after that, the work that was going on on "Best
23 Practice, Best Care" was -- this was really a starting
24 point for all of that work. There was a process of
25 discussion with all the Health and Social Services

1 bodies, so there was an awareness that there were issues
2 around things like risk management, the profiling and
3 that these were things that they needed to address. But
4 there was no specific prescription given to them until
5 the policy of "Best Practice, Best Care" came out.
6 Q. And when they would have been made aware that there were
7 issues coming out like this, what would they have
8 understood about the department's expectation of them
9 ahead of the department's policy being issued?
10 A. That they should be putting their house in order.
11 Q. And would you be monitoring that, whether or not they
12 were actually doing that?
13 A. Not on a very frequent basis.
14 Q. No.
15 A. But there was the Deloitte & Touche material, which was
16 seen as a check on where they stood on these things.
17 Q. Yes. I'm going to come to Deloitte in a minute, which
18 was in 2003. But this is intended to signal to them
19 that the department is aware of certain concerns in
20 these areas. However limited you regarded this
21 information to be, it identifies concerns and that you
22 expected them to put their house in order. As opposed
23 to just leaving them to put their house in order, what
24 sort of oversight did you intend to have about the
25 putting of the house in order?

1 A. Well, can I go back to what I'd said at the start? This
2 to us was the baseline information to allow us to work
3 on the issues that needed to be addressed in the policy.
4 In feeding back the information, it wasn't intended to
5 give them a prescription of the action they needed to
6 take. It was an indication to them that the department
7 was working on these issues and was going to produce
8 something and that their score gave them a hint of where
9 they stood. It wasn't presented to them as a league
10 table, as I understand it; it was simply their own score
11 without any reference to how others had done. It was
12 a warning, I suppose, rang a warning bell to them that
13 they should be doing things, but we weren't, I don't
14 think, from this, telling them what they should do other
15 than the individual scores on the dimensions of the
16 survey.
17 Q. Okay. Can I ask you another issue in relation to the
18 information that the department had at its disposal?
19 This is slightly earlier than that, this is published in
20 1997, and it's to do with inaccuracies in death
21 certification in Northern Ireland. One of the things
22 that the 1998, published in 1999, report had indicated
23 was some concerns about record keeping and so forth --
24 and that's a theme that you see picked up in the NIAO
25 report, and one assumes that if you don't have accurate

1 medical records maybe you don't have accurate death
2 certification.
3 But in any event, if I pull up this, 338-012-001 and
4 002 alongside it. So this was a comparative study that
5 was carried out by Alison Armour, who was in the
6 State Pathology department at the time when Adam's
7 post-mortem was carried out, and Hoseni Bharucha, who
8 was also in the department of pathology. They carried
9 out this study, essentially to see how accurate the
10 death certification was in Northern Ireland, and the
11 result was it doesn't seem to have been very accurate at
12 all. You can see in the summary what some of the
13 commonest inaccuracies of death certification were and
14 they say in the middle of that section, under the
15 summary in bold:
16 "Areas of poor terminology, sequence errors,
17 unqualified mode."
18 And so on. In fact, they say that inaccuracies were
19 serious enough to warrant referral by the registrar of
20 deaths to the coroner. You may be aware now that there
21 was an issue about the accuracy of death certification
22 in relation to some of the children that this inquiry is
23 looking at.
24 A. Yes.
25 Q. And that ultimately, two children were referred to the

1 coroner, who hadn't previously had inquests.
2 A. Yes.
3 Q. Then you see that the hospital doctors, if we leave
4 outside the general practitioners, they had a perhaps --
5 they got a different percentage for error. But the
6 hospital doctors were responsible for 62 per cent of the
7 inaccuracies. That's a pretty high level of inaccuracy
8 in death certification, would you not say?
9 A. Yes.
10 Q. Is that the sort of information, the result of this
11 study, that you'd have expected to be brought to you in
12 some form?
13 A. Yes.
14 Q. And are you aware of what happened about it?
15 A. No.
16 Q. No? Who is the person that you would have expected to
17 have brought this to your attention?
18 A. Since this involves clinicians making decisions as to
19 what to put on their death certificate, I'd have
20 expected the Chief Medical Officer to have been
21 informed.
22 Q. And in some way that would have come to you either at
23 that specialist meeting that you had with all the senior
24 people or even mention it to you in some other way, but
25 you'd have expected her to have brought that information

1 to you?
2 A. I think that looks serious enough to warrant her raising
3 it with me, yes.
4 Q. Were you aware that there were concerns as to the
5 accuracy of death certification?
6 A. No.
7 Q. At all during your period of time?
8 A. No.
9 Q. Before I introduced that, you were explaining that you
10 weren't prescriptive to the trusts, that in fact what
11 you largely were focusing on, in this area, was the
12 development of your policy, which ultimately would be
13 published with guidelines and so forth, for the benefit
14 of the boards and trusts. Was that fair?
15 A. Yes.
16 Q. If we look at what was happening then. In 2000, the CMO
17 writes out to doctors. We can see that at 338-006-001.
18 (Pause). That's an error there. I'm so sorry, I'm not
19 quite sure how that's crept in.
20 She writes on 29 March and she addresses that letter
21 to all doctors. I'm trying to see if I can find an
22 alternative reference to it. She refers to the clinical
23 governance work that's being done in the rest of the UK.
24 I have it here. 338-008-001. Can we try that? And
25 pull up 002 with it. Yes, that's it. Thank you.

1 So if we start with that page while the other is
2 coming, she's referring to these developments in the
3 rest of the UK to promote high quality clinical
4 performance and ensure its continued maintenance. She
5 specifically refers to the introduction of clinical
6 governance, and along with that, another effort, which
7 is continuous professional development and regulation
8 and part of that went into consultant appraisal and so
9 forth.
10 A. Mm-hm.
11 Q. But I'm really focusing on the clinical governance side
12 of it. She refers to the fact that:
13 "There are no formal mechanisms in Northern Ireland
14 in relation to clinical governance, but the frameworks
15 are under development in the trusts."
16 What were those frameworks, Mr Gowdy, so far as you
17 understood them to be?
18 A. I'm struggling to recall.
19 Q. Are you likely to have known about this level of
20 communication or not?
21 A. Not necessarily, no.
22 Q. She refers to having asked -- it's at the third
23 paragraph -- Dr Ian Carson to establish a group to
24 produce guidance on clinical performance. Would you be
25 aware of something like that?

1 A. Again, not necessarily. This looks to me like the sort
2 of thing that the Chief Medical Officer would perhaps
3 have mentioned in passing that she was doing work on
4 this. It would certainly be part of the overall
5 approach being taken by the department to the
6 development of clinical and social care governance. And
7 this was a dimension of it which was wholly in the
8 medical field.
9 Q. Well, one of the --
10 A. I wouldn't necessarily have needed to know the specific
11 detail.
12 Q. I understand. Sometimes I'm asking the question because
13 I don't really know at what level something is likely to
14 have come to you. But if you see in that second
15 paragraph, she says:
16 "Whilst clinical governance provides the framework
17 to provide the quality of service within the
18 organisations, there are parallel developments [and this
19 is one of them] to address individual performance."
20 Why I put that to you is because it's one of the
21 things I was asking you about. Yes, you're going to
22 have an overall framework that you are going to, at some
23 stage, finalise and issue, but while that's happening
24 there is still surely scope for improvements and changes
25 to be made on some of the things which might ultimately

1 be included under that framework and she's certainly
2 addressing that. She's saying in a way, "Look, we can
3 get on with monitoring performance in the sense of, for
4 example, continuous professional development, that sort
5 of thing".
6 A. Yes.
7 Q. And if she could do that in relation to that aspect of
8 clinical governance, why could the department not be
9 seeking to have other aspects also addressed before it
10 issued its final policy?
11 A. I would take it on the basis that what could be done
12 should be done. If there was the capacity to do
13 something, it should be done.
14 Q. So to the extent that any of those concerns that had
15 been flagged up in the 1999 report could have been
16 addressed in the meantime, then they should have been?
17 A. If they could have been addressed, they were things that
18 were worthy of doing, yes.
19 Q. And they should have been?
20 A. Um ... It's always a question of addressing your
21 priorities with the resources that you have available to
22 you. I couldn't say that that would necessarily rank as
23 a higher priority than some of the other issues that
24 needed to be addressed at that time.
25 Q. There would at least be a discussion --

1 THE CHAIRMAN: Ms Anyadike-Danes, I've got this point at
2 least twice.
3 MS ANYADIKE-DANES: Then if we go on, she discusses this in
4 one of the CEMACH meetings on 28 February 2001 and
5 refers to the fact that:
6 "For some time the department has been considering
7 how to take forward the quality agenda in
8 Northern Ireland."
9 And she says that:
10 "It's anticipated that a paper on clinical quality
11 and clinical governance will be issued within the next
12 few weeks for consultation."
13 Were you aware of that?
14 A. Sorry, which paragraph is this?
15 Q. It's not in that paragraph. The reference is
16 320-008-002, I beg your pardon. If you look at
17 paragraph 4.1, this is a CEMACH meeting of
18 28 February 2001:
19 "CMO said that for some time the department had been
20 considering how to take forward the quality agenda in
21 Northern Ireland."
22 A. Yes.
23 Q. What do you say had been the subject of that
24 consideration, what were they considering exactly?
25 A. Who, the CEMACH?

1 Q. No, the department. She's reporting to CEMACH what the
2 department is doing. This is now 2001.
3 A. This is the work that the department had been trying to
4 take forward on clinical and social care governance.
5 There was a hope that things would be moved forward more
6 quickly than actually transpired. Sorry, what date is
7 this document?
8 Q. It's dated 28 February 2001.
9 A. Yes. The "Best Practice, Best Care" consultation paper
10 was published?
11 Q. April.
12 A. In April of 2001 and that was the clinical quality and
13 clinical governance plus social care governance.
14 Q. So that was to let the health field know the
15 department's thinking and the policy that's going to
16 issue in relation to the area?
17 A. Yes.
18 Q. And then we get, as I had mentioned before, 306-119-001.
19 That is a letter dated 13 January 2003, and this goes to
20 the chief executives and this is guidance to enable you
21 to formally begin the process of developing and
22 implementing clinical and social care governance
23 arrangements, starting with effect from the date of
24 this, which would be 13 January 2003.
25 A. Mm-hm.

1 Q. So is that the first signal to them that that's what the
2 department expected them to be doing?
3 A. Well, this follows on from, as I was saying earlier, the
4 sort of conversations and dialogue that had been going
5 on with the bodies in the Health Service because
6 although we were expecting that we would have been
7 getting information from them, it was equally important
8 for us to give them information. So I was certainly
9 telling boards of all the bodies in the programme of
10 visits I did with them that we were developing these
11 sorts of policies, so there was an awareness that this
12 was coming.
13 What this circular was doing was codifying it, was
14 saying, "This is where we are, these are the features of
15 the policy that we're putting in place, these are the
16 sorts of things that need to be addressed".
17 Q. And was it not also really, on the next page, indicating
18 what was required was a consistent approach to doing
19 this across the region? So whatever might have been
20 your discussions with them, this is now the department
21 instituting a regional attempt to deal with the
22 introduction of clinical and social care governance?
23 A. Yes, it is.
24 Q. And so this would be the first time they'd be able to
25 see what the uniform approach is going to be? Would

1 that be correct?
2 A. Other than the consultation paper earlier had been
3 sending signals to them. I mean, the consultation paper
4 was setting out where we thought we should be going and
5 it was giving people the opportunity to respond. So the
6 trusts would have been fully aware that this is the
7 direction of travel.
8 Q. Yes. And then before you get to the actual guidance,
9 which will give them the definition that they are to use
10 and so forth, and all of that doesn't happen
11 until July 2004, before you get there you have, as you
12 indicated, the Deloitte & Touche reports.
13 A. Mm-hm.
14 Q. The first of those is published on 19 September 2003.
15 Why did you commission the Deloitte & Touche report?
16 A. Again, this was a desire to know where we stood. This
17 was asking for an independent look at what was actually
18 happening out there in the Health Service, both on the
19 work that they might have been doing on clinical and
20 social care governance and also specifically on the
21 reporting of serious incidents.
22 Q. So you had an indication of where matters may lie in
23 1998/1999, and now you're looking at 2003 to see where
24 are we now, and that would give you some guidance on how
25 well anybody had been able to respond to the kinds of

1 concerns you had signalled to them off their own bat?
2 A. Yes.
3 Q. Without anything more prescriptive coming from the
4 department?
5 A. Yes.
6 Q. And in fact, the results aren't terribly encouraging;
7 isn't that fair?
8 A. That's fair, yes.
9 Q. The Eastern Health and Social Services Board, which is
10 the one for the Royal, what's recorded there for them
11 is:
12 "Significant weaknesses included no risk management
13 policy, no complaints/customer care training, no
14 communication policy, no workforce plan, no system for
15 promoting best practice, no clinical governance policy".
16 A. Mm-hm.
17 Q. That's quite damning.
18 A. Yes. Yes.
19 Q. I'm being reminded actually that the consultants who did
20 the 1999 report did an updated survey of their results
21 in 2002. I'm not sure that we've got the report of
22 that, but in any event, on this basis, that's quite
23 damning. So having identified some concerns in 1999 to
24 be able to have a report, whatever you would have been
25 signalling to them or hoping they would do, to have a

1 report that gives you that information in 2003 must have
2 been a concern.
3 A. Yes, it was. And the response to that was we engaged
4 the clinical governance support team from the
5 modernisation agency in the NHS to come across and have
6 bilateral meetings with all the HPSS bodies, and that
7 happened in the period around the end of that year.
8 Q. Yes, but before we get to what your response was, did it
9 surprise you to receive those concerns or that report
10 from Deloittes?
11 A. I was disappointed.
12 Q. Did it surprise you?
13 THE CHAIRMAN: I'm sorry, why does it matter if he's
14 surprised or disappointed? Let's move on,
15 Ms Anyadike-Danes. We have to move on rather more
16 quickly than this.
17 MS ANYADIKE-DANES: If I can just ask you this: did it
18 indicate to you that whatever systems you had for
19 learning what was going on actually in the hospitals may
20 not be as sensitive or as accurate as you would hope if
21 you could get a report like this?
22 A. I will be very honest and say it suggested to me that
23 they weren't taking it as seriously as we were.
24 Q. They weren't, but if you didn't know about it then, it
25 might indicate to you that your systems for knowing

1 what was going on --
2 A. Oh, I see what you mean.
3 Q. Did that indicate that to you?
4 A. Yes. It certainly would have suggested that we didn't
5 know enough about how they were progressing on this
6 issue.
7 Q. And if it did that, what discussion was there within
8 your department as to the changes you might institute to
9 ensure that you were able to have a more accurate feel
10 of what was happening in the hospitals?
11 A. Well, there were regular meetings going on each year,
12 there were accountability reviews, the department had
13 a couple of units who were keeping in touch with the
14 trusts to see how they were delivering their services.
15 Q. But you had accountability reviews before 2003.
16 A. Yes, it suggested that maybe those weren't detailed
17 enough in terms of the information we were getting back.
18 It's why it was important for us to follow up once we
19 got that Deloitte & Touche report. I mean, it was
20 a disappointment that things weren't moving along at the
21 pace that we would have wanted, and that's why we got
22 the NHS Modernisation Agency to send across their
23 clinical governance support team to give us an outside
24 view and to reinforce with the HPSS bodies the sort of
25 things they should be doing.

1 Q. And when did they come in to work?
2 A. They came across at the end of 2003, after the Deloitte
3 & Touche report, which was September 2003.
4 Q. That's correct, it was. In fact, there was another
5 Deloitte & Touche report of the end of March,
6 31 March 2004.
7 A. Yes.
8 Q. And that report was really focusing on the adverse
9 incidents and near-miss reporting.
10 A. Yes.
11 Q. And that report, as at 2004, was noting inconsistencies
12 in approach, including the incident reporting systems,
13 the monitoring, the analysis and follow-up. All of
14 those were subject to some criticism in that Deloitte &
15 Touche report.
16 A. Yes.
17 Q. Is that correct?
18 A. Yes.
19 Q. And they made certain recommendations as to what you
20 might have to do to try and improve the position.
21 A. Yes.
22 Q. And did all of that feed into your guidance of
23 7 July 2004?
24 A. Yes, the circular that went out.
25 Q. Sorry, I can put it up so you can see what I'm talking

1 about. It's witness statement 062/1, page 314, and if
2 one also pulls up 315.
3 A. Yes.
4 Q. This refers to itself as an interim guidance, so you
5 still you hadn't got your full guidance out.
6 A. Yes.
7 Q. That came later on.
8 A. Yes.
9 Q. But this is --
10 A. But as you can see, it was very detailed indeed.
11 Q. It was. The question is, before we go into the detail
12 of this, are you saying the reason why it took so long
13 from having been aware of what was happening in the rest
14 of the UK, having been alive to some of the concerns
15 that you had in Northern Ireland itself, the reason why
16 it took so long to get this out was to do with partly
17 devolution matters. What else hampered getting this out
18 sooner?
19 A. There were, I suppose, two main sets of issues. One was
20 the diversion of addressing the needs of the devolved
21 administration and the preparations that needed to go on
22 to ensure that that was a smooth transition. That was
23 obviously a high political priority for us, which did
24 divert people away from some of the things that they
25 would otherwise have been doing.

1 The second one was that it was a more complicated
2 exercise for us because of the need to embrace social
3 care within the governance arrangements. Those would be
4 the two main issues that affected ...
5 THE CHAIRMAN: Okay, thank you.
6 MS ANYADIKE-DANES: Thank you. Then if we see that
7 definition there on 315, you can see that if this policy
8 had been in place at the time when the children which
9 are the subject matter of this inquiry had their
10 treatment and had died, they would have satisfied the
11 criteria as serious adverse incidents and they would
12 have been reported?
13 A. I'm sorry, I'm not sure where that is.
14 Q. If you look at the definition of what constitutes
15 a serious adverse incident, would the death of these
16 children that the inquiry is concerned with have
17 satisfied that criteria?
18 A. Yes, it would.
19 Q. So if this had been in place, they would have been
20 reported?
21 A. Yes. Well, one would hope so.
22 Q. Sorry, it would be intended that they would be reported?
23 A. Yes.
24 Q. Quite apart from the matters that you've explained to
25 the chairman that made it more difficult to get this out

1 sooner, do you take any responsibility for such guidance
2 not coming out sooner?
3 A. Yes, it happened on my watch. The Permanent Secretary
4 is responsible for what goes on. I wouldn't duck that
5 responsibility.
6 Q. And does that mean although there might be, as you've
7 given them, explanations for why things could have taken
8 longer than in the UK, nonetheless does that indicate an
9 element that we could have done it sooner here in
10 Northern Ireland?
11 A. No.
12 Q. You don't think so?
13 A. We could have done it more quickly if we hadn't had to
14 deal with the raft of other business that was happening
15 at that time. There was no lack of will, there was no
16 lack of direction. There was a very clear desire to
17 move this agenda forward and, unfortunately, it didn't
18 happen and I find that disappointing.
19 THE CHAIRMAN: Thank you.
20 MS ANYADIKE-DANES: Yes. Then given that you have that
21 view, in fairness to you, because Professor Scally has
22 specifically addressed that, he considers that there was
23 a leadership role for the department and for the senior
24 people within that department in relation to quality of
25 care. Would you disagree with that?

1 A. No.
2 Q. So there was a leadership role?
3 A. Yes.
4 Q. And he says, effectively, that those who had that
5 leadership role bear some responsibility for the pace of
6 change not being sooner, and that you disagree with?
7 A. Yes. There was no lack of will to get this done.
8 Effort was made to make sure it happened. I had
9 a consistent view right from 1997/1998 that we needed to
10 move forward on an agenda which covered risk management
11 and the means of ensuring patient safety. So there was
12 no lack of emphasis on this as an issue. Circumstances
13 prevented us from delivering.
14 Q. When you came in as Permanent Secretary in 1997, did you
15 regard quality of care -- just so that we're clear about
16 this because there have been some slight differences --
17 as an important element for the department --
18 A. Yes.
19 Q. -- and a responsibility of the department? Not
20 necessarily in the delivery of it, but to ensure that it
21 was being delivered.
22 A. Yes. As a strategic issue, ensuring quality of care
23 delivered in the Health and Social Services system was
24 a fundamentally important thing for us.
25 Q. And I think you've told the chairman that one of the

1 ways in which you sought to understand or learn what was
2 happening in the trusts was through accountability
3 reviews.
4 A. Yes.
5 Q. And in your evidence in your witness statement, we don't
6 need to pull it up, but at 062/2, page 6, you say:
7 "They were conducted by the department with the
8 trusts each year to scrutinise their performance across
9 a range of their business."
10 Did you discuss quality of care issues in those
11 accountability reviews?
12 A. I wasn't directly involved in those meetings. I think
13 my recollection's a little bit skewed on that. The
14 accountability reviews where -- the trusts, I think,
15 came in around 2001. It had previously been with the
16 boards, who were the commissioners of the services from
17 the trusts.
18 Q. When they came in in 2001, did you participate in them?
19 A. No.
20 Q. Did you receive reports from the accountability reviews?
21 A. Not composite minutes of the entire meeting, but I would
22 have, from time to time, been acquainted with some of
23 the issues that had come up.
24 Q. Okay.
25 A. They were many and varied, from some of the issues of

1 policy delivery through to financial issues.
2 Q. Then maybe I haven't quite identified the correct source
3 of your information. When "Best Practice, Best Care"
4 was published, which was published as a framework for
5 setting standards and delivering services and improving
6 monitoring, when that happened, how did you expect,
7 since you're ultimately accountable for it all, to
8 receive the information in relation to how that was
9 being implemented, the themes within that?
10 A. In a number of ways. The department did have a group of
11 people under Paul Simpson's area who were responsible
12 for keeping in touch with the boards and trusts. They
13 would have regularly met any issues that were of concern
14 or anything beyond the norm would have been fed through
15 the system to us. All of us, as senior people in the
16 department, had regular meetings with all of the Health
17 Service bodies. I certainly made a point of visiting
18 all the boards of these bodies each year and having
19 a discussion about their performance. To call it
20 a formal accountability review would give the wrong
21 impression, but they were certainly meetings where an
22 exchange of information went on about how the objectives
23 of the Health Service were being delivered.
24 Q. Was there any structure built round the information that
25 you were seeking in relation to those elements of "Best

1 Practice, Best Care"?
2 A. There was no formal monitoring system at the time I was
3 there.
4 Q. Do you think that might have been helpful?
5 A. Yes. Yes, there were discussions around what should
6 happen and I'm not sure if those subsequently came into
7 effect after my departure.
8 THE CHAIRMAN: When you say there were no accountability
9 reviews for the trusts until 2001, they started to be
10 formed from about 1993; is that right? Was the Royal
11 one of the first in 1993 and others came in 1994 and
12 1995?
13 A. Yes.
14 THE CHAIRMAN: Does that mean from then until 2001 the
15 accountability reviews were limited to the department on
16 the one hand and each of the four boards on the other?
17 A. The trusts had accountability reviews with -- sorry, had
18 meetings with the boards, who then had accountability
19 reviews with the department, and they were asked at
20 those accountability meetings how their trusts within
21 their area had been performing.
22 THE CHAIRMAN: Thank you.
23 MS ANYADIKE-DANES: In fact, Mr Chairman, Dr Paddy Woods
24 earlier this year, who's Deputy Chief Medical Officer,
25 wrote a letter trying to correct a misunderstanding that

1 had developed over what was dealing with them. It's at
2 323-001aa-001.
3 The upshot of it is that the twice-yearly
4 accountability meetings with the trust weren't happening
5 prior to 2001, so he simply confirms that. He thought
6 they were and he had misunderstood the situation; they
7 weren't and he recognised that.
8 So in terms of holding the trusts to account, then
9 is it back to what Mr Hunter said, that was actually
10 done by holding the boards to account --
11 A. Yes.
12 Q. -- in large part?
13 A. Yes. The trusts were formed on the basis that they
14 would have a very high degree of autonomy and that they
15 would be able to determine how to deliver the business
16 with minimum interference. But because the money to
17 purchase those services came from the boards, the line
18 of accountability initially was to those boards.
19 Q. And even when that changed in the sense that the
20 Management Executive in that era, when things were sort
21 of slightly separated off, even when that changed and
22 the Management Executive came within the department and
23 there was a shift in emphasis and you had a greater
24 oversight or more direct oversight over the trusts, that
25 still persisted, didn't it, until about 2001?

1 A. In the sense of having formal accountability reviews,
2 which were big set-piece meetings between chairman,
3 minister, Permanent Secretary, et cetera. There were
4 meetings with the trusts, which really did the same sort
5 of job. They were looking to see how the trusts were
6 performing. So it wasn't that no check was made on
7 them, they were certainly scrutinised by the department.
8 Q. And did you receive reports of those?
9 A. Not unless there was anything -- I didn't, as a matter
10 of course; only if there was something which came up,
11 which needed to be raised to my level.
12 Q. So do you then see that if these kinds of deficiencies
13 that we've been working through this morning could be
14 alerted to you by independent consultants, that there
15 must have been some failing in that system?
16 A. Well, I don't see it in those terms because what those
17 meetings, the accountability-type meetings, were doing
18 was checking whether they were providing the level of
19 service that was required, quality, in the sense of
20 addressing the priorities that had been established by
21 ministers, and also making sure that their financial
22 performance was up to scratch. On the clinical and
23 social care governance side, we were developing
24 a policy, so it wasn't a sense in which they could be
25 checked against that, other than by the baseline study

1 that we did through the HRRI folk.
2 Q. Then before I move on to audit, just one final question
3 on this area of responsibility and so on -- and it's
4 a question that I've asked all those who have come
5 before you -- which relates to the extent to which the
6 chief executive and the board of a trust had
7 responsibility for the quality of care that was being
8 delivered by the trusts and the hospitals within the
9 trust. The department's view is that they did and
10 that's been the department's view, as very clearly
11 stated in its opening. A number of other senior people
12 have believed that they did, but a stark difference
13 would seem to be Mr McKee, who was, at the relevant
14 time, the chief executive of the Royal Trust. His view
15 is that neither he nor the board had that kind of
16 responsibility until the change in legislation in 2003.
17 Firstly, do you --
18 A. I see where he's coming from in the sense that there was
19 no statutory requirement placed on the bodies until the
20 order was made in 2003. But I think, in practice,
21 there's no escaping a responsibility for the quality of
22 the care provided.
23 Q. Well, he actually didn't confine it or didn't express it
24 in terms of just what his statutory responsibility was,
25 which of course changed in 2003, which introduced it.

1 He answered in broader terms than that as to what he
2 believed was an absence of his responsibility or that of
3 the board for the care being provided within the trust
4 and the hospitals in that trust. So that was quite
5 clear. I have taken everybody through the transcript
6 before on that and the chairman has it; it's quite clear
7 that was his view. My question to you is: did you know
8 that he had that view?
9 A. No, I didn't.
10 Q. No?
11 A. No.
12 Q. Do you think you ought to have known that, that somehow
13 that should have come to your attention?
14 A. Yes. Very clearly, yes. These bodies were set up on
15 the basis that they would deliver a safe, good-quality
16 standard of care, and the board of the body had to be
17 responsible for ensuring that that happened. I can't
18 see any other way.
19 THE CHAIRMAN: You have set out about five reasons in your
20 written statement about why he's simply wrong.
21 A. I'm very clear, yes.
22 MS ANYADIKE-DANES: If I ask you one final question on the
23 quality of care and responsibilities for it. We had
24 asked the CMO whether she felt she had any part or role
25 to play in terms of quality of care, and her view was

1 that she didn't, that wasn't something that was within
2 her own role. Did you see it in those terms or did you
3 think she had a part to play in quality of care?
4 A. I think the chief professionals all had a role in
5 quality of care.
6 Q. Yes, but we if leave aside that because, of course,
7 she's a doctor, but if you think in terms of her role as
8 CMO -- I think, in fairness to her, she was talking
9 about her role as CMO. In her role as CMO, did you
10 think that part of her role involved advice on quality
11 of care?
12 A. Yes.
13 Q. Thank you. I would like to ask you one quite brief
14 question to do with audits.
15 As we have been looking at the minutes of the
16 Directors of Public Health meetings, who had meetings
17 with the department, there's reference in there to "area
18 audit committees" or, as they're sometimes called,
19 "regional audit committees". Were you aware of what
20 they were and what role they played in terms of
21 gathering information or checking on information
22 in relation to trusts?
23 A. Was this in the sense of medical audit? I was aware
24 that there was the regional multi-professional audit
25 group, which I think had groups feeding into it from the

1 different regions.
2 Q. It may have been that this was a matter that was of
3 greater significance for Mr Hunter, for example, when
4 he was chief executive and Mr Simpson when he was
5 in that role and even when he was the head of the
6 management group because Mr Hunter certainly regarded it
7 as a management tool and a way of knowing what was
8 happening.
9 The point that I want to put to you is that there
10 seemed to be a concern by the Directors of Public Health
11 that these audit committees were not operating in an
12 entirely satisfactory manner and I was going to ask you
13 whether you were aware of it.
14 If we pull up 320-067-007. This is an extract from
15 the minutes of a meeting of 5 February 1996, so it's
16 just the year before you come into your post. If one
17 sees down at the bottom, this is Dr McConnell noting
18 that:
19 "The regional audit committee had not published
20 reports."
21 And there was a concern that it wasn't possessed of
22 any direction and perhaps needed to be restructured.
23 Then Dr McClements -- who's an official within the
24 department, that's correct, isn't it?
25 A. Yes.

1 Q. He says:
2 "The committee was intended to be the driving force
3 behind audit in Northern Ireland, but probably lacked
4 the infrastructure to accomplish this effectively."
5 If he from the department is making an observation
6 like that, is that something that you would expect to
7 come to your attention as one of those mechanisms that
8 doesn't appear to be working terribly satisfactorily?
9 A. I suppose it depends on how easily it would be fixed --
10 and I don't mean that in any facetious sense. If this
11 was an issue of needing the doctors to lend a bit of
12 support to servicing the committee, well then that would
13 be easily fixed without reference to anyone else. If,
14 however, they needed support in a different way from the
15 department through additional funding or allocating
16 people to it, yes, I would expect it to be brought into
17 the department at a higher level. So I don't really
18 understand what he's getting at there, whether there is
19 a fundamentally significant problem or whether this is
20 just something that needs to be addressed simply and
21 easily.
22 Q. Was it ever brought to your attention that there was any
23 problem with embracing the concepts of audit and any
24 difficulties that the regional audit committees were
25 experiencing?

1 A. No.
2 Q. Was that brought to your attention?
3 A. No, it wasn't.
4 Q. Thank you.
5 I was then going to go on, Mr Chairman, to deal with
6 the notification of SAIs, and that is a bit of
7 a departure. I wonder whether this might be a good
8 time?
9 THE CHAIRMAN: No, let's get started now, and then we'll
10 break at about 1 o'clock. Okay?
11 MS ANYADIKE-DANES: Certainly.
12 Until the guidance came out, there was no
13 requirement for the trust to report a death to the
14 department other than in two particular respects; isn't
15 that correct? The particular respects are to do with
16 defective equipment, if I can loosely call it that, and
17 other incidents occurring in mental and social care
18 homes.
19 A. No formal requirement other than those, no.
20 Q. Leaving aside the development of the overall clinical
21 governance, given that you had two instances where it
22 was thought appropriate to be told not just about
23 deaths, but broader than that, because the adverse
24 incidents and reactions to defective products wasn't
25 just about death, nor was the reporting of adverse

1 incidents relating to people in psychiatric or special
2 care hospitals. That wasn't just about deaths either.
3 A. No.
4 Q. But why was there no discussion about extending any of
5 those mechanisms to cover deaths, or at least deaths in
6 hospital?
7 A. I don't know. Obviously in the period before my time,
8 when I was there ... I suppose I was lulled into
9 a false sense of security by the fact that I was getting
10 reports about serious incidents from some of the
11 chief executives and chairs.
12 Q. Sorry, can I pause you there? Did you, when you were
13 answering that question to the chairman, say how many
14 you had in relation to deaths?
15 A. I had some in relation to deaths. I can't be clear on
16 how many. Maybe two. Two. But these were in the
17 social care field.
18 Q. Over what sort of period?
19 A. Probably over ... Probably the whole time I was there.
20 Q. And did you think that was an accurate reflection of the
21 number of fatal SAIs if you were getting two over that
22 period but from social care homes?
23 A. I certainly didn't expect to be told about deaths
24 generally.
25 Q. No.

1 A. The criterion would be whether these were of
2 a particularly significant nature because of the
3 circumstances.
4 Q. That's the only sort I'm asking you about. Did you
5 think if you only received two reports of deaths, as far
6 as you can recall, in social care homes over the whole
7 period of your time, did you think that meant there were
8 no deaths in hospital relating to serious adverse
9 incidents?
10 A. I suppose it's a case of you don't know what you don't
11 know, but --
12 Q. Did you think that meant that?
13 A. Um ... I assumed that deaths in hospitals would be
14 matters of clinical circumstance, which would be matters
15 directed to the Chief Medical Officer. I was expecting
16 to get notification of issues which were going to have
17 a wider significance that the minister would need to be
18 briefed on or where there was a lot of political concern
19 in the area or the media were raising issues.
20 THE CHAIRMAN: So for instance, if it raised an issue about
21 whether a unit might stay open in Tyrone?
22 A. Yes.
23 THE CHAIRMAN: If there was a death in an A&E in Omagh and
24 that raised an issue about the sustainability of the
25 service, that might be an issue that would come to you

1 because it has repercussions for the minister?
2 A. Yes --
3 THE CHAIRMAN: Or anywhere else. I don't mean to confine it
4 to Tyrone, but I do remember judicial reviews in the
5 1980s and 1990s about Omagh.
6 A. Yes, those would be the sorts of things that would come
7 to me as the Permanent Secretary responsible for
8 briefing the minister and dealing with the policy issues
9 and the strategic issues. Matters of professional
10 judgment would be matters that I would have expected to
11 go to the Chief Medical Officer, Chief Nursing Officer,
12 Chief Pharmaceutical Officer, because they would have an
13 understanding of what the point was that was being made
14 to them.
15 THE CHAIRMAN: Okay. So let's assume that during the
16 10 years that you were Permanent Secretary there were
17 some children or adults who died as a result of some
18 level of medical negligence, would you expect that
19 a death which occurred in those circumstances would come
20 to you --
21 A. I would have --
22 THE CHAIRMAN: -- either directly or through the CMO?
23 A. Yes, either way. My hope would have been that I would
24 have been notified of all of those, but my expectation
25 in practice was that those issues would go to the Chief

1 Medical Officer because they had a medical dimension.
2 THE CHAIRMAN: Right. And then it would be a matter for her
3 discretion as to whether the particular circumstances of
4 an event needed to be referred to you?
5 A. Yes.
6 THE CHAIRMAN: And you then have a discretion about whether
7 you need to raise this with the minister or not?
8 A. Yes.
9 THE CHAIRMAN: Right.
10 MS ANYADIKE-DANES: And to the extent that, as I think you
11 earlier referred to, you were accessible, so
12 a chief executive could pick up the phone and contact
13 you. Alternatively, and the way that you have just
14 answered the chairman, that kind of information could
15 come to the Chief Medical Officer.
16 A. Yes.
17 Q. Did the department issue any guidance around the kind of
18 death that it particularly wanted to know about?
19 A. At that time, no.
20 Q. Given that you wanted to be told about certain sorts of
21 deaths, is there any reason why the department didn't do
22 that?
23 A. Um ... I assumed that the information that was coming
24 to me was actually the totality of the serious incidents
25 that I needed to know about.

1 Q. Sorry, doctor --
2 A. I assumed that the informal system was working
3 effectively because I was being told of serious things.
4 Q. Yes, Mr Gowdy, it's a slightly different question than
5 that. What I mean is: did you expect people to contact
6 you in certain sorts of circumstances?
7 A. Yes.
8 Q. In fact, you've been able to describe to the chairman
9 the sorts of circumstances you would expect to be almost
10 contacted directly --
11 A. Yes.
12 Q. -- and there were certain circumstances in which you
13 would certainly expect the CMO to be contacted.
14 A. Yes.
15 Q. And my question is: given you know what they were, why
16 did the department not release guidance so that
17 everybody would understand that in these circumstances
18 the Permanent Secretary or the department wants to be
19 told and in these circumstances the CMO is to be
20 notified, even though you weren't going to put on
21 a statutory requirement, but just for information
22 purposes so that you could at least have a consistency
23 about when certain sorts of deaths were being reported.
24 Why didn't that happen?
25 A. I'm sorry to repeat the answer again, but my assumption

1 was that there was a clear understanding on the part of
2 all of the chairs and chief executives that I needed to
3 know.
4 Q. And how did they get --
5 A. By -- I was out visiting them every year, I talked to
6 them about the sorts of things that ministers were
7 concerned about, I was getting phone calls from these
8 folk and erroneously, as it appears now, clearly,
9 I wasn't being given the totality of the information.
10 Q. So does that mean, so far as you're concerned, in your
11 various meetings with chief executives and so forth, you
12 had made it clear the circumstances in which you --
13 either the department generally or the CMO -- expected
14 to be notified of a death and that they had either not
15 understood that or failed to comply with what you had
16 communicated?
17 A. No, I never explicitly set out the sorts of things that
18 I wanted them to tell me about. But I made it clear
19 that ministers needed to be informed about serious
20 events, but we never had a discussion with an agenda
21 item: serious incidents, expectations.
22 Q. Even leaving aside the agenda item, did you not consider
23 that that was sufficiently important that it was worth
24 being clear about it so that there would be consistency
25 over people's interpretation of your expectations?

1 A. That understanding emerged as I was developing the risk
2 management approach. It became clear that if you're
3 going to learn lessons, you need to have a formalised
4 system, there needs to be a consistency of approach and
5 consistency of definition.
6 Q. And when roughly do you think that you had that
7 understanding that it would be helpful if your
8 expectations were communicated in a way that people
9 would respond in a consistent manner? When did you have
10 that?
11 A. Probably from around 2000, thereabouts, as we were
12 developing up on the "Best Practice, Best Care" policy.
13 Q. And so from around 2000, when you were engaging with the
14 chief executives, do you think that that sharpened your
15 exchange and it should have been clearer to them from
16 about that time the circumstances in which you wished or
17 the CMO was to be informed about deaths arising out of
18 serious adverse incidents?
19 A. I never had that sort of discussion with them, no.
20 Q. So they wouldn't necessarily know that in a consistent
21 manner?
22 A. No, they wouldn't have known that there was a need for
23 a specific approach, no.
24 THE CHAIRMAN: But from what you said earlier, you might
25 think that if a chief executive or somebody senior in

1 a trust rings you about some violence in A&E on
2 a Saturday night, that they might also ring you if
3 a child has died in their hospital through some sort of
4 medical inadequacy.
5 A. Yes. Me or the Chief Medical Officer, yes. Yes, yes.
6 THE CHAIRMAN: Because in the scale of things, however
7 disgusting violence in A&E is, it's rather less
8 significant than children dying through medical
9 inadequacy.
10 A. Yes, it is, although the particular two incidents that
11 I'm thinking of led to a lot of injury.
12 MS ANYADIKE-DANES: Then in relation to Adam's case, he
13 died, as I'm sure you know, in November 1995, he had his
14 inquest in the summer of 1996 and that attracted some
15 media attention. In fact, David Galloway from the
16 department actually picked up the fact that Adam had
17 died as a result of having seen the media coverage.
18 Does media coverage of that sort get tracked in any way
19 by the department?
20 A. The press office would keep a watchful eye on things
21 in the press.
22 Q. So if you didn't get told about Adam's death through the
23 channel that you would expect, which is directly from
24 the chief executive or by some senior person within the
25 trust, would you have expected that a report of a death

1 like that, which involved comments by the coroner as to
2 how there ought to be further investigations into deaths
3 of this nature and a change in the Royal's practice,
4 would you expect your press office to have picked that
5 up and that should have found its way through to, at
6 least, the Chief Medical Officer?
7 A. It would have been better than nothing, but it certainly
8 wouldn't be the best route for it.
9 Q. No, but would you have expected that to have happened?
10 A. Could I say, first of all, that -- the Adam Strain
11 inquest, I wasn't in the department, so I wouldn't have
12 had any information around that time. I expect that
13 sort of item in the press to be picked up by the press
14 office, yes, and to be circulated to people in the
15 department, yes.
16 Q. And so although it's not the route that
17 a Permanent Secretary would expect to learn of something
18 like that, it is a route?
19 A. Yes. It's not a perfect route because there were wodges
20 of press clippings every day, which you wouldn't
21 necessarily read in great detail.
22 Q. Yes.
23 A. So you really want a system that flags up a problem
24 rather than leaves it for you to find out. But as
25 I say, it's better than nothing.

1 Q. Yes.
2 THE CHAIRMAN: When you say you would expect it to be picked
3 up and circulated to people in the department, would
4 that be something that, accepting that you weren't there
5 at the time, that you would expect to be circulated to
6 the medical side first or would you --
7 A. No.
8 THE CHAIRMAN: -- I mean as in the CMO, or would you expect
9 it to be circulated to somebody at the level of
10 Permanent Secretary?
11 A. We didn't have -- well, I can't speak about that
12 particular time, obviously, but in my time there weren't
13 enough people in the press office to do a specialist
14 selection of press clippings for different folk. What
15 the press office did was to go through all the relevant
16 newspapers and journals and clip out any news reports
17 that they thought significant or worthy of note, and
18 would circulate those in a bundle to senior staff in the
19 department.
20 THE CHAIRMAN: Right.
21 MS ANYADIKE-DANES: Then in terms of the means by which you
22 might learn about these things, how reliable that was --
23 that's a perhaps a better way of putting it -- there's
24 an e-mail from Jonathan Bill, who's the deputy director
25 of the quality and performance unit. He's sending an

1 e-mail to Noel McCann. It's dated 28 May 2004, so
2 you're still in post at that time. We can pull it up.
3 010-025-180.
4 Firstly, it's being written to Mr McCann:
5 "For information because this could become a big
6 issue."
7 THE CHAIRMAN: Just for the record, Noel McCann was?
8 A. An assistant secretary within Paul Simpson's department.
9 THE CHAIRMAN: Thank you. And Mr Bill was?
10 A. One of the staff working to him.
11 THE CHAIRMAN: Okay, thank you. So this is Mr Bill
12 reporting up the line to Noel McCann?
13 A. Yes, it is.
14 MS ANYADIKE-DANES: Thank you. So he's flagging up because
15 he thinks this could become a big issue. The issue is
16 this:
17 "There's been a video conference briefing with the
18 minister."
19 And:
20 "[Jonathan Bill has] been doing some digging around,
21 looking at the numbers of informal notification of
22 incidents."
23 And the reason why that expression was used is
24 because that was the expression given to the
25 notification system before the requirement. It was

1 called an informal system. He says:
2 "Frankly, the picture is not a good one.
3 Notification is patchy, the numbers small and there is
4 no overall analysis. I do think minister is somewhat
5 vulnerable to the accusation that the department is not
6 aware what is going on as regards serious incidents."
7 And then in parentheses:
8 "Secretary --
9 Is that intended to be you, the Permanent Secretary?
10 A. Yes.
11 Q. "Secretary has taken the line that it was usual for
12 CMO/department to be notified and Lucy Crawford was an
13 exception. We have no empirical evidence to support
14 this."
15 Did you know about that e-mail?
16 A. Yes, yes, I did. In fact, I was grateful to
17 Jonathan Bill for giving me that information, that
18 he had been digging, because as I was saying earlier, my
19 expectation, my belief was that these serious issues
20 were being flagged up, either to me or the CMO, and the
21 fact that we hadn't heard about Lucy Crawford's death
22 was actually an aberration, whereas in fact, as Jonathan
23 is pointing out and is now clear, that was not the case.
24 Q. Yes. What I'm wondering is, you had a system which you
25 thought was good enough until you introduced a more

1 formal system.
2 A. I thought that the senior folk within the Health Service
3 bodies had an understanding that serious incidents
4 should be flagged up to the department.
5 Q. Yes. My question to you is --
6 A. Sorry. I thought that that was the case, that we were
7 getting the information. It was then the case that, at
8 around this time, that I had already got to the point
9 where I knew that we needed to have a more formalised
10 system with a proper definition of what the incidents
11 should be.
12 Q. I understand that, and that came in. But can I ask you
13 this, though -- the question that I wanted to ask you
14 is: in the same way as in terms of what was going on
15 in the hospitals and trusts you had them subjected to
16 analysis, so the consultants did analysis in 1998,
17 Deloittes, another firm of consultants, did an analysis
18 in 2003 and in 2004, and others I'm sure -- I have only
19 looked at the ones that bear on the subject matter of
20 this inquiry. So you were subjecting processes to
21 analysis to see how rigorous they were and what changes
22 needed to be introduced. My question to you is: did it
23 not occur to you, before this happened and Jonathan Bill
24 went off doing it of his own volition, that there ought
25 to be some analysis of how reliable it is that you

1 simply await for the chief executives to either contact
2 you or contact the CMO in relation to these fatal SAIs?
3 Did it occur to you: I should get that, just an audit,
4 from time to time to see how we're doing?
5 A. No, no, because until the Lucy Crawford case came up and
6 it was clear that we hadn't been informed, there were no
7 other examples where something came up subsequently
8 where we were able to say, "Didn't know anything about
9 that". I believed that we were getting information,
10 that I was getting it, that the Chief Medical Officer
11 was getting it, that perhaps the -- well, certainly the
12 Chief Pharmaceutical Officer was getting it in terms of
13 medication issues. It was only when the Lucy Crawford
14 case came up that it was crystal clear that the informal
15 arrangement wasn't working.
16 The Raychel Ferguson case was notified without
17 having a formal system. So you can see that there
18 wasn't a glaring gap because of evidence that it was
19 failing. We were getting information.
20 THE CHAIRMAN: So the fact that you came to know of
21 Raychel's death would actually suggest to you that the
22 system was working or what you thought was the system?
23 A. That there wasn't a gross failure, that there wasn't
24 a great gap there.
25 THE CHAIRMAN: And then what happens is you find out about

1 Lucy's death and there's a realisation, actually this
2 isn't working?
3 A. Mm. I learned about it --
4 THE CHAIRMAN: This may not be working, Jonathan Bill goes
5 off and does some work and says: look, this is patchy --
6 A. That's right.
7 THE CHAIRMAN: -- and you have to put in something better.
8 And then it emerges that you didn't know about Adam.
9 A. Yes.
10 THE CHAIRMAN: And it emerges that, however many people knew
11 about Adam, even fewer people knew about Claire.
12 A. Yes. The point for me was -- I realised that we needed
13 to have a more formalised system for reporting serious
14 incidents. That was clear as we were doing the work on
15 risk management and clinical and social care governance.
16 The reason that there wasn't an advance on that specific
17 issue was that it didn't appear that there was a yawning
18 gap that needed to be addressed immediately. The belief
19 was that we were getting the information that we needed
20 to have and there were no examples, until Lucy Crawford,
21 to disprove that.
22 THE CHAIRMAN: The trouble about that is that you only know
23 of an example when --
24 A. Exactly.
25 THE CHAIRMAN: -- if I put it this way, it comes to bite

1 you.
2 A. Yes, and you don't know what you don't know, so you need
3 to have a system to find out.
4 THE CHAIRMAN: Okay.
5 MR QUINN: Mr Chairman, could I come in with one point
6 there? There are two issues arising here from the
7 families' point of view. Does that mean that the
8 witness is saying that in his career, when he was in
9 office for eight years, that this witness only became
10 aware of two adverse incidents? That seems to be his
11 evidence so far. And if there were only two adverse
12 incidents that were brought to his notice, why on earth
13 did they have a report on clinical negligence? What was
14 that for? Because when one commissions a report on
15 clinical negligence, one immediately imagines that there
16 has to be some sort of negligence going on in the system
17 whereby people might be dying or there might be close
18 calls.
19 THE CHAIRMAN: Is that not about the amount of money being
20 paid out of the system?
21 MR QUINN: Yes, it was, but there surely --
22 THE CHAIRMAN: That's about the frequency of -- the incident
23 was highlighted before, I think, about the unreliable
24 system of reporting. I think it was the under-reporting
25 of incidents.

1 MR QUINN: Exactly.
2 MS ANYADIKE-DANES: Thank you, Mr Chairman. That was
3 actually what I was going to bring out.
4 Mr Gowdy, when you say that you thought you had an
5 informal system that was working, but you can't have
6 thought it really was working because you had had the
7 consultants' report in 1999 refer to under-reporting.
8 So that must mean that they're telling you that there
9 are cases out there that are not coming to you and, if
10 they're not coming to you, there's not a system that's
11 working. Did that not occur to you when you wrote that?
12 A. What you're dealing with here are the clinical problems
13 around the deaths of children. Now, serious incidents
14 go wider than that and can cover all sorts of other
15 circumstances.
16 Q. Yes, but --
17 A. I'm accepting that the system that we had was not fit
18 for purpose --
19 Q. Thank you.
20 A. -- and that it needed to be addressed, yes. What I'm
21 saying --
22 THE CHAIRMAN: My only quibble on that, Mr Gowdy, is whether
23 it was in fact a system.
24 A. No, it would be incorrect to describe it as a system.
25 THE CHAIRMAN: It's a bit flattering to it to describe it as

1 a system, isn't it?
2 A. Yes. It wasn't even an arrangement, actually.
3 MS ANYADIKE-DANES: And you knew that before Jonathan Bill's
4 e-mail in May 2004?
5 A. Yes.
6 Q. You knew that, whatever it was you had, it was not fit
7 for purpose. So you can't really say, "I thought it
8 might have been fit for purpose because I'd actually
9 received two reports to do with something happening in
10 social care homes". You knew it wasn't fit for purpose.
11 A. I haven't said I'd only had two. I was getting quite
12 a few reports.
13 Q. Deaths --
14 A. I was quoting examples for the benefit of the chairman.
15 Q. Yes, but what I'm saying is you knew, whatever it was
16 you had for letting the department know about deaths in
17 hospital, you knew that that was not fit for purpose and
18 you knew that before May 2004.
19 A. Yes, I knew that that was not the system that we needed
20 to have. What I was trying to get across to the
21 chairman was that there were reports coming to me and,
22 as I understand it, to the Chief Medical Officer about
23 serious reports. It was not just two cases. I had
24 quite a few over the years that I was there and I was
25 just simply quoting examples of the sorts of things that

1 people were bringing to my attention.
2 Q. If you know about under-reporting in 1999 and you've
3 concluded at some point that what you have is not fit
4 for purpose, there has to therefore be a risk that there
5 are people dying in hospital in circumstances that you
6 should know about that you don't know about.
7 A. Well, I don't want to sound defensive on this because
8 I'm accepting that there is a need for us to have --
9 there was, at that stage, a need for us to put in place
10 a system. The point that I was trying to get across
11 was, yes, I knew that this wasn't fit for purpose, that
12 we needed something better, but alongside that I was
13 actually getting through the arrangement information
14 about serious incidents. And there were no examples
15 that I can think of, until we get to Lucy Crawford, of
16 where something subsequently appeared which I hadn't
17 been told about. So as far as I was concerned, the
18 arrangement that we had was addressing the need pro tem
19 and that the development of a serious incident reporting
20 system would be embraced within the wider risk
21 management policy that we were developing.
22 THE CHAIRMAN: Okay.
23 MS ANYADIKE-DANES: Finally, can I ask you, Jonathan Bill
24 specifically says in that bit of parentheses which
25 directly relates to you -- he takes your statement and

1 then he says:
2 "We have no empirical evidence to support this".
3 Is there a reason why you had taken a line for which
4 there was no empirical evidence?
5 A. I would repeat again what I've just said.
6 THE CHAIRMAN: It was your experience?
7 A. The experience I had was that I was getting reports from
8 people, nothing subsequently was jumping out of the
9 woodwork to suggest that there was a failure to report
10 things to me or to the department in general until we
11 got to the Lucy Crawford case. When we had that
12 meeting, that was what I was saying, and I was very
13 grateful to Jonathan Bill, who's one of my staff, a very
14 able chap, who then had a look subsequently, and he put
15 this very helpful piece that there wasn't any empirical
16 evidence, which lent further weight to the view that I'd
17 already formed that we needed to have a more effective
18 system.
19 MS ANYADIKE-DANES: Thank you.
20 THE CHAIRMAN: We'll take a break now and resume at 2.15,
21 Mr Gowdy. Thank you very much.
22 (1.20 pm)
23 (The Short Adjournment)
24 (2.15 pm)
25 (Delay in proceedings)

1 (2.21 pm)
2 MS ANYADIKE-DANES: Just finishing off from where we were
3 before the lunch break. The interim guidance comes in
4 in July 2004; that's correct, isn't it?
5 A. Yes, that's right.
6 Q. And then you actually retire in -- I think
7 it's July 2005.
8 A. That's right, yes.
9 Q. When that interim guidance came in, did that mean that
10 this non-system that you had of reporting deaths to the
11 department was replaced by a system, a formal system?
12 A. Yes, in the sense that there were definitions and
13 requirements placed on the various bodies, yes.
14 Q. And would that mean for that final year of your tenure
15 that there was a system of formal reporting to the
16 department?
17 A. Yes.
18 Q. And you were aware that that had started and it was
19 working -- I'm not necessarily asking you how
20 successfully, but it was in operation?
21 A. Yes.
22 Q. And were you aware of that because you had been informed
23 that that was happening or it came to you in some other
24 way?
25 A. I don't recall, I'm afraid. I don't remember anyone

1 actually saying anything about this to me.
2 Q. Then if I help you: are you sure that you're aware it
3 was in operation before you left?
4 A. I think I'd have to say no to that. I know that the
5 circular went out, I know that from discussions with
6 Noel McCann that various bodies had received it and were
7 aware of what the expectations were.
8 Q. So it was intended to be in operation?
9 A. Yes.
10 Q. But you can't say personally that you are aware that it
11 was?
12 A. Personally, I can't.
13 Q. If there'd been difficulties, as there probably are when
14 you institute a new system, would you expect those to be
15 brought to you?
16 A. Oh, yes.
17 Q. Thank you. I want now to move to something completely
18 different, really, which is the 2002 hyponatraemia
19 guidelines. Were you aware that the CMO was developing
20 or was having developed hyponatraemia guidelines for
21 children?
22 A. No.
23 Q. The CMO's evidence is that it was actually quite unusual
24 for her to be personally involved in the development of
25 guidelines. That was something that would be done, for

1 example, by CREST, which had been established as far
2 back in 1988 with that as a remit. So if it's an
3 unusual thing and it had been prompted by a death that
4 was reported in the non-system, then is that not
5 something you would have expected to know about?
6 A. Not necessarily. I would have regarded that as a matter
7 of clinical guidance that didn't require me to make any
8 input to it.
9 Q. I understand.
10 A. Nor would I have expected the minister needed to be
11 advised of it.
12 Q. Yes.
13 A. I think it was -- it was in the nature of technical
14 guidance out to the profession and the system.
15 Q. But you did know about Raychel's death?
16 A. I knew about Raychel's death after I learned of
17 Lucy Crawford's death.
18 Q. Ah, so you didn't know about Raychel's death at the
19 time?
20 A. I didn't, no.
21 Q. Would you have expected to know about her death at that
22 time?
23 A. Um ... As long as the department had been informed, and
24 particularly as long as the Chief Medical Officer was
25 informed and was taking action to deal with whatever the

1 implications were, I wouldn't necessarily have needed to
2 know. I would have needed --
3 THE CHAIRMAN: Sorry, Mr Gowdy, I have obviously
4 misunderstood you. I thought that before lunch you were
5 describing to me that learning about Raychel's death was
6 an example of the system working.
7 A. Mm-hm.
8 THE CHAIRMAN: I now understand from you that you didn't
9 know about Raychel's death in 2001.
10 A. No, I didn't know of it in 2001.
11 THE CHAIRMAN: So even that isn't an example of any system
12 working?
13 A. Well, in the sense that it was an unusual -- well, yes,
14 it was reported to me after the inquest rather than
15 at the time of death, but that is true.
16 THE CHAIRMAN: Right. So it was reported to you after the
17 inquest, it is not reported to you when Raychel dies in
18 2001, despite the fact that she is an otherwise healthy
19 girl who has her appendix removed and the operation goes
20 smoothly, but she then dies in Altnagelvin. Nobody
21 thinks that's worthy of reporting to you?
22 A. Mm-hm.
23 THE CHAIRMAN: Well, it seems to me to be another example of
24 the process failing.
25 A. Yes, I think any example where we weren't being told of

1 something significant is a failure of the system, yes.
2 MS ANYADIKE-DANES: It's not really "we" not being told
3 because the CMO learned about it; it's you not being
4 told.
5 THE CHAIRMAN: The CMO did know about it. This is a curious
6 point then because the CMO did know about it and the CMO
7 regarded it as sufficiently serious to set up a working
8 party, which introduces guidelines, which put us ahead
9 of the rest of the UK.
10 A. Mm-hm.
11 THE CHAIRMAN: All of that is important, all of that is
12 positive and all of that stands to the credit of the CMO
13 and various other people.
14 A. Mm-hm.
15 THE CHAIRMAN: But this series of events doesn't make its
16 way to you until after Raychel's inquest; is that not
17 curious?
18 A. From my perspective, the important thing was that action
19 was taken on an issue which needed to be addressed
20 quickly. She did that. It was in the nature of
21 a clinical issue on which I would have had no input.
22 Therefore, I would have been quite content that she was
23 taking appropriate action and I didn't need to be
24 informed.
25 THE CHAIRMAN: I thought we'd been discussing late this

1 morning, before lunch, on the basis that the department
2 would have expected to have known about the deaths of
3 each of the children in the inquiry. Let's tidy that up
4 a bit because what I now understand you to be saying
5 is -- because I misunderstood you earlier -- is that the
6 department knew about Raychel's death, which was
7 appropriate, but it was "the department" in the sense of
8 the CMO knew about Raychel's death and that was
9 appropriate. But you're indicating that to you it's
10 acceptable that the news of Raychel's death and the
11 action which that death triggered did not come to you?
12 A. Yes.
13 THE CHAIRMAN: And in turn, that meant that it didn't reach
14 the minister.
15 A. Yes.
16 THE CHAIRMAN: So the CMO's exercise of her discretion that
17 something has gone badly wrong, I'll set up a working
18 party, we'll introduce guidelines and that a child has
19 died in Altnagelvin, all of those are issues which don't
20 need to come to you?
21 A. As long as action is taken which is appropriate.
22 THE CHAIRMAN: Then which of the earlier deaths should have
23 gone to you? Because if Raychel's death doesn't come to
24 you and Raychel's death prompts Northern Ireland
25 guidelines, why would you expect to know about Adam's

1 death or why would you expect to know about Claire's
2 death?
3 A. The point, I think, is -- maybe I've expressed it
4 incorrectly -- the department needed to be told of these
5 unusual incidents and usually that needs to be at
6 a sufficiently senior level for it to lead to
7 appropriate action. The CMO is the person who has the
8 expertise on the clinical dimension. If it's an issue
9 which refers to clinical medical practice then I would
10 expect the CMO to deal with it. If she felt that it
11 needed to be raised to my level for some reason, that
12 would be obviously, for her, a decision to make.
13 THE CHAIRMAN: Sorry, did you and I not have an exchange
14 this morning where you indicated that you had made
15 yourself sufficiently available to senior people in the
16 Health Service, including in the trust, that they would
17 ring you if there were incidents in A&E or if there were
18 other incidents of concern?
19 A. Mm-hm.
20 THE CHAIRMAN: I thought that you had also indicated that if
21 they were ringing about those incidents, you're
22 disappointed that they wouldn't equally ring you about
23 the avoidable deaths of children. But now you're
24 saying, in terms of Raychel, that you're not really
25 disappointed about not being told about Raychel's death

1 because the CMO was told?
2 A. What I'm saying is that there will be a causal set of
3 factors involved in any case, which will have
4 ramifications that need to be addressed. In some of
5 the -- in the sorts of things that I was being told
6 about, the minister needed to know because of the
7 likelihood of questions being raised or a firestorm of
8 media interest or whatever, or --
9 THE CHAIRMAN: I'm sorry, Mr Gowdy, a firestorm of media
10 interest is far less important, it seems to me, than the
11 fact that a young boy or girl has died. I understand
12 that the minister expects you to prevent him being
13 doorstepped about something that he hasn't heard about
14 and I don't underestimate that; that's a perfectly
15 legitimate basis upon which to bring information to the
16 minister. But is it not at least as relevant a basis to
17 go to the minister by saying: whether you're asked about
18 this or not, I have to tell you, minister, that I'm
19 receiving reports, which we'll have to look into, that
20 a child has died in Altnagelvin or a child has died
21 in the Royal or a child has died in the Erne in
22 circumstances which look very unhappy for our service?
23 A. Well, I would certainly expect to tell the minister if
24 it looked as though the system had a systemic problem
25 around the clinical cause of the death, which certainly

1 became apparent once a number of cases came up. But the
2 first case was the one that excited the medical
3 profession's interest because of the way the treatment
4 regime had worked, and the CMO was the one who
5 understood those issues, who was able to make the input
6 on it. I wouldn't have expected it necessarily to come
7 to me.
8 My point would be that the department needs to be
9 told. If chief executives or chairmen had decided that
10 those cases needed to be brought to me, I would
11 certainly have been talking to the Chief Medical Officer
12 about them. Once it became apparent that there was more
13 than just one issue or one case, it became apparent that
14 we needed to take the minister in and acquaint him -- or
15 her, was it, at that time?
16 THE CHAIRMAN: Well, does that analysis apply to the deaths
17 of Adam and Claire and Lucy and Raychel, or --
18 A. You mean separately in each individual case?
19 THE CHAIRMAN: Separately, yes.
20 I gathered that from your witness statement in
21 Lucy's case you had a concern when it came to you that
22 the schism, if I can call it that, in Sperrin Lakeland
23 raised concerns about what was going on in
24 Sperrin Lakeland, which raises a question mark about the
25 paediatric service generally.

1 A. Yes, there would have been concerns that in a trust with
2 only a few people within that specialty, if one was not
3 demonstrating the level of competence required or there
4 were issues of practice, that'd be something that would
5 need to be addressed.
6 THE CHAIRMAN: Right. So that raises another issue, which
7 you don't quite see for the other children?
8 A. Um, the issues in Sperrin Lakeland were rather wider
9 than simply that case. I have no reason to believe that
10 there were the same sorts of issues in the other trusts.
11 THE CHAIRMAN: Okay, thank you.
12 A. I'm talking about organisational and administrative
13 issues, not clinical ones, when I say that.
14 THE CHAIRMAN: It gets into a rather unhappy debate about
15 what the lessons are and what the organisational lessons
16 are from any of these incidents. Let's move on,
17 thank you.
18 A. Can I just add to it? I mean, there is -- whenever you
19 have cases of this sort coming up, what you're asking
20 yourself is: what needs to be done? And as far as I'm
21 concerned, yes, it would have been the right thing for
22 me to have been told. But it wasn't necessarily the
23 thing that was going to solve the case, that was going
24 to see the appropriate action taken. That really was
25 something that would have to be passed to the Chief

1 Medical Officer because of the clinical issues. I had
2 no idea what hyponatraemia was when it first came up.
3 For me, the important thing was to make sure that the
4 information came into the department and went to the
5 right place so that action was being taken.
6 THE CHAIRMAN: Okay. Just to tidy it up, when you did find
7 out about Raychel's case after her inquest, can you
8 remember why Raychel was then drawn to your attention at
9 that point?
10 A. Because the Lucy Crawford case had already been
11 mentioned to me and this had then come in -- this came
12 to me subsequently as another example of the same sort
13 of medical problem.
14 THE CHAIRMAN: I want you to think very carefully about
15 that, that you were aware of Lucy's death before
16 Raychel's inquest, because that's not the information
17 I have.
18 A. I was told of Lucy Crawford's death in February 2004 and
19 I was told about Raychel Ferguson subsequent to that.
20 THE CHAIRMAN: Right. But by February 2004 Raychel's
21 inquest was over; isn't that right?
22 MS ANYADIKE-DANES: Yes.
23 THE CHAIRMAN: So what you learnt about Raychel and her
24 inquest didn't just -- you know the sequence here. It
25 was because of Raychel's inquest that Lucy's case came

1 to light in a broader way.
2 A. Mm-hm.
3 THE CHAIRMAN: So you learned about Lucy's case emerging
4 after Raychel's inquest, which was actually the trigger
5 for Lucy's case emerging?
6 A. Mm-hm, yes.
7 THE CHAIRMAN: Okay.
8 A. That's exactly right.
9 MS ANYADIKE-DANES: I think there may be a query in relation
10 to that, but I'll wait to see how it develops. We'll
11 move on from that.
12 Where I was with you was in relation to the
13 guidelines. If I just put it in context for you, what
14 prompted those guidelines was not just because
15 Lucy Crawford had died or died in the way that she had
16 died, but some other things that were happening at the
17 time, information that was provided to the CMO. The
18 first was that there was a concern that other children
19 being treated in district hospitals could be at risk
20 because there might not be as great an awareness as one
21 would like of the dangers of that particular therapy,
22 which was a very common one for use with children. And
23 in fact, when we had some of the consultant
24 anaesthetists and intensivists giving evidence earlier,
25 they knew of the fact that there was sometimes a failure

1 in understanding and that there were fluid management
2 issues and they dealt with those by speaking to the
3 treating clinicians at the time. But they were aware of
4 that, so when Lucy Crawford's case came to light, it
5 came in the context of a problem that some of these
6 clinicians were already aware of. So that was one
7 issue.
8 The other issue was, it would appear -- at least
9 certainly the CMO had this information -- that the
10 Children's Hospital had actually changed its fluid
11 management regime and apparently no longer used that
12 particular IV fluid that was in such common usage in the
13 district hospitals, and it had done that, so it was
14 thought, because of concerns about the risks associated
15 with it.
16 So there are a number of things that would take it
17 into that regional dimension that gave rise to the CMO's
18 decision to move by formulating some guidelines to be
19 applied throughout the region. Some of those things
20 I've said to you are matters that are of the kind of
21 significance, surely, that you may want to know about.
22 Not how the problem is going to be resolved, but that
23 there is a problem like that.
24 A. I would have preferred to have known, yes.
25 Q. Yes. So if the relationship is working in the way that

1 you would like it to work so that you're alerted to
2 possible difficulties, then Raychel's death and the way
3 that the issues coming out of it were going to be
4 addressed are the sort of thing that you'd have wanted
5 to be alerted to?
6 A. It would have been helpful to have been told.
7 Q. So in any event, the CMO goes about having a working
8 group established to formulate those guidelines and to
9 issue them and, on your evidence to the chairman,
10 you were out of the loop, as it were, in relation to
11 that and you didn't know that was going on.
12 A. No, I didn't.
13 Q. They are finally issued in March of 2002. She sends out
14 a letter or a letter is sent out that goes to all the
15 trusts and with it is a requirement that they would
16 audit the compliance with that and also local protocols
17 that were to be developed.
18 The fact that there's going to be lot protocols and
19 so forth is maybe a level of detail that you wouldn't
20 expect to know about, but is the fact that she has
21 required an audit to be carried out, which is something
22 that in due course can be measured, is that something
23 that you would want to know about?
24 A. Given the way all of this has developed, it certainly
25 would have been helpful to know.

1 Q. And if she had required an audit to be instituted by
2 those trusts, I presume you would have expected that to
3 happen, and if there were any difficulties about it
4 happening in the same way as you said you'd expect to
5 know about difficulties about other things, you'd expect
6 to know about a difficulty about that?
7 A. Yes, I would.
8 THE CHAIRMAN: Presumably, depending on the extent of the
9 difficulty?
10 A. Yes.
11 THE CHAIRMAN: Your job would be completely undoable if
12 every difficulty came to your attention.
13 A. Yes.
14 THE CHAIRMAN: But you will be concerned about any
15 significant failing --
16 A. Yes.
17 THE CHAIRMAN: -- which emerges in the introduction of an
18 improved service?
19 A. Yes.
20 MS ANYADIKE-DANES: If there's a requirement to institute
21 audit arrangements or an audit mechanism, do you expect
22 the CMO or whomsoever has issued that letter or circular
23 to require confirmation that that's happening in the way
24 that, for example, Mr Hunter required confirmation that
25 the change in practice around consents was to be

1 received? Is that fairly standard or not?
2 A. Well, it's a judgment call in each particular instance.
3 In this instance, I would have expected that, yes, there
4 would be. This was so important that we'd want to be
5 sure that what had been asked to happen did happen.
6 Q. And presumably, maybe not at your level, but at
7 somebody's level an opportunity to satisfy themselves
8 that those monitoring or auditing arrangements were
9 appropriate?
10 A. Yes.
11 Q. In fact, as I'm sure you know by now, that didn't
12 happen. There wasn't a requirement for that
13 confirmation as the letter went out with the poster for
14 enshrining the guidance. It wasn't until 2004 that the
15 CMO actually sought confirmation that the implementation
16 of the guidance was being monitored. Does that surprise
17 you that it took two years for that to go out?
18 A. Well, I mean, I can see from the CMO's point of view,
19 she's dealing with intelligent people who are adult, who
20 have an understanding of the importance of what's going
21 on. I'm sure she would have expected that something
22 coming from the CMO that had had such a wide input from
23 the system would be implemented. But I think it's
24 similar to the adverse incident reporting issue. It's
25 really important to copper fasten it and I would have

1 expected that it would have been followed up and
2 followed up fairly quickly.
3 Q. Not least because you'd have wanted to satisfy yourself
4 that everybody is monitoring and assessing it in an
5 appropriate way. There are different ways, I presume,
6 of monitoring implementation and you'd want to be sure
7 that you were getting the appropriate feedback as to the
8 implementation of that new policy?
9 A. Yes, and also because this had arisen because of the
10 deaths of children and you'd want to be sure that action
11 was being taken quickly to try and prevent further
12 incidences of that happening.
13 Q. When did you first know that guidelines had been issued?
14 A. It was at the time that I learnt of Lucy Crawford.
15 Q. Which would have been 2004?
16 A. February 2004 when I -- when that case came up, it was
17 raised by the Deputy Chief Medical Officer at the
18 departmental board because the Chief Medical Officer was
19 away and I was keen that we needed to take action and
20 I wanted to check what action had been taken on the
21 medical front and I also wanted the trusts to be pursued
22 because we hadn't been told. That then subsequently was
23 addressed in the 2004 guidelines, and I was told by
24 Don Hill, who's the deputy secretary on that side of the
25 house, that a notification letter was being sent out.

1 It's recorded in the note of the February 2004
2 departmental board.
3 So I had then followed up by talking to Ian Carson
4 after the meeting to find out what hyponatraemia was all
5 about. I then, probably within a week had -- the CMO
6 was back then, I had a chat to her and some of her staff
7 to find out more about what was going on and I learned
8 about the guidelines. I saw the guidelines at that
9 stage.
10 Q. You saw them. Well, did you ask -- those guidelines
11 went out in March 2002: given how the matter has now
12 come to me, so I see its significance and importance,
13 what do you know about the level of compliance with
14 those guidelines? Did you seek to have that
15 information?
16 A. No, no, I didn't.
17 Q. Would that not have been an appropriate thing to do?
18 A. Well, I had been talking to the Chief Medical Officer
19 and her staff about what had happened and I was
20 satisfied --
21 Q. She didn't know the level of compliance with them
22 either. That's why I'm asking.
23 A. No, I didn't ask that question.
24 THE CHAIRMAN: When you learned about Lucy's death, would
25 you have taken some comfort from the fact that the

1 department was already ahead in the sense that it had
2 drawn up and issued guidelines?
3 A. Yes.
4 THE CHAIRMAN: Because had that not been done, that might
5 have been something which you would have --
6 A. Yes.
7 THE CHAIRMAN: -- activated at that point?
8 A. Yes.
9 THE CHAIRMAN: So you're aware that guidelines have been
10 issued. You didn't know whether they had been
11 implemented, but on the basis that you're dealing with
12 adult, responsible people, you would assume that the
13 guidelines had been implemented; is that right?
14 A. Yes, on the basis that I understood from the CMO, that
15 there had been representatives of many of the trusts on
16 that working group and that the messages had already
17 gone out round the system and that what she was doing
18 was reinforcing that. So I had no reason to believe
19 that it hadn't been implemented. I took it on the basis
20 of the assurance I got from her that this had gone out.
21 THE CHAIRMAN: Okay. As it turns out, as governance
22 develops, you end up, I think, relying less on
23 assumptions and asking for confirmation; that's one of
24 the developments of governance, isn't it?
25 A. That's a clear message emerging.

1 THE CHAIRMAN: Yes.
2 MS ANYADIKE-DANES: When you heard about the guidelines and
3 began to understand what the problem was that they were
4 seeking to address, did you want to know what had been
5 done about education in relation to it? Yes, one
6 formulates guidelines and they go into the trusts, but
7 there was an issue about ensuring that new doctors being
8 trained understand the implications of fluid management.
9 Did you ask whether the postgraduate dean or anybody on
10 the education and training side had been kept in the
11 loop in terms of the guidelines?
12 A. No, I didn't, no. That was largely on the basis that,
13 as I understood it, there was -- what had been produced
14 was a large poster.
15 Q. Yes.
16 A. That would be placed within the relevant spots in
17 hospitals so that the staff would be reminded of the
18 concerns over hyponatraemia. I didn't see it as
19 an issue for training as such.
20 Q. Well, in fact, the CMO writes to Professor McCluggage,
21 who's at the Northern Ireland Council for Postgraduate
22 Medical and Dental Education in July 2004. We can see
23 it at 075-007-017. So this is now July 2004, shortly
24 after when you first became aware of Lucy's death and
25 the guidelines. And at this stage, you know about Lucy,

1 you know about Raychel. Do you know about Adam at this
2 stage?
3 A. I don't think so. July 2004 ... I don't think so.
4 Q. Okay. She refers to:
5 "A number of recent coroner's inquests highlighted
6 the need for better training in fluid administration and
7 management, particularly in children."
8 She says:
9 "As part of a strategy to address this problem,
10 I would be pleased if you would ask the training
11 committees to consider it as a priority area."
12 And she refers to the guidelines that have been
13 developed and she says:
14 "It is essential that doctors in training
15 participate in such audits."
16 Which was, of course, the audit that she wants to
17 have confirmation in 2004 of having been carried out.
18 A. Mm-hm.
19 Q. So she's seeing the broader implications of this. And
20 is any of that discussed with you?
21 A. No, no.
22 THE CHAIRMAN: But that's positive by the CMO again, isn't
23 it?
24 A. Yes.
25 THE CHAIRMAN: In this rather patchy picture, that's again

1 an important and positive step for the CMO to have
2 taken.
3 A. Yes. And it is the sort of thing that I would have
4 expected the CMO to be doing.
5 THE CHAIRMAN: Yes.
6 MS ANYADIKE-DANES: But you might want to know about
7 something like that because if this comes to the ear of
8 the minister, probably the minister is going to ask you,
9 "What's been going on?", and this enables you to say,
10 "Well, we've had guidelines out, they're being audited,
11 we've alerted this one in relation to education,
12 training and so forth". What is happening is that you
13 don't have a full picture, apparently, of what's going
14 on at this stage.
15 A. I wasn't aware of that letter going out, but I was
16 satisfied that the main planks of an approach to deal
17 with hyponatraemia were in place.
18 Q. Conor Mitchell died in 2003. When did you know about
19 his death?
20 A. I think it was around October 2004. I think the
21 sequence in which I knew of the deaths would have been
22 Lucy Crawford, followed reasonably quickly by
23 Raychel Ferguson, followed several months later by
24 Conor Mitchell and then Adam Strain at the later stages.
25 I think that's the sequence in which I heard. And then

1 Claire Roberts, I think, I learned of after I'd retired.
2 Q. By 2004, when you first became aware that there had been
3 deaths in relation to hyponatraemia, would you not have
4 wanted to hear about all the deaths that occurred?
5 A. Yes. Yes.
6 Q. You heard about one, which led you to believe that there
7 had been more than one because you say you heard about
8 Lucy and Raychel in fairly close proximity to each
9 other. So now you have two and you know you're not
10 hearing them contemporaneously so you're hearing them
11 after the event. Did you not ask "What is the incidence
12 of hyponatraemia in Northern Ireland"?
13 A. Yes, and I was told it was a fairly rare event.
14 THE CHAIRMAN: But how could anybody tell you that? One of
15 my concerns, Mr Gowdy, is that -- I'm sorry if this is
16 repetition for everyone who's here. Adam's death came
17 through the system in the normal way in the sense of
18 death certificate and inquest, so did Raychel's. But
19 Lucy's didn't and Claire's didn't. Lucy's is picked up
20 by a particularly alert Stanley Millar in the
21 Western Council. Claire's death is picked up by her
22 alert parents watching television. And to be told --
23 I'm sure it is a fact that hyponatraemia deaths are
24 rare, but if two out of the four deaths that I'm
25 interested in were missed, what reassurance is there to

1 be told that they're rare? I don't know and you don't
2 know if there's a fifth death out there. I don't
3 suppose there's a rash of deaths that we're not aware of
4 and it may be that there's no other deaths that we're
5 aware of, but I don't know how I could be assured that
6 there are no other deaths.
7 A. I was relying on information that I was getting from the
8 medical experts.
9 THE CHAIRMAN: And the medical experts, in turn, are not
10 able to base that information on any review of what has
11 been going on over the previous number of years.
12 A. I can't speak for them. I don't know how much they
13 knew.
14 THE CHAIRMAN: If anybody did review what had gone on over
15 the previous number of years, they haven't come to the
16 inquiry to tell us about it. Okay.
17 MS ANYADIKE-DANES: In your first witness statement for
18 us -- if we can pull up WS062/1 at page 2. Perhaps if
19 we can just increase the size of (ii):
20 "With whom did you discuss their deaths?"
21 So there we have a summary of what you've been
22 telling the chairman: you first became aware of Adam's
23 death in October 2004, Lucy in February 2004, Raychel
24 you're not sure, but shortly after Lucy. Okay?
25 A. Yes.

1 Q. And then you're asked:
2 "With whom did you discuss their deaths, when and
3 for what purpose?"
4 And you say:
5 "I discussed the circumstances of the deaths with
6 colleagues in the department, particularly the Chief
7 Medical Officer ... in the aftermath of the
8 Lucy Crawford inquest and in the light of the media
9 comments over subsequent months."
10 That's what you were doing:
11 "My purpose was to find out more about the
12 circumstances of the deaths, to learn more about
13 hyponatraemia --"
14 And here's the one I'm going to ask you about:
15 "-- and to review the action which had been or which
16 needed to be taken on foot of these deaths."
17 What was involved in that review and who was part of
18 it?
19 A. That's simply an expression for -- I spoke to the CMO
20 and her staff to ask them to let me know what had
21 happened, what action they had taken or what they
22 proposed to do on foot of the deaths. It wasn't
23 a formal review.
24 Q. It wasn't a formal review? But in terms of what needed
25 to be done on foot of these deaths, so they would have

1 told you they'd instituted the guidelines in 2002. What
2 was the discussion around what more should be being
3 done?
4 A. Well, the assurance I was getting was that the issue had
5 been addressed by the work that the group that the CMO
6 had put together had done and the issue of the
7 guidelines that had been made to the HPSS at large.
8 Q. Did you know that a review of the extent of
9 implementation and compliance with the guidelines had
10 been carried out by Dr McAloon at the Antrim Hospital?
11 A. No.
12 Q. And were you told that the results of that were to show
13 that there wasn't actually full compliance with the
14 guidelines? In fact, it was a little concerning and
15 that therefore more work needed to be done, perhaps even
16 to revise the guidelines; did you know that?
17 A. No.
18 Q. But how can you begin to decide what action is to be
19 taken if you don't know some of the difficulties that
20 are arising in relation to the action that has already
21 been taken?
22 A. Well, you don't know what you don't know. There was no
23 basis for me to ask any further questions on it given
24 the reassurance I was getting that the problem had been
25 identified, recognised and addressed by way of guidance

1 out to those who would be dealing with future cases.
2 Q. And if you --
3 A. To me, that was the key consideration: that we needed to
4 be sure that, having recognised that there was
5 a problem -- a very serious problem given that
6 children's deaths were involved -- that action was being
7 taken.
8 Q. But if you're having this discussion in 2004, which is
9 after Conor's death -- and I believe after Conor's
10 inquest, one of the issues concerning Conor's treatment
11 is not that he died of hyponatraemia, but there were
12 some really serious concerns about his fluid management,
13 which, even on the face of it, didn't appear to be
14 entirely in accord with the guidelines.
15 A. I didn't know of Conor's death at the time I had the
16 discussion. I'd only just learnt of Lucy's and
17 Raychel's.
18 Q. Yes, but at this time the CMO would have known about
19 Conor's death.
20 A. Well, if she did, she didn't tell me.
21 Q. Well, would that have been something that you would want
22 to know, that after the introduction of the guidelines
23 there had been another death in which fluid management
24 was an issue? Let's put it that way.
25 THE CHAIRMAN: I think you need to be careful about this,

1 Ms Anyadike-Danes, because we need to remember what the
2 inquest verdict was and we need to remember what
3 Dr Sumner's oral evidence was at Conor's inquest, which
4 was that the fluid management was acceptable. He did
5 then seem to resile from that in his letter after the
6 inquest.
7 MS ANYADIKE-DANES: Yes, and the CMO had that letter. As
8 I understand it, that letter was sent to the CMO.
9 THE CHAIRMAN: I am afraid that's a rather cloudy area in
10 light of what happened at the inquest.
11 MS ANYADIKE-DANES: But in any event, would you have wanted
12 to know about Conor's death as it happened after the
13 guidelines?
14 A. Yes. There was an emerging picture being built up here.
15 Q. I'll give you an example. Let's just say for the sake
16 of argument that the outcome of Conor's inquest was to
17 show that we had guidelines in place and actually they
18 had been complied with scrupulously and, unfortunately,
19 Conor died but for other reasons. That would have been
20 quite a good thing to know that the guidelines had been
21 issued in 2002 and that they were being followed.
22 A. Yes.
23 Q. I'm still not entirely sure from the answer you've given
24 whether you're indicating that you had asked whether
25 there was compliance with those guidelines and you

1 received a satisfactory answer, or you'd asked, "Well,
2 have you addressed the question of hyponatraemia?", and
3 you'd got an answer, "Yes, we've issued guidelines".
4 They're two slightly different questions.
5 A. The latter.
6 Q. So you hadn't asked the degree of compliance with that?
7 A. No.
8 Q. But you'd accept that's a relevant thing to know? It is
9 all very well issuing very guidelines; if they're not
10 being followed, that's not terribly helpful.
11 A. Yes, but I was leaving that to the CMO. It was properly
12 in her territory to follow it up.
13 MS ANYADIKE-DANES: Mr Chairman, I think there might be
14 something that one of the other parties wishes me to ask
15 and, after I've asked this question, if I might just
16 have a couple of minutes to clarify that.
17 You gave a talk at the Northern Social Services
18 board conference on patient safety. Do you recall that,
19 giving a talk?
20 A. Yes.
21 Q. I think that was in 2005. That must have been just
22 before you left.
23 A. I don't recall it exactly.
24 Q. But you recall giving it?
25 A. I recall giving it, yes.

1 Q. There's a particular aspect of it which I would like to
2 ask you about. That is the report itself starts -- we
3 don't need to pull this page up -- at 073-003-015. The
4 page that I would like to go to is 073-003-019. And if
5 we can pull up alongside that 020.
6 In this talk on patient safety, you start off with
7 the Hippocratic oath about "First, do no harm" and you
8 talk about the importance of knowing that errors have
9 been made and learning from those errors.
10 A. Mm-hm.
11 Q. In this particular part of the talk, you refer to
12 changing the culture, essentially.
13 A. Mm-hm.
14 Q. And if you look at that last full paragraph you say:
15 "What is clear is that we need to avoid two common
16 errors in our approach. One is a tendency to bring the
17 spotlight of blame to bear on those involved and such an
18 approach makes it difficult for people to admit errors
19 and is certainly not conducive to the sort of atmosphere
20 we need for learning lessons."
21 And:
22 "The other approach is that of what we might
23 describe as the error-free work ethic."
24 But if we go to the spotlight-of-blame point,
25 a number of witnesses have been asked about that, about

1 the context in which you're trying to encourage people
2 to report essentially errors, some of which may be
3 clinical errors of judgment or nursing errors, and what
4 you're talking about here is for people to feel that
5 they can do that without retribution in some way and
6 that if you encourage that, then you'll have a better
7 chance of, (a), knowing something's gone wrong in the
8 first place and, (ii), being able to learn from that.
9 And that is what you were talking about here; is that
10 right?
11 A. It is, yes.
12 Q. Can you help with what had brought that to your
13 attention as a culture that needed to be addressed in
14 Northern Ireland -- because that's where you're
15 speaking -- by this time of 2005?
16 A. A lot of this goes back to the point I was making this
17 morning that I'd become very interested in risk
18 management and as part of that we needed a learning
19 process, we needed to be sure that we knew what the
20 risks were and how they might be tackled. One of the
21 obstacles that someone mentioned in one of the
22 discussions I had was that people in our environment at
23 that time tended to avoid admitting to things that they
24 might be punished for or blamed for or their reputation
25 affected by. So I thought it important to flag up that

1 that was something that people needed to bear in mind
2 and, in addressing these issues, we needed to recognise
3 that that was one area of concern that people should be
4 keeping in their mind when they're talking to their
5 staff and others about how they best tackled it.
6 Q. If what you're trying to do is to get people to address
7 what's been called the blame culture -- in fact you go
8 on in your paper to talk about the blame culture. Did
9 you have any ideas as to how that might be addressed?
10 Because it remains a problem even now, it's something
11 that the PAC and the NIAO reported just recently about
12 in relation to nurses. So how did you think that you
13 might introduce something that could improve the culture
14 for reporting?
15 A. I'd had a belief -- I don't really remember all of the
16 text of what I delivered as my contribution. It was the
17 keynote speech to a conference that was addressing these
18 sorts of issues and I wanted to flag up these points as
19 a helpful starter for discussion around these things.
20 But I had in mind that a bit of training on how to
21 handle people who found themselves in the situation
22 where something had gone wrong was really quite
23 important because it's a hearts-and-minds thing that's
24 involved here. People aren't going to admit to things
25 unless they have a clear message rattling round their

1 brain that it's very important that they come clean and
2 that those who deal with them don't immediately react
3 with blame, but react with support. So it's training
4 both those who might be involved in committing the
5 errors and those who would be either their bosses or
6 those who might then be judging them.
7 Q. Yes. That's then on the reporting side. The other side
8 that you addressed in this talk is the side of the
9 patient or the patient's family. If we can put up two
10 pages, 023 and 024.
11 The final point you make in relation to patient
12 safety is the communication with the patient or, if it's
13 a child, their parents or their family.
14 A. Mm-hm.
15 Q. You say in that final paragraph:
16 "We have to acknowledge that something has gone
17 wrong and that harm has happened to an innocent party
18 who has placed their trust in us to protect their
19 well-being. And at the very least an apology is merited
20 and, at its most basic, there is a need to be open and
21 honest in explaining the problem."
22 At the time that you were making those remarks, did
23 you have any information, any knowledge, that that was
24 not happening to the degree that you would like it to?
25 A. No. No. It was a message I thought was important for

1 us to keep in mind, but I had no basis for saying that
2 this was a major issue.
3 Q. In fact, that has been an issue in the children which
4 are the subject of this inquiry.
5 A. Yes.
6 Q. And in --
7 A. When did I give this speech? I'm sorry, I can't
8 remember when it was.
9 Q. 2005. I can tell you exactly, it's February 2005. In
10 fact, it says "10 February 2005". The reason we know
11 that is that there's an e-mail asking for a copy of the
12 remarks you're going to make at that speech that day.
13 As it happens, that has been an important issue for
14 the families of these children. I'm just wondering if
15 you might have come at it from the point of view of
16 claims that are made and recognising that a way perhaps
17 of avoiding them or dealing with them is, as early as it
18 can be done, to offer an apology and to accept and admit
19 responsibility. Had it come to you in that way, the
20 issue?
21 A. I was aware that it was one of the type of complaints
22 that tended to be made in trusts that the families of
23 a patient felt that they hadn't been kept in the loop.
24 And I wanted to get across that this was actually
25 a very, very important issue, which is why I put it

1 towards the end of my address.
2 MS ANYADIKE-DANES: Thank you. Mr Chairman, I don't have
3 anything further.
4 THE CHAIRMAN: Mr Gowdy, I think you're almost finished.
5 Would you just wait for a moment or two and we'll check
6 if there are any questions from the floor?
7 (3.16 pm)
8 (A short break)
9 (3.20 pm)
10 MS ANYADIKE-DANES: It's one discrete issue, but there might
11 be just a few questions related to it. The issue
12 concerns when you knew about Claire's death.
13 In your witness statement, 062/2, at page 10,
14 you are asked at question 9:
15 "How and when did you first become aware of the
16 death of Claire Roberts?
17 "I cannot give a precise date, but I believe it was
18 after my retirement."
19 And your retirement was July 2005?
20 A. Yes.
21 Q. So then there's a UTV documentary in February 2003,
22 "Vital Signs" it's called, and it's primarily
23 concentrating on Raychel's death. Do you know about
24 that documentary?
25 A. No.

1 Q. Are you surprised not to be knowing that UTV is doing
2 a documentary about the death of a child in a hospital
3 in Northern Ireland --
4 A. Yes.
5 Q. You are surprised?
6 A. I am surprised.
7 Q. Who is the person who should have told you about that?
8 A. It depends who knew. If people in the department had
9 known, I would have expected to have been told. If the
10 press office knew about it, I would have expected them
11 to alert me to it.
12 Q. Okay.
13 A. May I ask you, when was the documentary?
14 Q. The documentary was in February 2003. There were two
15 documentaries, actually. "When Hospitals Kill" is
16 a documentary that went out in October 2004; this is
17 a documentary that went out in February 2003.
18 A. I think I was away on holiday then.
19 Q. If you came back from holiday and there had been
20 a documentary like that, would you not expect to know?
21 A. Yes, I would.
22 Q. And if there were questions before you went on holiday
23 in order to get, as so often happens in documentaries,
24 the position of the department or information, you'd be
25 expecting to know there was a documentary in

1 preparation?
2 A. Yes.
3 Q. Thank you.
4 A. In fact, more than that. I would have expected to be in
5 a position to inform the minister that this was going to
6 be a matter of public interest.
7 Q. Yes, for the reasons you've already told the chairman.
8 A. Yes.
9 Q. Then if we go to the UTV documentary, that airs on
10 21 October 2004.
11 A. Yes.
12 Q. And were you aware that that documentary was going out?
13 A. Yes.
14 Q. You were. And that's the documentary that Claire's
15 parents watch, they watch it and they are able to make
16 a connection, as non-medical people, between what is
17 being said in that documentary and what they recall
18 being said about their daughter when she was being
19 treated at the Children's Hospital in 1996.
20 You're chairing a meeting of the DHSS departmental
21 board. We have one of those minutes. You've appended
22 it to your witness statement, 062/1, page 525. Can we
23 bring that up alongside page 526?
24 Dr Campbell's at that meeting. And if you see,
25 under "Chairman's Report":

1 "The chairman [that's you] referred to the UTV
2 'Insight' programme concerning the deaths of two
3 children from hyponatraemia, which had been screened on
4 the previous night. He stated that some serious issues
5 had been raised which the department needed to consider
6 more carefully."
7 Then if we go over the page:
8 "Given the gravity of the allegations, there was
9 a need for an independent investigation."
10 And then you conclude by saying that:
11 "The department would need to reflect very carefully
12 on the issues raised and seek agreement of the minister
13 of the appropriate action to be taken as a matter of
14 urgency."
15 So can we understand from that that the matters that
16 related to this issue, you wanted to be kept in the loop
17 and you wanted to have as much information as possible
18 as a matter of urgency. Would that be a fair way of
19 characterising your position?
20 A. Yes.
21 Q. And in fact, something that comes out of that is the
22 knowledge of Claire's death. But you don't know about
23 that, it would appear, until after July 2005?
24 A. I have no recollection of hearing about it before
25 I left.

1 Q. Well, the rest of the chronology in relation to Claire
2 is that same day that you're having that departmental
3 board meeting, her parents are contacting the hospital.
4 That's how quickly they made the connection. They meet
5 the relevant clinicians on 17 December. There's
6 a letter written to the coroner on 16 December.
7 Professor Young is brought in to advise, also
8 in December. The minister knows of Claire's death
9 in February 2005. By that time the inquiry has already
10 been established -- that was announced on
11 1 November 2004 -- and the minister is being alerted to
12 the possibility of another death which the inquiry might
13 have to look into and that other death is Claire. And
14 if the minister knows that in February 2005, can you
15 help us with why you didn't know about it?
16 A. Maybe I'm mistaken in when I learned of it. As I said
17 in my statement, I couldn't recall exactly when I had
18 heard of it. If the minister knew, I certainly was
19 likely to have known then as well.
20 Q. Well, you might be mistaken because it would seem that
21 there is a letter from the chairman of the inquiry to
22 you, dated 27 January 2005. I don't know whether this
23 will come up on the pagination, it's 322-041-001. What
24 this letter says is:
25 "I have been made aware this week of a death in 1996

1 of another child, which may be relevant to my work.
2 Hyponatraemia has not yet been established as the
3 probable cause of death, but the Royal has now referred
4 the case to the coroner with an indication that
5 hyponatraemia may have significantly contributed to the
6 young girl's deterioration and death. This appears to
7 be a case where hyponatraemia was not identified at the
8 time as causing or contributing to the death and,
9 subject to further investigation, I do not anticipate
10 that it will have been referred to on the death
11 certificate."
12 And then you're being told that the chairman wants
13 to know, as a matter of urgency, whether there have been
14 deaths in Northern Ireland in the last 25 years in which
15 hyponatraemia, however described, has been identified as
16 a primary cause of death or even as a secondary or
17 contributing cause.
18 When the inquiry was established, so you're going to
19 have an inquiry that's established to look into the
20 deaths of three children, did it occur to you at that
21 stage to seek to identify how many other children there
22 might be out there in which hyponatraemia might be
23 implicated in their deaths?
24 A. I believed that would be something that the inquiry
25 would pursue.

1 Q. No, but you might be gathering the information.
2 A. Well, at that stage there were only three specified --
3 well, there were two initially specified in the
4 instrument that set the inquiry up. At the chairman's
5 request we added another one.
6 Q. Yes. And two of them are ones that you didn't about
7 at the time, so it's not beyond the bounds of
8 possibility that there might be others out there and
9 what I am asking you is as --
10 THE CHAIRMAN: Sorry, there were three in the original terms
11 of reference.
12 A. Oh yes, that's right, yes, and one was removed
13 subsequently.
14 THE CHAIRMAN: Adam, Lucy and Raychel.
15 A. Yes.
16 MS ANYADIKE-DANES: But you knew Raychel's death had come to
17 the attention of the CMO; these other two had not come
18 to the attention of the CMO contemporaneously is what
19 I meant. So what I'm asking you is, given that that had
20 happened and there was a possibility of that, did it
21 occur to you, that when you're establishing something as
22 significant as a public inquiry, to start gathering the
23 information or to seek information as to whether there
24 are in fact other cases like that?
25 A. No, but that was on the basis that the inquiry was set

1 up to investigate these three cases that had received so
2 much public attention, so it was a matter of public
3 interest to get this underway quickly and to have it
4 explore the issues as soon as possible. And the
5 expectation was that, in doing its work, the inquiry
6 would, as it has been doing, explore all of those issues
7 and see if there were other cases, plus the fact that
8 quite often in these circumstances where an inquiry is
9 set up, once it's set up people out in the public domain
10 will write in and ask for their issues to be brought on
11 board. So I didn't feel that we were cutting anything
12 off. It was more the urgency of getting this up and
13 running in the public interest because there had been
14 a lot of speculation, a lot of comment in the press, and
15 I considered it very important to get this underway.
16 Q. Then do you accept from the letter that I've just read
17 out to you, which is dated 27 January 2005, that you
18 probably did hear about Claire's death, even if you
19 didn't have the name Claire to put to it, but you heard
20 about that death before you retired?
21 A. I think that sounds likely. I really don't recall, but
22 it sounds likely.
23 THE CHAIRMAN: It must be right. If I wrote to the
24 minister, it's hugely unlikely that that would not have
25 been shared with you.

1 A. Yes.
2 MS ANYADIKE-DANES: In fact, Mr Chairman, you also did write
3 to Mr Gowdy. You wrote to Mr Gowdy on 27 January 2005.
4 I'm looking at it; it just hasn't come up on the system.
5 THE CHAIRMAN: There we are.
6 A. Okay.
7 MS ANYADIKE-DANES: Thank you.
8 THE CHAIRMAN: Any questions? Any questions from the floor?
9 Mr McMillen?
10 MR McMILLEN: No, Mr Chairman, thank you.
11 THE CHAIRMAN: Mr Gowdy, thank you for your time, thank you
12 for coming back to help us. We've no more questions for
13 you. Unless there's anything further you want to say,
14 you're free to go.
15 A. No, other than to just commend the inquiry for what
16 I see as a very comprehensive review of these issues and
17 I hope that at the end of the day the families can feel
18 that they have at last learned the truth.
19 THE CHAIRMAN: Thank you very much indeed. Ladies and
20 gentlemen, we'll break now until 10.00 tomorrow morning
21 for Dr Campbell. Thank you.
22 (3.32 pm)
23 (The hearing adjourned until 10.00 am the following day)
24
25

1 I N D E X
2
3 MR CLIVE GOWDY (called) 1
4 Questions from MS ANYADIKE-DANES 1
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25