Wednesday, 26 June 2013

(10.15 am)

(Delay in proceedings)

(10.23 am)

THE CHAIRMAN: Good morning. Doctor, thank you for coming back. Could you come forward, please?

DR IAN CARSON (continued)

Questions from MS ANYADIKE-DANES (continued)

MS ANYADIKE-DANES: Good morning. I want to pick up a few things with you from last time and then to go through some of the other issues that we would like you to assist us with.

The first goes back to questions arising out of the draft statement, we call it C5, that was attached to Dr Taylor's deposition to the inquest into Adam's death. The reference for it is 011-014-107a, if that could be pulled up, please. I'm sure you're familiar with this now. The particular part that is of interest on the question I'm going to ask you now is just literally at the end of that second paragraph:

"All anaesthetic staff will be made aware of these particular phenomena and advised to act appropriately."

When I had asked you about that the last time you were giving evidence on this issue, on 11 June, the reference for what you said is at page 144. You said:

"I would have expected the clinical director for anaesthetics, the clinical director for paediatrics, myself, the chief executive, Dr Murnaghan and possibly others to have been signatories almost to that document."

And I think you were saying that in the context of if a statement is going to be made like that, tendered to a coroner to have some sort of evidential value, then that's how you would like a statement like that to be authorised; would that be a fair way of summing up your position?

A. I think any statement issued on behalf of the Trust would need to have had the authorisation and the signatory -- the signatures from the chief executive and senior officers of the Trust, yes. In relation to the expectation of what was commented on there I would expect, if you like, the delivery of that and the operationalisation of that to have been handled within the directorates, be it paediatrics, be it anaesthetics.

Q. I understand?

A. And the senior officers may not have had hands-on responsibility there, but a statement issued on behalf of the trust I think needed to have been passed before the senior officers of the trust.

Q. Yes. Let's first off deal with the authority for it and

how that might be. The statement itself has a bit of a history as to how it arises. In fact, there are two statements. If I can pull up 060-014-024. Let's pull up 060-014-025. Let's try that. Thank you. That one will do. Could we pull up next to it 060-018-036?

This is a document which, if you see from the cover fax on the left-hand side, is being provided by Dr Murnaghan to the Trust's solicitors.

A. Mm-hm.

Q. "Here is a draft composed today by Dr Gaston [he is the clinical lead for anaesthetics], Dr Taylor, consultant involved, Dr McKaigue and subsequently approved by Dr Crean."

As you know, Dr McKaigue and Dr Crean are senior paediatric anaesthetists. So these are the consultant paediatric anaesthetists who will be involved in such clinical problems in the future and so they've drafted it. If you took to what's being drafted there it starts off in much the same way as C5:

"In the light of the Adam Strain case, a number of renal transplants and the Arieff article, we make the following recommendations for the prevention and management of hyponatraemia arising during paediatric surgery."

And then you have those recommendations, very much

the same, the electrolyte imbalance issue and the serum sodium of less than 128, and operating theatres to have access to timely reports. Nothing there about all anaesthetic staff being advised of those issues.

And then if we go back to the genesis of the C5 document, if we pull up 060-019-037, and alongside that pull up 059-008-025. This is the draft that ended up as C5. It's distinguishable by that reference in the second paragraph to:

"All anaesthetic staff will be made aware."

Do you see that? That is missing from the other document that all the consultant paediatric anaesthetists approved.

We asked for an explanation of what the standing of these documents was and we received that explanation from the DLS itself, but I will come to that in a minute. The important thing to recognise is that on the first document you have got the clinical lead involved and you've got Dr Murnaghan, who was director of risk and litigation management. He is also involved, because it's being sent to him, in this version. So he's there for both versions. Let's pull up 305-020-001.

This is the letter that we got from the DLS. The first document I showed you, you can see the explanation

for that in the second paragraph:

"The recommendations may be considered substantive in that they were drawn up by the only anaesthetists in Northern Ireland who were performing such work."

And that relates to transplant surgery or major paediatric surgery. That's how that was produced.

Then if you look at the draft statement one, which is the one that got handed to the coroner -- I am reading from the penultimate paragraph:

"This was prepared as a layman's version of the above recommendations by the Trust's management in conjunction with the Trust's solicitor. It remains labelled 'draft' and its sole purpose was to inform the media and it was forwarded to the Trust's director of corporate affairs in June 1995 in anticipation of media interest at the conclusion of the inquest."

And in fact, we know that it did get released in some form because I can pull up for you 070-016-073. That's a press clipping. If you look at the bottom of the first column:

"All anaesthetists will be made aware of the possible complications."

So they haven't exactly transcribed it, but that's the issue that they've got it there.

Then I ask you: if that statement with that

commitment was produced in conjunction with the Trust's management as we're told by the DLS, its solicitors, and is released to the press, how can that happen without the Trust's senior management knowing about it in the way that you indicated to the inquiry you would wish them to know?

A. My only interpretation, my personal interpretation, is this is Dr Murnaghan acting on behalf of the Trust without formal reference to senior officers, namely myself as medical director, to whom he, in a sense, professionally reported, and the chief executive.

Q. Does that mean, so far as you're concerned, he was not authorised to do this?

A. Um ... I think if he's acting on behalf of the Trust. He should have referred the matter higher in the organisation.

THE CHAIRMAN: So if it's a combination of Dr Murnaghan, George Brangam and the doctors who are directly involved in Adam's case, they might think this is an appropriate way forward, but they should not be endorsing and publicising that without you being informed of it? You might have thought this was an appropriate way forward, but you might not, but you should have known about it.

A. I think -- once it goes into the public domain, the director of corporate affairs should properly also have

cleared any Trust statement with the chief executive. He reported and was accountable to the chief executive. So I think what we've got here is evidence of Trust operatives not -- you know, and the significance of this, not referring the matter right to the top of the organisation. And one could also argue that the chairman -- I mean, in terms of the public domain, the chairman of the Trust board should also have been apprised that an event of such significance was going to appear in the media.

THE CHAIRMAN: Can I ask you this: in terms of the content of the statement, do you have any reservations about the content? Do you want to bring it back up?

A. Well, I'm obviously concerned that the two pieces of evidence we've seen are draft statements and we've never seen -- I have yet to see, if you like, what would be considered a formal statement on behalf of ... So in terms ... You know, I question the status of the statements if they're just referred to as draft documents.

THE CHAIRMAN: The final version which talks about staff being trained does seem to appear to be the final version, even though it has the word "draft" at the top of it, if you ignore the word" draft".

MS ANYADIKE-DANES: I can bring it up, it's 011-014-107a.

THE CHAIRMAN: Let's ignore, doctor, the word "draft" at the top. In terms of what the statement commits the Trust to do or announces that the Trust will do, do you have any reservation about the content of it?

A. Without studying it in great detail, no, I wouldn't have any reservation because I think the intent was good. And let's remember, I was a practising anaesthetist at that time, working with children in the cardiac surgical unit. I can't say that I was fully apprised of what was happening within the children's environment. Are you with me?

THE CHAIRMAN: Does that emphasise the point that, whatever about your management role, as a clinician you're one of the people to whom this episode should have been highlighted?

A. Would have had a bearing. I think the intent was good; the practical application of it was not thorough.

MS ANYADIKE-DANES: Yes. Just to round up that last point, as the chairman put it to you, leaving aside the fact that you were medical director, so from that point of view you should have known about a statement like this being given as a commitment to the coroner and published in the press to give the public comfort. But leaving aside that, actually your discipline was one in which you ought to have known about this as well. So you

don't know on either limb. Is that, from your point of view, not a serious issue for you at that time?
A. I think -- I mean, yes, and I would expect that that would not happen today. I think also that there were children being anaesthetised throughout the Trust, there were children who would be having intravenous fluids elsewhere in the trusts.
Q. And do you think they all should have known?
A. But all of those anaesthetists were members of the anaesthetic directorate.
Q. Yes, but it didn't get to them because it stayed with the four consultants whose names I read out to you. That's exactly the point.
A. No, I accept that and I recognise that. I think the things that were clouding the issue here were the fact that it was paediatric renal transplantation, that was the primary focus. Also, the fact that complex paediatric surgery of very sick children was going to be within the domain of the Royal Belfast Hospital for Sick Children. I think the intent of what they have expressed in this statement was good intent, but it was not carried through.
Q. Can I just ask you one final point about that and then I'll come on to an interesting point that you did mention, which is what it was thought to be addressing.

If a statement like this appears in the media, presumably the Trust have a way of tracking statements that refer to it and its conduct in the media?
A. That would be, I'm assuming, the duties of the director of corporate affairs who would be responsible for --
Q. The director of corporate affairs already knows about it because it's already been sent to him. So here the statement does in fact get into the media and yet your point is that it's missing a stamp of authority from the highest level, and so there would appear to be some disconnect between the director of corporate affairs and the highest level because it gets into the media and nobody is querying: what are we doing about this commitment that has been made?
A. Well, that's a presumption, yes.
Q. Then can I ask you this following on from what you said about the focus of this --
A. I'm not sure -- sorry, can I interject there? I do not know what communication would have taken place between the director of corporate affairs and the chief executive. I'm not aware of -- I was not party to it --
Q. But whatever took place did not find its way down to you as the medical director?
A. And I was certainly not involved, yes.

Q. And if it had gone from the director of corporate affairs to the chief executive, it would have had to come to you because you would be in charge of the medical aspect of implementing such a commitment.
A. That would be correct.
Q. Yes. Then if we go then to the scope of it, which is what you were going on to talk about, why it might not have gone to all the anaesthetists dealing with fluid management for children, the coroner was giving evidence yesterday and he was very clear about the significance of that inquest. In fact, he described it as the most important inquest he'd done. In his witness statement for the inquiry, which is 091/1, page 2 -- and I'll pull it up for you in case you haven't had an opportunity to read his evidence. There you are.
It says right at the top:
"My understanding was that so far as the Children's Hospital was concerned, the hospital would learn from what happened."
That was the first thing he said. And then if we go to the next page of this, please:
"I had assumed that the Children's Hospital would have circulated other hospitals in Northern Ireland with details of the evidence given at the inquest and, possibly, some best practice guidelines."

Here's the point about the wider application that he goes into:
"Children are not always treated in a paediatric unit and, in the event of surgery, the anaesthetist may not be a paediatric anaesthetist."
And what the coroner was pointing to is he had taken the discussion that was in the Arieff paper that is cited in that draft statement -- I'm sure you know it -- of 1992, which is not a paper that's addressing necessarily the dangers of hyponatraemia and low sodium fluids in post-operative children; it's assessing that danger generally, particularly in relation to healthy children. And he had taken that point on and believed that that was an issue that the Trust had acknowledged and it was for that reason he thought that the Trust would develop a broader aspect to it as opposed to seeing it simply within the confines of the particular case of Adam that had given rise to the problem.
What I wanted to ask your comment on is: he had that impression, it's quite clear from what you said that, in your view, the Trust didn't have that impression, and I want to pick up an extract from the chief executive at the time, William McKee's, statement to the inquiry. It is his statement of 25 June 2005 and the reference to it is witness statement 061/1, page 2.

It's the answer to (ii):

"It is my understanding that the expert clinical opinion at the time was that the complication of hyponatraemia had occurred during specialised renal transplant surgery in a child with renal failure. I am not personally aware of wider dissemination of lessons learnt from this inquest to the wider Health Service in Northern Ireland and elsewhere in the United Kingdom or that this was identified to be required at this time."

So the chief executive, of course not present, so he's reliant upon the feedback that he gets from the inquest, is of the view that it is a narrow question, and if that's so then one can see why it would only be something of relevance to those carrying out major paediatric surgery and therefore that keeps it within the Children's Hospital.

The coroner, on the other hand, believes the lessons are wider than that and that is one of the reasons -- not only does he think the Children's Hospital will take certain action, but also one of the reasons why he wants the case to be published in the academic literature.

What I want to ask you is: what system was there to ensure that whatever are the lessons that are emerging out of an inquest -- as it happens we're looking at Adam's -- do accurately get back to the Trust management

so that they can be incorporated into whatever system they're going to have for dealing with those lessons? What system did you have?

A. At that time I do not think there was any system that would have ensured that findings or verdicts coming from a coroner's inquest would have found their way to Trust management.

Q. From a governance point of view, do you not think that there should have been a system?

A. In the light of developments of governance, that has evolved and happened, but at that time I do not think that that was custom and practice or common practice anywhere within the NHS, not just in Northern Ireland.

Q. I appreciate that, but I'm putting the question to you in a slightly different way. Given that in inquests it is possible that the coroner brings in specialist expertise, there's expert reports, and lessons to be learnt, did you not think at the time that there ought to be a system that could be introduced to capture that learning?

A. I think, yes, that could have been put in place, but I'm just -- I have to go back to the culture at the time and the practice at the time and there was certainly no guidance or instruction either from the Court Service, the coronial system, or from the Department of Health to

say that this should be in place.

THE CHAIRMAN: Can I ask you this: you have just said that that was the position at the time, but that things have evolved since then. Is it different now? I know you have been out of the system for some years, doctor, but by the time that you left the Trust and then left --

A. I don't think it is explicit, chairman. I don't think it is explicit. I think we're still dependent on express, clear instructions from the coroner coming out of an inquiry. We're also, I think, dependent on individual clinicians taking back into their clinical practice changes to their practice and we are also dependent on a system, a healthcare system, that has regional responsibility for dissemination of guidance, instruction, and that sits alongside what I'll just call a general professional educational information through publications and literature, through presentations at clinical meetings, through presentation at national and other fora. So --

MS ANYADIKE-DANES: I see that, but I'm wondering --

A. That's not to say that the latter didn't happen. We know that it does happen.

Q. I understand that, but I'm wondering why there couldn't have been something slightly more formal done. I see what you say when you refer to how you've got a number

of clinicians who are attending as witnesses at an inquest and so how to gather together from them what may be their own individual take, their own individual interest in these things to distil from that the learning points, that might require some thought. But if I use Adam's case just again as an example, you had your director of risk and litigation management, Dr Murnaghan, he was present at Adam's inquest, so he's not attending as a clinician going to give evidence as a clinician with his own particular perspective; he's attending as a Trust representative, if I can put it that way.

A. Yes.

Q. So he is in a position to, coming back from that, to decide, "We actually need a system". In fact, he was halfway there --

A. He was.

Q. -- because he sent you a little sort of update, a bit of feedback as to what should happen. We don't need to pull it up, but just so that you have it, it's his handwritten note, 059-001-001, going on to 002, and in that he tells you directly:

"I think we need to deal with this as a risk management issue."

And that he's going to put together a seminar and he

indicates the sorts of people that he wants to attend that seminar, and of course both the relevant clinical leads are there, including yourself.

A. Mm.

Q. So there's a germ of something and all I think that those focusing on the missed opportunities for getting the message disseminated more broadly is -- how was it that that couldn't have got itself into a system and, from what you say to the chairman, still hasn't perhaps got itself into a system?

A. Well, I think Dr Murnaghan had every intention of using that as an opportunity to not only bring everybody involved clinically together to develop a formal guideline and to disseminate the lessons from the coroner's inquest throughout the hospital, beyond the Children's Hospital, including anaesthetists working elsewhere. It might have been possible, there's nothing to say that one could not also have disseminated that learning elsewhere outwith the Royal Group of Hospitals. One can't say that that might not have happened. At that time, I think -- and maybe even today -- we made reference at my last attendance to the role of specialty advisory committees and the communication up to the department. That would have been -- and I suspect that is probably still the main way of communicating

with the service. I don't think individual hospitals within a large trust or a trust itself would have taken on the responsibility of disseminating guidance to the service in Northern Ireland.

Q. I understand. Then one last document to put to you, it comes out of Dr Gaston's evidence, and it's witness statement 013/1, page 4. There has been quite a bit of discussion in all of these cases in relation to clinical audit meetings. This one is dated 10 December 1996 so it's within six months of Adam's inquest. From the substance of it, this is nothing to do with Adam's case at all. In fact, we're not sure that Adam's case ever was subjected to a clinical audit meeting, but be that as it may.

What I wanted to point your attention to is there are two cases here being discussed. In the first of which the principal topic that's being concluded from there is anaesthetic record keeping, but if you look, you see of the two problems identified, one was inadequate records and the other is no records at all. And then you see:

"Common areas of inadequate information were to be found in: drug and fluid administration, and untoward events."

The reason I'm putting this to you is because Adam's

case also gave rise to some concern about the adequacy of records. It certainly gave rise to concern of fluid administration and, of course, an untoward event, and this could have been an avenue to get the very issue that had been included in that statement to the coroner into discussion.

Ironically, the question of fluid administration, although of course we don't know in what terms, is actually being discussed, and this is within six months of a statement being given to the coroner that that was an issue that would be circulated within the relevant anaesthetists.

What I'm asking you is: what actual systems did you have to ensure that the right sorts of issues that were of concern -- and the fluid administration of Adam was of concern -- actually get into a system where they can be discussed and translated into any improved protocols or practices? Because it doesn't seem to have found its way into this system.

A. Could you scroll down to the -- so I see the very top of the document?

Q. Yes. There we are.

A. This is a record of a clinical audit meeting held at that time, and I think -- and obviously there's an attendance register.

Q. Yes.

A. And I'm going back to points that have been raised previously, so obviously there's an attendance record kept. The responsibility for developing the agendas, if you like, for clinical audit meetings would have been the responsibility of the audit coordinator within each directorate. They would gather intelligence about cases that have happened within the directorate, these were held usually monthly, so in the previous month or maybe the month prior to that they'd have gathered knowledge, awareness of cases, and they would decide which cases are going to be discussed and presented and you have seen that within the paediatric directorate.

Q. I understand that.

A. This happens to be an anaesthetic one.

So the Trust is very dependent -- I think this is one of the things that I think is important to try and recognise, that the Trust, organisationally, is very dependent on staff at directorate levels compiling audit agendas, educational agendas. Reference was made last time to my responsibility as medical director for education. My responsibility is to ensure that our obligations to the postgraduate council and to the university are fulfilled. I'm not involved in the detail of compiling educational or audit agendas.

Q. I'm not suggesting that you should be involved in what I would call this micro-level.
A. I understand.
Q. I'm not suggesting that at all and I hope that I had made it clear last time that I'm talking about systems and procedures. So at some level, because you're the medical director, you have to have a way of knowing that these things are working. And if they're not working, that it comes to your attention that they're not working, and steps can be taken to try and improve matters. And all through these things what I have been trying to find out is: what was the oversight system that you had of knowing that these things were or were not working?
A. I had no indication that I can recall of am aware of that these systems of audit meetings, of educational fora, were not taking place and doing what they were expected to deliver. I had no indication of that. I had also no system to robustly provide any assurance to my -- so I had no awareness that these activities were not taking place.
Q. Can I ask you in present day then? So contemporaneously, you don't know whether -- unless you're told -- a clinical audit meeting has taken place, it has been successful or not. But when --

THE CHAIRMAN: In present day, Dr Carson has been out of the system for some years. With all due respect to Dr Carson, I think it's factually correct we can't ask you about the current day position; is that fair or not?
A. I'm not aware of what's happening in the Belfast Trust now. I can't comment on today. But at that time --
MS ANYADIKE-DANES: I'm not going to take you out of when you were there. What I'm going to ask you is: when it becomes clear to you -- and it's actually become clear in the course of this inquiry -- that certain of these deaths don't appear to have been subject to a clinical audit meeting. If in your time that had become clear to you and there was a concern that a child whose death, to all intents and purposes, should have been the subject of clinical audit, it wasn't or it was the subject of clinical audit but not a very effective one. What is the system that you have for dealing with that?
A. If I remember, this varied from directorate to directorate. My understanding from reading statements and transcripts of this inquiry in relation to the Royal Belfast Hospital for Sick Children, statements have been made to the inquiry that every death was discussed at morbidity and mortality meetings in the Children's Hospital. My understanding is that was roughly 30 children a year, whatever the quantum was. So I am

dependent on that activity taking place. It has to be emphasised again that, in 1996, as Trust medical director, I did not have an infrastructure, I did not have staff working for me to deliver what you're calling a robust governance arrangement. That took many years to develop and it is still developing.
Q. Well, for example, and we'll move on, but for example it's not clear that Lucy's case was ever the subject of a clinical audit meeting, and she died in 2000.
A. And I think the two latter cases -- I think there are issues in relation to those --
THE CHAIRMAN: I've got the point.
A. -- that maybe explain that.
THE CHAIRMAN: I've got the point and to some extent we're going over ground that was covered both in Adam's hearing and Claire's hearing, so let's move on.
MS ANYADIKE-DANES: In Raychel's case, one of the ways in which Lucy's case came to light as a hyponatraemic death, if you like, was because after Raychel had had an inquest, the results of that were presented to the Western Health and Social Services Council. I can just pull up the first page of a letter that shows you that structure. 013-056-320.
In fairness, let me pull up the second page, 321, so you see who you're dealing with. This is

Mr Stanley Millar, the chief officer of the Western Health and Social Services Council. He was supporting Lucy's parents through her death and their effort to find out what had happened. And the inquest into Raychel's case -- the members of the Western Health and Social Services Council received a briefing of that, on all the events that led up to Raychel's case, and it's when he heard the details of Raychel's case that he was able to make a connection with the case that he did know about, which was Lucy's case, and that's what he did, and when he made that connection he wrote to the coroner.
What I wanted to ask you is: so far as you were aware, when you were involved in the Royal, was there an equivalent to the Western Health and Social Services Council?
A. Yes.
Q. What was that?
A. Each of the four area boards would have had a Health and Social Care Council, which was a patient representative -- a patient advocacy group. So each of the four health boards had a council, which assisted families, primarily in the area of complaints, but other support was available as well.
Q. Yes. And is that somewhere where, for example, any of

these other children during your time whose death had been the subject of a complaint, is that somewhere where that could have been taken?

A. I would not have been aware -- at least to the best of my knowledge I'm not aware of a systematic approach whereby trusts would communicate with the councils about incidents, adverse events or deaths taking place within the trust. The councils were there primarily to support and provide information and assistance to families. It was an avenue through which families could obtain information from the provider organisations.

Q. I understand. Thank you very much. Then can I move on and take up a different subject? If I could pull up your witness statement, 306 --

A. Sorry, could I maybe just add to that? I do recall on a small number of occasions meeting with representatives from the Eastern Health and Social Care Council, within which the Belfast Trust -- and those would have been ... It would have been a, "Hello, how are you, what's happening?", and they might have raised issues with us around excessive waiting times, for example, in A&E departments, or issues that were being raised by families in relation to how they were being looked after in the organisation. I can only think of one or two occasions in my tenure that such an opportunity or an

engagement took place. Obviously, the whole agenda for patient and client engagement has changed a lot in recent years and the role of the patient and the advocacy for the patient and the opportunity for patients to have their voice heard, that has changed quite a lot since the mid-1990s.

Q. Thank you. Then if I pull up witness statement 306/1, page 7. You refer to expecting the Sperrin Lakeland Trust, the coroner, and the associate medical director to have been informed. I think it's the answer to 14:

"From your perspective as medical director at that time, what steps would you have expected senior medical staff in the Children's Hospital to have carried out in order to investigate the circumstances and cause of Lucy's death?"

The steps that you think should have happened are:

"To inform the referring clinical colleagues in Sperrin Lakeland Trust. To inform the office of HM Coroner. Inform the office of the associate medical director in the Royal."

Can I ask on what basis you had that expectation?

A. My expectation would have been, one, a professional expectation that senior medical staff would have undertaken that professional responsibility to have undertaken it. I think -- and again, we're referring

again to senior medical staff here, and I am talking principally about the consultant in charge of the case management of the patient, I'm talking about a clinical director in an organisation within the context of paediatrics. I would have expected them to have communicated along the lines that I've outlined in the statement. It would have been a professional expectation.

It would also have been an organisational expectation, even if that was not written down as a definitive instruction or guidance. People working in a hospital such as the Royal where regional referrals to a regional centre were commonplace, I would have expected a consultant who had a patient referred to them to have had a continuing and an open communication with the referring consultant. And again, the issues pertinent to this particular case I would have expected senior members of staff to have known what steps to take following an outcome such as this.

Q. I understand the point that you make in terms of the professional expectations, that would just be a good and sensible thing to do from one clinician to another, if I can put it that way, but when you talk about an organisational expectation, where are these senior staff to understand that as an organisational expectation?

A. I think senior medical staff in the organisation knew of not just their own professional responsibilities, but they would have understood the structures that were in place at that time within the trust. As I said, I cannot recall that there would have been any definitive instruction or guidance written down as to what steps a doctor would take in an individual circumstance. I think these are general expectations that would have been expected of any senior member of staff.

Q. Let me put it to you in this way because Professor Scally, as the inquiry's expert, has put it like this: he agrees with Dr MacFaul, who's also an expert for the inquiry, that:

"The Children's Hospital should have informed Sperrin Lakeland Trust in a formal manner and that this requirement arises out of a general obligation in the case of a death that may have been caused by inadequate treatment and is reinforced by the Children's Hospital's role as a regional centre of excellence."

The reference for that is 251-002-017.

So he has not just that the -- clinician to clinician, if I can put it that way, should have informed, but in his view the Children's Hospital should have informed the Sperrin Lakeland Trust in a formal

way. Firstly, do you agree with that?
A. Um ... I do not recall and I do not think there was a formal mechanism in place at that time in Northern Ireland for that to be carried out or conducted by the Royal Belfast Hospital for Sick Children. I think communication, formal communication from the trust to another trust, would have needed to be at a senior level within the organisation, either through my office or through the office of the chief executive.
Q. Yes, but do you see any reason why that couldn't have happened?
A. In that I didn't know about the death of the child?
Q. No, the question to you is: do you see any reason why there shouldn't have been a formal communication? So assuming you had been advised of the fact of the circumstances of Lucy's death and that she had received treatment that some of your clinicians considered to be inadequate and that that had contributed to her condition, do you see any reason why you, on behalf of the Trust, couldn't have written a formal letter to Sperrin Lakeland?
A. There is no reason why that could not have happened.
Q. Would you have thought it appropriate?
A. It might have been appropriate. I did not know about the --

Q. I appreciate that.
A. -- the death until much later. I ...
Q. The reason being that Professor Scally is highlighting that you're the regional centre of excellence, your clinicians, with their greater experience of these things, have come to a view, which, for all they know, those in the referring hospital may not have been aware of that the fluid regime that was instituted for Lucy was one that was not appropriate for her. So you communicate as a learning exercise and from your position as the regional centre of excellence. That is the context in which Professor Scally was thinking you might do that, and whether or not you'd ever done it before, what I'm putting to you is: would you agree that that might have been a good thing to do and something that could have been done?
A. I think in this case that could have been done, it probably should have been done. I also think that in a sense -- and I'm trying to recall from Dr Crean's evidence to the inquiry that he in fact did communicate at a personal level with clinicians --
Q. He did indeed.
A. -- and raised issues.
THE CHAIRMAN: He spoke to Dr Jarlath O'Donohoe, in effect to say: it rather looks as if this young girl received

more fluid than you planned. It's not clear, however, how much things went beyond that, if they went beyond that at all. That's the opening of the door.
A. That's the weakness of the system as it pertained. One, I've said quite clearly, there is a professional responsibility for doctors to communicate, but if the doctors don't themselves communicate organisationally within the system, then the system side of that is weakened by clinicians not referring to senior officers within the organisation. And I would have expected that, as I said, any formal communication from the Trust should either have gone chief executive to chief executive or medical director to medical director.
MS ANYADIKE-DANES: Yes. Do you think in circumstances where an individual clinician may not entirely want to phone up his opposite number or co-colleague and say, "I think you've dropped the ball here", that a more formal communication might be an easier way of doing it?
A. I think it's not only an easier way, but a better way of doing it because it actually formalises it.
THE CHAIRMAN: Does this bring us back to the problem that you put your finger on last time, which is in the phrasing that you used at that time, "We advertised our successes, not our failures", and therefore to write in any sort of formal way to the medical director in the

Erne to say, "Look, your people really have serious questions to answer" ...
A. Well, whenever I ... "The culture at that time was that you would not advertise your failures" pertains to maybe a case that was being badly managed within your own organisation. I think whenever a case is referred to a centre like the Children's Hospital for an expert's intervention or more skilled interventions, then I think that feedback is easier to do. I have to say that the culture -- there were lots of cultural issues at that time and, while many of those have changed, you asked me, chairman, can I acknowledge how things have changed. We see through Mid Staffs that those cultural issues still exist in the service as a whole, so while things have improved, one cannot absolutely give a blanket assurance that things will not happen again.
THE CHAIRMAN: Mr Leckey said yesterday that a main reason why he thinks things have improved is that families now are more questioning.
A. Absolutely.
THE CHAIRMAN: It might reassure you, doctor, that they're more questioning of lawyers too, but people are more questioning generally, and if you ask questions sometimes the questions turn out to be a bit silly and can be easily responded to; sometimes the questions

raise difficult issues that people don't feel comfortable facing up to.

A. While the culture has in many ways changed and improved, chairman, I think that very questioning, that very challenging environment that we're now in today, whether it comes from families, whether it comes from families' solicitors, whether it comes from coroners' inquests, whether it comes from the clinical negligence High Court scenario, whether it comes from public inquiries, that has not made the culture necessarily any easier for individual clinicians, for people involved in management. So we're in a difficult -- while things have improved and I think that's good and I hope that during my time within the Trust that I made every effort to try and stimulate and create improvements, I still think the situation is very difficult currently.

MS ANYADIKE-DANES: Doctor, you've clearly thought about that issue, the cultural point and what are the drivers and triggers for that. Have you reflected on what trusts could do to try and facilitate what is a development, it may be pushed or dragged, but nonetheless is a movement? Have you reflected on what the trusts might be able to do?

A. Well, I think a huge effort was made by the Royal Group of Hospitals Trust and by other trusts, I have to say,

in Northern Ireland to try and change the culture within their organisations, first of all, and they did that through various seminars, conferences that colleagues from other organisations were often invited to attend, and they were multi-disciplinary; it wasn't just doctors, we're talking about nurses and other clinical professionals, all being involved in this. I think there was what I'll call an enthusiasm and an excitement for the quality agenda as it emerged in the early 1990s and through into the mid-1990s. I think clinicians actually felt here was something that they could make a contribution to. And I think trusts did try very hard -- and I think, to a certain extent, quite successfully about changing aspects of culture within the quality agenda and a more open and not just -- and trying to move away, chairman, from what I said, advertising your failures to actually building on your failures to build systems and processes. And that was shared in Northern Ireland.

I can recall conferences that were held in the Waterfront Hall, a very significant conference that was organised, I think, by Green Park Trust on the whole area of developing clinical governance, and it was very widely attended by clinical staff from right across the Province. So I think there was an enthusiasm for this

quality agenda. But while that enthusiasm is good, it doesn't necessarily deal with all the complex issues or the complex systems and processes that needed to be put in place.

Q. No, and what it requires, though, is an environment where clinicians and nurses can concede that errors are made and concede them in such a way that others can understand how those errors got made so that changes can be made. Even if that requires other clinicians being able to point to the errors of their colleagues, somehow to create an environment where errors can be acknowledged and faced up to. That's at the heart of what has to be conceded, is it not?

A. That is correct, and there has been a huge focus on that over the last 10 or 15 years. Sitting alongside that, however, there is a culture of fear --

Q. Yes.

A. -- within the profession. And as long as there's a culture of fear and retribution or whatever that is, where loss of professional reputation, even removal from the professional registers, et cetera -- as long as that culture exists -- and I believe that needs to change, I personally believe that firmly needs to change -- then we will find this journey into a more open and transparent culture -- until we address that issue,

I think we're going to have difficulty getting to where we would like to be.

Q. The benefit of the carrot is outweighed by the threat of the stick?

A. Very much so.

Q. Thank you. Then just one particular point in relation to reporting to the coroner's office. I think you said in your witness statement, 306/1, page 3, that it was your expectation that if the coroner was notified about a death, Dr Murnaghan or Dr Walby would be informed by the responsible consultant.

A. Mm-hm.

Q. It's the answer to question 1(e). On what basis did you have that expectation and how was that communicated so that clinicians would know that's what they had to do?

A. The communication would have been -- I don't think there was any written communication or any written guidance on this. Induction meetings for new staff would certainly have addressed that and would have mentioned the fact that the expectation would be that if a case had been referred to the coroner, that Dr Murnaghan's and Dr Walby's office should be informed, and that ... So that would have been how that would have been communicated. The expectation is, I suppose, again, not earthed in any instruction or formal guidance. I don't

think there would have been any clinician in the Trust, any doctor in the organisation at a senior level or even at a junior level, that would have not known what the role and purpose and function of Dr Murnaghan's office -- what it was there to serve, what the purpose of his office was.

Q. Sorry, one of the reasons I asked you that is because Dr Hicks, who was a paediatric clinical lead, didn't have a system for knowing all the reports of paediatric deaths, that's the first thing. And if she didn't have a system for it, she certainly didn't know and appreciate that they should be communicated to either Dr Murnaghan or Dr Walby.

A. I fail to understand how Dr Hicks could have that --

Q. You said that last time when I asked you. What I was going to build on then to say is: if there was supposed to be a system like that, so this is information that was supposed to be transmitted during induction, presumably, you would imagine, be reinforced by clinical leads who you would expect to have a system, I presume, where they knew what was being reported, how did you satisfy yourself that that was working or for that matter how would Dr Murnaghan have satisfied himself that that was working?

A. Well, I suppose there was regular and frequent

communication between the coroner's office and Dr Murnaghan's office. I suspect that, if you like, the flow of communication would have been more from the coroner's office to Dr Murnaghan to say, "Dr Murnaghan, I've had a case referred to me last night, a patient had died, could you gather evidence, statements, witness statements on my behalf from the clinicians".

Q. I can see if it gets taken up to that level because he would certainly be involved.

A. Dr Murnaghan would then go back to the clinicians involved and say, "You didn't ring me or tell me that this patient had -- this death had occurred", and he would rap knuckles. Dr Murnaghan was not slow at doing that and his reputation within the Trust -- and I can't ... Dr Walby -- I retired not long after or left the trust, I should say, not long after Dr Walby was in place. So the function of that office was well understood in the organisation.

Q. Thank you. Then the coroner produced a statement, 277/2, page 5, he refers to a concern, you can see it under 4:

"It remains my concern that when the death of a child is reported to my office, the proper questions may still not be asked."

How that became developed when he was giving his

evidence yesterday is his concern, essentially about the quality of information that is provided from the clinician to his office, and as you might have appreciated, at that time there was no medical -- by "that time" I mean right up until you left as medical director -- there was no medical adviser in the coronial office so those who were taking the reports of deaths had no medical knowledge in particular, no medical education, and they were heavily dependent on the clinicians giving them the appropriate information so that they could provide that to the coroner and the coroner could make his decisions as to whatever he thought was appropriate to do next.

Yesterday, the coroner was raising a concern -- and he had also taken it up with Professor Jack Crane at the State Pathologist's office in the same vein -- about the quality of information, medical information, that was being provided. So if I turn it back to you then at the Trust: what system did you have for monitoring that your clinicians were providing quality information to the coroner so that they were being able to properly discharge their statutory obligations?

A. The medical director's office did not have a system to carry that out. I think there was the -- there would have been opportunities within the context of clinical

audit in any individual clinical directorate to do an audit of cases referred to the coroner's office and thereby learn lessons in relation to the quality of data, but formally, as an organisation, structurally there was no system other than what might have taken place through what we'll call the clinical audit system.

Q. Were you aware that audits of information like that were done from time to time, just to keep a check, if I can put it that way, on how that reporting system was working?

A. I'm not aware, to be quite honest. I can't recall, but I can't ... It would be quite feasible for that to have -- I can't recall whether it did or did not take place.

Q. There's another aspect that the coroner dealt with yesterday. I raised it with him yesterday, which is a potential tension that might exist between, on the one hand, the role of the director of risk and litigation services -- who was Dr Murnaghan or the associate medical director in the litigation management office, which was Dr Walby -- their role was in managing and avoiding litigation or at least containing it, if I can put it that way, in the interests of the Trust, and also being part of the way in which relevant medical information got to the coroner in a transparent manner.

And I think he acknowledged that there was a potential for tension in there. Do you see that yourself?

A. I would recognise that also, that potential tension. I think it is pertinent, however, to contextualise how this arose. As we all know, in the late 60s/early 70s, 1980s, the Royal Victoria Hospital in particular was very much in the front line of what we call The Troubles. And there would have been many incidents linked with our civil unrest that either came to the Royal for treatment or whatever, including many fatalities. And at that time, and as is frequent elsewhere, coroner's officers who were quite often in England, quite often retired policemen, and in Northern Ireland the coroner's office used what was then the RUC. It was very difficult for members of the security forces to come and take statements, to visit the scene of a death in a hospital situation at that time. I mean it was not -- I can recall at that time individual members of the RUC, flanked by soldiers wearing flak jackets, carrying weaponry, walking down the main hospital corridor going into a ward to get a statement from a junior nurse, a very threatening and intimidating environment in any situation.

So I think an accommodation was reached between the coroner's office and Dr Murnaghan that Dr Murnaghan

would act on behalf of the coroner to ensure that statements were obtained and provided and patient records and everything gathered, secured, on behalf of the coroner. That was the context within which the arrangement arose. But I can appreciate that the dual responsibilities or activities of Dr Murnaghan's office, as well as other things that he was involved in, had potential, but it was a needs must and the resources that we had at that time to try and handle issues like that.

Q. Well, one might say there was a potential conflict in a way by him having those two roles. If it was recognised that there was that tension, what, from a governance point of view, was it thought could be done to try, insofar as it could be put in place, a system to ensure that the needs of protecting the Trust didn't outweigh the obligations to assist the coroner? That must be something that was discussed.

A. Well, it wasn't.

Q. Well, maybe not formally, but it must be something that was recognised.

A. I don't think it was recognised. I think that has emerged in the context of the inquiry itself. I don't think it was as evident as you're suggesting. I have to say, my knowledge professionally and also in terms of

Dr Murnaghan's probity -- Dr Murnaghan was pretty ruthless in trying to ensure that there was clear separation here. He acted, I think, very -- with due diligence on behalf of the coroner. And he made that pertinently clear, I know, to clinical staff, doctors, nurses and otherwise.

Q. Yes. Dr Carson, I'm talking about the systems and structures that are in place. So if you have a system whereby the same person who is there with the title to deal with litigation, but is also there as the collector of information and provider of information to the coroner, some of which information might actually have an impact on the litigation -- and in fact in Adam's case litigation had already started by the time the inquest hearings were commenced, so in that situation you don't need an inquiry like this to see that there is a potential, or there is a tension in that dual role. In fact, you've acknowledged that you can see that there is one. What I was asking you is: recognising that, what could be done to try and ensure that the needs of the one didn't, if you like, compromise the requirements of the other?

A. I can only respond to that by saying at that time that awareness, that was not ... We were not conscious of that conflict at that time.

Q. Thank you. Then if I move on and ask you about -- sorry, did that ever change and that structure separate out?

A. Not during my time as Trust medical director, and I'm not sure what has happened subsequently in the Belfast Trust.

Q. By the time you left, and that system was still in place, was the rationale for it still present? You have described the history as to how it came about.

A. I think we had moved into a period of relative calm.

Q. So was there any reason why those two roles couldn't have been separated out?

A. They could have been separated out, yes, but we had no awareness, certainly during my time, that the system was inappropriate. We had no sense that there was a tension or a conflict there. Let me put it to you: it had never been raised to me either by clinicians within the Trust, who might have felt that, nor was it raised with me by the coroner.

Q. Thank you. Then if I ask you about the death certificates. It's a similar structure really in terms of systems and processes. So far as you're aware, were audits done of the accuracy of death certificates or death certification, I should say?

A. I honestly cannot recall. But a bit like information on

cases referred to the coroner's office, there's absolutely no reason why that could not have been carried out within the clinical audit arena.

I personally can't recall either it being formally requested to be carried out or it being voluntarily done within a clinical directorate audit programme.

Q. These matters that I've put to you, this is perhaps a second or third when you've acknowledged that there wasn't any reason even at that time why it couldn't be done. In terms of those initiatives, in your structure, do you expect the clinical leads to institute those initiatives? Is that how it works, they have that level of autonomy, they do that and report to you, or how would it have worked?

A. Well, as medical director I would have been very dependent on the initiative taken by clinical directors, audit coordinators, educational supervisors within the individual directorates to take initiatives like that forwards.

Q. Yes, I understand that, but I'm trying to see where the responsibility lies for developing them. You were a practising clinician yourself, so you're just as able to see in that context things that might improve matters, but when you sit as medical director, are you expecting your clinical leads to have those initiatives,

develop them and report to you? What's the process for that kind of improvement?

A. I think what you look for in an organisation is leadership which stimulates these sorts of agendas, whether that is a clinical director or an audit coordinator. So internally within the organisation, you try to appoint people to these roles who are enthusiastic, motivated and will pick up a wide range of initiatives. So that's the internal side of it. But you also feed into that anything that might come from, at that time, area audit committees or regional audit committees where maybe there were specific themes that were felt appropriate for individual trusts to look at, either separately or collectively. So you're looking for motivated, enthusiastic leadership to develop energetic programmes that are going to capture the engagement of individual clinicians and say: that was really good audit meeting, we covered a lot of very useful -- and we've changed practice as a consequence.

Q. So they have the autonomy?

A. They have autonomy to do that, but it can also be influenced by external agendas, be they Northern Ireland initiatives or issues that were coming out nationally.

Q. Thank you. And then if I turn to something that arose in relation to the practice of awaiting the result, at

least the preliminary autopsy results, before issuing a death certificate. I think you may know by now that Professor Lucas has his concerns about that. He thinks that's inappropriate and what should happen first is a clinician should institute or issue, if he can, a death certificate. If he can't, then it's reported to the coroner. But if he can, he issues a death certificate and if he wants to know a little bit more about the mechanism of death, then if the family are content or consent, rather, then there can be a hospital autopsy. That's what he regarded as the natural order of things, and it's in his report at 252-003-011.

To that extent, Dr Crean had a similar view: you either can issue your death certificate or you can't, and you shouldn't be using the post-mortem process as a way of enabling you to issue your death certificate. That was his view in his evidence.

Against that, though, is a view from Dr Keeling, who's also an inquiry expert, and she was of the view that it might be possible to wait at least for the preliminary report back.

I don't know if you've had an opportunity to see that comment from Professor Lucas.

A. I can't recall it, to be quite honest. But I was -- I've heard it referenced. I was surprised, I have to

say, at his comment. Professionally, as a doctor, I was surprised at his comment and I would have tended more to support Dr Keeling's view. Yes, by all means if you have all the information that's pertinent to enable you to issue a death certificate, a death certificate should be issued. If you have any doubts, it's where doubt arises or information is not fully available to the doctor who is signing the death certificate, then I think it does raise issues about getting the appropriate process in place.

Q. The question I was going to ask you is not so much to comment on that aspect of it as a micro issue, although of course you can, but your witness statement was to the effect -- it's at 306/2, page 2, which is:

"In [your] view, it was common practice not to issue the certificate until the preliminary autopsy results were known."

A. Yes.

Q. That was the part that I wanted you to help us with, if you can, which is: what, so far as you're concerned, was the origin of that common practice at the Royal?

A. I don't know what the origin of it was, but given that there was a mortuary, a department of pathology, that the State Pathologist, the forensic pathology department was located in the Royal, in that pathologists in the

Trust not infrequently attended morbidity and mortality meetings, given that the proximity of pathologists to clinicians who were seeking either a consented hospital post-mortem or making a referral to the coroner for a coroner's post-mortem, I think that the very proximity of having pathologists conveniently available maybe led to the fact that a post-mortem would be carried out and a death certificate awaited the outcome of that post-mortem. We're not talking about something that took two or three weeks to take place, this was usually done within 24 hours of the deceased. So it was, I would have thought, quite common for a clinician to speak to the pathologist or the pathologist to speak to the clinician after a post-mortem and say, "Yes, I can confirm", or, "No, I cannot confirm", so I would have thought that that's the origin of it.

Q. Let me just pull this up for you. This is the guidelines from the Royal College of Pathologists. 319-025bc-015. Thank you very much. Under "Consented post-mortem examination", the second paragraph:

"If you agree to a consented post-mortem examination, the doctors will issue the medical certificate of death before the post-mortem so that you can proceed with the arrangements for the funeral."

So that was the pathologist's position from there,

the guidelines. But do I understand you to say that you're not entirely sure where the practice originated from, but that was the practice all the time you were at the Royal?

A. Well, I can't give an assurance that that was what happened in every case, but I would have said that it would have been common practice to await the outcome of a post-mortem. I mean, the situation in Northern Ireland is very different from the situation in England where there might be a considerable delay from death to burial or cremation. The custom and practice in this part is that burial follows very shortly after death. So there would have been information coming back following a post-mortem that would have been readily available to enable the hospital to release a body after a post-mortem for burial by families. So I personally wasn't aware of this statement from the Royal College of Pathologists.

Q. Thank you. Then if I can just move on to take up a particular point in relation to adverse incident reporting and critical incidents. It's a point from one of your witness statements; perhaps you can clarify it for us. It's 306/1, page 5. It's the answer to 6. The question that's put to you is:

"By April 2000, specify [so this is all in relation

to Lucy] the steps that had been taken at the Royal Belfast Hospital for Sick Children to implement a clinical governance and/or risk management strategy."

And what you say is:

"The development and implementation of clinical governance and risk management strategies were trust-wide. Arrangements in the Children's Hospital were no different from those conducted within other clinical directorates, and responsibility for local implementation lay with the management team in the paediatric directorate. While some elements of governance and risk were in place even before the Trust became a legal entity, it was recognised that arrangements required further development, organisation and resources. In many aspects there was an absence of regionally-approved guidance."

I wonder, can you help us with what you mean by the second paragraph in answer to that question?

A. That some elements were in place?

Q. You say:

"While some elements of governance and risk were in place even before the Trust became a legal entity, it was recognised that arrangements [I'm just not quite sure what you meant by 'arrangements'] required further development, organisation and resources and that there

was an absence of regionally-approved guidance."

If we leave aside the absence of regionally-approved guidance, what were the arrangements that from your perspective required further development and organisation?

A. Well, a classic example would be the whole area of incident reporting. That was not in place formally or in any comprehensive fashion before the Trust became a legal entity. It took a considerable period of time before arrangements could be put in place. It needed the development of a strategy for it, it needed a structure to be put in place, it needed resource, it needed staff, it needed documentation. So that was, if you like, one of those developments that did take place. Whereas the concept of medical audit in particular was in place before we became a trust, issues in relation to discipline and management of underperformance were in place before we became a trust, they weren't very good and they were improved during our time as a trust and have continued to develop and improve long since I'd left the organisation.

THE CHAIRMAN: In other words, none of this comes from absolutely nowhere? What is now called governance was developing but not entitled that through the 70s, into the 80s, into the 90s, and then becomes more formalised,

more developed and more coherent?
A. A lot of the elements of this were in place before trust status came into being. I think the development in a Northern Ireland context -- we were looking at what was happening in England and we were trying to learn from that, but it wasn't up until 2003 that this actually had a statutory basis, a piece of legislation that was going to actually make this an explicit requirement for that legal entity. So the development was going on certainly before 2003 and it's continuing to develop; we're seeing further developments even currently.
MS ANYADIKE-DANES: In that context, can I pull up your witness statement, 306/1, page 3? If you see, it's the second paragraph in the answer to (e). (e) is:
"Where a patient has died and where the death is unexpected and unexplained, what were your particular responsibilities and where did those responsibilities come from?"
Then if you go to the second paragraph, you say:
"The initial responsibility would be with the consultant to consider the issues relating to or contributing to that death."
Then you go on to say:
"This would have been a convention that was a common

professional practice for many years. It would involve the consultant convening an early meeting with nursing colleagues and any junior medical staff involved."
Can I just pause there and ask you: in the context of Lucy's case, would you have thought that that convention should have led to the consultant who had taken the lead role, if you like, in dealing with her death and its aftermath, Dr Hanrahan, convening such a meeting? Is that what that would mean?
A. I think Lucy's case is complicated by the fact that the circumstances which led up to Lucy's death took place in another hospital. If Lucy had been treated initially in the Royal Belfast Hospital for Sick Children and the outcome was the same, I would have expected that consultant to have carried out an early, almost immediate -- certainly the next morning ... To sit down with clinical staff involved and carry out a review of what factors were contributing to it. I would have expected exactly the same to have happened in the case of Adam Strain and of Claire Roberts.
Q. But if we focus on the Lucy example because that is an interesting distinction, but if we focus on it. What we do know about it is that Dr Hanrahan wasn't entirely clear why it was that Lucy had died like that. In his view, she'd come in with, if anything, gastroenteritis.

That's not something you expect children to die of in the western world, certainly not that quickly -- she had died really quite quickly -- and he really wasn't sure why she had and yet the death is recorded in the Children's Hospital, so certain formal things are going to have to happen as a result of that fact alone. Would you have thought, although it's a slightly different basis for gathering your colleagues together, that that sort of convention would have involved a gathering together of those consultants, some of them quite senior, who had had the conduct of her treatment, to try and get some sort of consensus as to what had happened?
A. Yes, I see absolutely no reason why that approach could not and should not have happened within the Children's Hospital.
Q. Is that what you might have hoped would happen?
A. I think it's ...
THE CHAIRMAN: There's an alternative, doctor, which is this: there was a review which was started in the Erne.
A. Yes.
THE CHAIRMAN: There's issues about how good a review that was, but one of the issues about why it wasn't a good review was that there was effectively no involvement of doctors in the Royal.
A. Yes.

THE CHAIRMAN: You wouldn't be looking for a review of the same event in two different places, but what you would expect is that if there's going to be a review in the Erne, it's going to be a good review and it will involve the clinicians who have something to contribute from the Belfast end.
A. I think that would have been a more preferable and an ideal approach to it. I think it was a complex scenario, but that would have been a preferable and an ideal way to deal with it. And we're just talking here about the immediate clinicians involved. To go back to my statement, my expectation after any death -- any death, whether it was expected or unexpected -- is that a consultant would sit down with his or her nursing staff and his or her medical staff to say ... If he comes in on a Monday morning to find that Mrs X is no longer in the bed, I would expect professionally an early clinical discussion around why that patient had died. That is as distinct from actually carrying out any investigation, if you understand what I'm getting at. So --
THE CHAIRMAN: Is that something which has been going on for decades or are we talking about a recent development then?
A. No, I think the convention that I referred to there,

that happened when I was a junior doctor.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: That's why I asked you about that, doctor, because if something like that had happened and, as the chairman said, not yet getting into a formal review or any of that sort, "Let's just take stock as to what's happened", if that sort of thing had happened, then if the doctors discussed it in a way they gave their evidence, then it would have been clear that there would have been some difference amongst them because some of them, the anaesthetists, were of the view that what the problem is here is the fluid regime -- or at least a significant problem is the fluid regime instituted at the Erne, whereas Dr Hanrahan may have wanted to have discussed that a little further and not been entirely sure. But that would have been the start for trying to tease out their own thoughts before you then go and see, "How might we assist a review that we should anticipate is going to happen at the referring hospital?".
If I move you to that point, which is the one that the chairman raised with you, if you were going to do that, which you thought was a preferable thing to happen so that you take your expertise of what happened at the end point, if you like, and provide that to the

referring hospital's review, what would be the mechanism for being able to do that? This is in 2000. How, in 2000, would you have been able to do that?
A. Well, I think the initial clinical discussion would have been a clinician-to-clinician initiated meeting --
Q. You mean clinician at the Children's Hospital to clinician at the Erne?
A. The consultant in charge of Lucy's care in the Children's Hospital should have communicated with the clinician responsible for -- and in this case it would have been the referring clinician, I assume, because Dr O'Donohoe actually came up. So there was an opportunity there, I think, for those two senior clinicians to carry out a clinical discussion.
I go back to when I was a junior doctor and the boss came in on a Monday morning and said, "I see Mr So-and-so's not ...", he would have carried -- and if, in the context of that, issues were to emerge, it would be the responsibility of that senior doctor then to trigger other actions either and say, "Has the coroner been informed? Has a post-mortem been requested? Are there issues here about performance of any one member of staff or equipment issues or other resource issues?". So the responsibility is very much a professional responsibility to trigger escalation, if

you like, of intervention.
Q. Yes.
A. I think if there had been an early clinical meeting of all of the clinicians involved there, then referral to Dr Kelly or to myself as medical director in terms of what the next steps might have been -- and I don't think -- and you've heard Dr Kelly's evidence on this. I have to say that -- and I made reference on a previous occasion to concerns that Sir Liam Donaldson raised for doctors who are coming into medical director roles, about their skills and experience of handling difficult issues like that, particularly if a performance issue was being challenged. I think that's when a discussion would take place between, say, Dr Kelly and his director of public health and myself, maybe, into the Eastern director of public health or even the CMO. That's the level of experience and skills that the medical director then has to exercise.
Q. Then if we go to that level, so we've got above the level where the clinicians, the directly-involved clinicians have talked to each other, and it becomes clear that there is -- I think you called it a performance issue -- and that's probably going to generate some sort of investigation at some stage, have you got any experience of the one hospital to another,

so in this case it'd be the Children's Hospital being the one referred to, actually involving itself in terms of its clinicians in a review at another hospital? Do you have any experience of that?
A. I can't recall at this moment in time a joint review of the care management. I can't recall -- personally, I can't recall that happening. That's not to say it didn't, I just can't bring to mind --
Q. At that time, have you ever been aware of something like that happening subsequently?
A. Well, I was going to, in my closing remarks, make reference to another situation, but um ... I can't recall off the top -- I'm sure it has taken place. I am absolutely convinced it has taken -- I can't just recall when it ...
Q. If there are any instances, that might be helpful to see, particularly as to where they originate from.
Just finally, drawing the threads of it together, and recognising your position as medical director, when we were looking at your role and areas of responsibility, if I perhaps pull up 306/1, page 16.
Mr Chairman, this is the final section. I'm just looking at the time. It's midday now.
THE CHAIRMAN: Let's finish the final section and let Dr Carson away.

MS ANYADIKE-DANES: Then if you look at the areas of responsibility, if we perhaps pull up the next page as well. A rather formidable list of responsibilities, but those that I wanted to highlight in particular were the "professional standards" as a responsibility and the "oversight of clinical functions" and the:

"... supporting of the clinical directors and leading them in managing services and quality responsibilities. Ensuring the professional standards are maintained. Ensuring an appropriate system of clinical audit is in place. Coordinating and promoting the high standards at all stages of medical education and providing leadership on medical standards and liaising with other medical directors and also taking responsibility for certain aspects of the public image of the Trust."

So bearing that in mind, that's your remit, if you like, and if we draw together the threads of some of the things that you've been helping us with in the context of these cases, I'm just wondering if you could help us with these instances.

Firstly, the process of monitoring the management of the heads of directorate and the instances which we have been discussing is the quality of the induction and training. I'm not for one minute suggesting that you

are involved in the induction and training. This is all at your level, medical director, to manage these things and ensure that they happen. That's the level at which I'm asking you to comment.

So we've had the issue of induction and training and compliance with protocols and good practice. The adherence to commitments, you've been seeing that in relation to the coroner. The compliance with statutory obligations in relation to the coroner also, particularly the reporting of deaths and completing of death certificates. The effectiveness of internal investigations. There have been those issues and whether they were properly audited and so on and lessons learnt, properly identified and disseminated. And then the cross-directorate issues that arise because when you're dealing with children, they partly -- in PICU, partly in ATICS if the paediatric anaesthetists are dealing with them.

If we stop with that because all of those issues arguably come under the head that you have to process and monitor the management of the heads of directorate. So given that you've now had all these things trailed before you as to what happened, so this is with hindsight of course you can see that, but what were the systems and processes that you would have had available

to you to even know that these things had happened?

A. Initially -- and it's interesting that this guidance from the management executive came out at least a year after the trusts and executive medical directors were in post. And again, they're a catch-all for everything, and I have to say initially the systems were either non-existent or were extremely embryonic and it took a lot of time and effort and energy by Trust medical directors to individually put these in place within their own organisation.

Certainly, it wasn't until -- I certainly didn't feel that we got anything put in place of any structure until just after Dr Murnaghan retired and the resources which became available when he did retire to enable me to appoint two associate medical directors in place. I don't think we actually, as a Trust, got a proper structure really in place until roughly that time, so we're talking 1998/1999. I can't remember exactly.

The other thing that I think I did mention in terms of accountability -- because this all comes down to accountability and the systems that are in place to provide a level of assurance. It wasn't until we got what I would call the clinical directorate accountability reviews that the director of finance, who obviously made sure that the directorates were working,

staying within their budget and all the financial aspects -- the director of planning who actually chaired those accountability reviews, he was primarily looking at activity and compliance with the contracts that were held with the various health boards or GP fund holders, and then myself as trust medical director looking at governance issues. There might, in any one year, have been a particular theme that we were focusing on, that being maybe the development of appraisal arrangements or the development of clinical audit or whatever.

So it was only when we got that -- and that was three of us sitting on one side of a table with the clinical director, his or her business manager and his or her nurse manager. So it was a -- and that took place right across the trusts. I can't remember precisely the date that that was instituted.

Q. Roughly when would you say?

A. I would have said it was around 1998 or thereabouts that we started it. I can't remember precisely.

Q. But then, in that sort of system for the medical issues, because that's the particular aspect of that that you're dealing with, what is the system of making the clinical leads accountable to you for these areas that you've devolved to them and given them a degree of autonomy as to how they address them?

A. Well, they all had a contract of appointment as a clinical director. It was explicit in that contract that they were accountable and reported to the chief executive. Let's remember that. But professionally, they would have reported to me on issues around clinical audit, research, teaching, education and appraisal, management of performance issues, staffing issues, et cetera. So that's the level that it took place. To cover this agenda in any one accountability meeting is virtually impossible, so you've got to focus in on priority issues for the Trust, strategic issues for the Trust. You cannot cover every aspect of this responsibility for either the medical director or the individual clinical director. It's extremely complex.

Q. I know that you can't be precise about it, but you think you had that kind of system, say, established by about 1998, let's say.

A. Yes.

Q. So it is established by the time of Lucy's death in any event in 2000?

A. Yes.

Q. Lucy, as you've already pointed out, was not a child who was essentially treated at the Children's Hospital, but nonetheless there are areas of concern, would that be fair, that have arisen in relation to what happened in

her death and its aftermath? Would you have expected any of those matters to have come to you, given that the clinical leads were accountable to you for how they ran their directorates?

A. I doubt if it would have emerged in the accountability review meetings that we had, but I have to say that I was not remote from clinical directors; I met all the clinical directors collectively once a month in the medical committee meeting and there was every opportunity -- I had a very open-door approach to my office and any clinical director -- and some of them were frequently in my office on a weekly basis discussing issues with me. So there's every opportunity for a clinical director to bring to my attention, to bring to my notice, any concerns or difficulties that they were having, whether it be a colleague of medical staff or in terms of putting in place, within their directorate, issues relating to governance.

Q. Yes, I understand that, but the question was in a slightly different way. Of the sorts of issues that have given rise to concern -- and Dr Hicks has been quite candid in her concern about the way Lucy's death was reported to the coroner, the way the death certificate was issued, those sorts of things, the apparent lack of agreement amongst the clinicians as to

what had happened and so forth, that sort of thing -- would you have expected those issues to have come to you? I don't mean that you had an open door, and of course they could come and tell you those things.

A. They should have come to me.

Q. Thank you. That's what I was trying to ask you. So in some form or other, whether it's at those meetings or in some way, that kind of concern should have ultimately found its way to you?

A. That should have happened in certainly three of the children, if not the fourth.

Q. Thank you. Then just the other half of what I wanted to ask you about, which is the process for learning about and determining what improvements ought to be made to the management of the sorts of issues that come to you and which you're addressing in the field of governance.

If it appeared, as seems to be the case, that clinicians were unclear about the risks posed by low-sodium IV fluids, they had different views about that, there seemed to be insufficient, inadequate training about the whole coronial points that you've already heard about and that cases were not being appropriately, perhaps, reported to the coroner or appropriate information being given, there may have been deficiencies in clinicopathological correlation and

audit. If that does come to you, so we had what was the mechanism, we now establish whatever that mechanism was, these matters have come to your attention, then what was at your disposal for ensuring that there is an improvement and that those matters are addressed by whoever is the responsible person to do that? I'm not suggesting that you hands-on have to do it.

A. Well, what I would have done in that scenario is, first of all, I think there are two aspects to it. One, what are the implications within the specific clinical team, and in this case in the paediatric directorate, but I think more importantly my role as a trust medical director would be, "What are the implications for the across the Trust?" Because exactly the same sort of scenarios could have happened, with some variations, in the medical directorate --

Q. Of course.

A. -- in the care of the elderly or children being --

Q. Take the reporting to the coroner --

A. -- or in the intensive care. All of these things could arise anywhere in the Trust. My first avenue for raising this issue would have been through the medical committee where all of the clinical directors came together and, if I had a concern about issues around reporting to coroner or issues in relation to death

certification or issues around incident reporting and lesson learning, if I felt there was a deficiency or a shortcoming in that area I would have addressed it initially at the medical committee. In other words every clinical director would have known that I have a concern about this. I would have then maybe asked one or two of those clinical directors to set up a working party. They would have done a piece of background reading, background research, maybe come up with standards, if they didn't exist regionally within Northern Ireland to look elsewhere put together a document and say, "Here is a way forward, here is some guidance on how this should be done", we would have then had to bring that to the hospital council to get formal approval from hospital council. It may or it may not have been referred to the Trust board if the chief executive felt that it was necessary, but many of these things did not need to be referred; they just needed to be done within the organisation.

So the first thing would have been for me to have raised it with the clinical directors collectively, maybe put together a small working party to establish a direction, a way forwards, and then to implement that and take it forwards across the Trust. That would be the way that I think these issues should be handled and

that's the way I would expect them to be handled nowadays, and I can't comment specifically on what's happening in any of the five trusts at the moment, but that would be my expectation of how a thing got escalated, formalised and then recommendations put in place.

Q. And then maybe if one closes a loop on that, so you've got your working party, it has produced some recommendations, you bring those recommendations back, they get approved, that cascades down, I presume, to the clinical leads, or whomsoever are the appropriate clinical leads, to make sure that those standards are put in place and then, if they are failing or there's a failure to adhere to them properly, that becomes another matter that you would expect to come back up to you?

A. That could emerge -- once we had formalised an approach to how this would be handled across the Trust, that would then become an issue for the accountability review --

Q. Exactly.

A. -- and each clinical director would report on whether they've delivered that or whether they have been unable to deliver it and then there would obviously be consequences.

I mean we -- over my tenure as trust medical director, those nine or ten years, or whatever it was, we came across business managers who weren't up to the mark and even clinical directors, and we've had turnover of clinical directors whenever we felt it was necessary to move on.

Q. So the result of all of that is you did have a system which could have addressed some of these things, but that system could only have got into gear, if I can use the colloquialism, if you are being appraised of these difficulties? Once you're seized of them, then you can put your machinery in place, but the problem may have been that for whatever reason, and so maybe lower down, you have your governance failing, those deficiencies weren't being picked up and channelled up to you; would that be a fair summary of it?

A. I think that's a fair summary. And I have to say that every trust medical director -- and I am not referring to myself here -- once it gets escalated to that level, they're very clear on what their responsibilities are.

MS ANYADIKE-DANES: Thank you very much.

THE CHAIRMAN: Are there any questions from the floor? No?

Doctor, just before you go, when you were here in January giving evidence in Claire's case, there were a couple of governance issues that you raised and I just

wanted to follow up on one of them.

You said at that time that you were co-chairing a group with Mr David Lavery about the work of coroners. Is that still sitting or --

A. No, no, that piece of work was completed at that time. I think there was an expectation that further work needed to be -- and I understand this would be around ... I'm getting cramp, sorry.

THE CHAIRMAN: Do you want to take a break?

A. It's okay. There was further work to be done around death certification, chairman. One of the points I was going to make by way of summary today was --

THE CHAIRMAN: You go on ahead then.

A. I think one of the key issues -- and I think maybe one of the -- in terms of the product from the inquiry in terms of your report, I think one of the key issues is around the area of investigation of death. I think it's a greater issue than the problems that arise around certification of death and I think, in terms of the work that was being done nationally following the Shipman inquiry and various other initiatives around the coronial system, I think there is need for real clarity around how investigation of death is to be followed through.

THE CHAIRMAN: Do you mean within the hospital setting, or

is that the starting point?
A. I think that's the start of it. I think there's a much wider issue that goes outwith the individual, clinical domain into the hospital and system-wide. Because these -- thankfully deaths of children are, in relative terms, less than they are with other age groups. But can I just draw a comparison here? I think if you take the situation of children who die under the care of Social Services and whether it's child protection issues or what, trusts are required -- in a situation of a child under social care, under management of Social Services, trusts are required to report death to a safeguarding board. There is an immediate case-management review panel established with an independent chair. There is a time frame for a report to be compiled, that's either 12 or 26 weeks, if I recall. There are powers under enabling legislation in relation to the safeguarding board. So here we have a situation where children under the care and auspices of Social Services where there is an immediate case management review.

If you take, for example -- and everybody will be familiar with the Briggs case, for example that took place locally here, and we've got Baby P and the Lewis review --

THE CHAIRMAN: Sorry, doctor, for those who don't know, doctor, the Briggs case was about twins who came over from Romania with the intention that they be adopted in Northern Ireland and one of the children was killed.
A. One of the children died as a result of injuries and there was a case-management review put in place for that and there was subsequently a review of the effectiveness or otherwise of that. But what I'm emphasising was it was the fact that there was a requirement to carry out a case-management review with an independent chair. And also pertinent to that particular review of the Briggs case, steps were taken to put in place a child death review protocol. Now, we're talking -- the Briggs case, I can't remember the precise date, but we're still waiting for that child death review --
THE CHAIRMAN: It's about 10 years ago.
A. Right. We're still waiting for this child death review protocol. To the best of my knowledge, that protocol on the investigation of a child death has not been issued.

So if we move on from Social Services, if a child is under the care of Mental Health Services in Northern Ireland, under the Mental Health (Northern Ireland) Order (1986), it requires that a serious adverse incident is reported within 12 weeks to the Health & Social Care Board, to the Regulation

Quality Improvement Authority, now that it has subsumed the functions of the Mental Health Commission, and an investigation is required to be opened up with an independent chair. Although it is conducted by the Trust, it's got to be conducted independently.

So it's interesting in a situation of Social Services and in the situation of children under mental health that there are more explicit arrangements in the investigation of death. Now, I think there is a gap in relation to children who die in any other situation outwith Social Services or outwith mental health, so I think there's a gap there.
THE CHAIRMAN: Just before you move on, if you are moving on to another point, the question then might be: which children's deaths are investigated? Because I presume you exclude from that children who have leukaemia or some other issues. Am I right in that assumption that you're excluding deaths by disease?
A. Well, this is the problem, and I suspect this is why all of the steps that were expected to be put in train after, for example, the Briggs case or after any other serious incident nationally, I suspect that this is one of the reasons why it has stalled because they were fearful of creating a bureaucracy around the investigation of deaths that would have been expected

or, if you like, natural death. But given that children's deaths, relative to deaths of older people, are fewer, maybe something could be put in place. And certainly even if the child was an expected death, in leukaemia, did that child die earlier than would have been expected or was it later? That's not to say that a lesson couldn't be learned from it.

I recognise there's obviously a danger here in terms of age that we maybe value deaths of children more significantly compared to any other vulnerable adult or an adult with learning disabilities or an elderly person, for that matter, so I recognise that there's a balance there.
MS ANYADIKE-DANES: If you were doing that, if you were instituting a system which at least required that all those deaths would be required and, to a degree, whatever was thought appropriate, investigated, would that not at least enable somebody interrogating such a system to see the parallels, similarities, those sorts of things to deduce from that what are some of the points that could be addressed and might have more general applicability?
A. Absolutely, and you're more likely to get regional guidance coming out that could then be formally disseminated to the service. What we've been talking

about has been far too loose and no real -- really no responsibility on the Children's Hospital other than "It would be nice", "it would be good practice", or "It would be beneficial". I think this would have more chance of actually formalising the development of guidance. We know that the department did put together -- actually in many ways way ahead of elsewhere in Great Britain or elsewhere in Europe -- guidance in relation to hyponatraemia. But I do think that if it was more formalised in some way or other then -- I do recognise also that root-cause analysis has developed and various other instruments are now available to trusts and they do use them on a regular basis.

Q. But your system would be across the region, though. The benefit of that is that you would be able to see the deaths across different trusts as opposed to each trust looking at their system to see if there are patterns of failings there. This would allow you to compare across the different trusts the incidence of any particular condition if that could be disclosed by the research going on or the investigation going on into those children's deaths?

A. And particularly in conditions that are not common. In this situation, I think we have got four children who have had almost quite unique features in terms of their

clinical conditions, but a number of common themes, not just hyponatraemia. The other thing I think that is needed -- I think doctors in particular -- maybe it should be extended to Health Service managers as well -- but doctors in particular are not trained in review methodology. Whenever you say it was the responsibility of a clinical director or a medical director to institute an investigation, I think that there's a real gap here. Doctors are required to give opinions and to write reports, particularly if they've got a medico-legal practice, but generally speaking doctors are not skilled in making statements, be it for the police, be it for the coroner, an investigation or an inquiry. And medical directors, certainly during my time and maybe even more recently, have had very little experience or training in how to convene an investigation. So I think there's -- if there was something more to be done around the investigation of a death, it would be to enable medical directors, and in particular chief executives, to ensure that proper arrangements were being instituted and put in place across the service.

(The witness withdrew)

THE CHAIRMAN: Thank you very much indeed.

Ladies and gentlemen, we're going to break for a few

minutes. I had intended to deal with the suggestions, Mr Quinn, that you put forward, but I've received a message which means it might have to be -- that discussion might have to be put off for a day, but let me go and follow up on it. I'll come back in five minutes. Thank you.

(12.30 pm)

(A short break)

(12.55 pm)

THE CHAIRMAN: There were two issues raised on Monday, Mr Quinn, on behalf of Mr and Mrs Roberts. One is about addressing some further questions to Dr Webb about midazolam; the second issue is a query about making enquiries about forensic testing of the original notes and records.

I think Miss Flanagan is here on behalf of Tughans. I understand that Dr Webb's position is to leave this in my hands. Thank you very much.

Mr McAlinden, does the Trust have any position on these issues?

MR McALINDEN: The Trust really adopts a totally neutral position in relation to this issue. If you, Mr Chairman, think that the tests are necessary, the Trust will certainly facilitate the production of the notes.

THE CHAIRMAN: I'll deal with the tests in a moment.

I think the easier one is about whether we should ask some more questions of Dr Webb on midazolam. Unless anybody who I haven't heard from yet, orally or in writing, has a contrary view, then I will go ahead and organise that.

MR QUINN: Could I make one further point? In relation to the fluid management of patient W2, there's one reference, and it appears at 150-016-004a. This record can't be brought up because of the nature of the record, but the record on that page, if you look at it, sir --

THE CHAIRMAN: Is this W2?

MR QUINN: This is W2's records. The page notation is 004a. And you'll see the page starts on 17/10/96. The importance of that particular record, to go along with what I've already submitted in writing, is that Dr Webb actually is commenting on the prescription of IV fluids, whereas my recollection -- I haven't checked this this morning -- is that when he gave evidence he said that he didn't normally concern himself with the prescription of fluids.

When that is set against the issues that I've raised in relation to W2 and midazolam, I would respectfully submit that some provision should be made for Dr Webb to come back and give evidence on this point because, on

the face of this documentary evidence, we have undermined his testimony in relation to the prescription of W2, and with the greatest of respect, sir, the parents would like to hear him on this point under oath.

THE CHAIRMAN: Let me see what he says in writing first and then we'll take it beyond that.

On the forensic testing of Claire's notes and records, Mr Quinn, there are two routes suggested. I think you have recognised in your note that there is a question mark about the feasibility of doing ink testing.

MR QUINN: Yes, there is. Mr Green and myself have discussed this and we've actually -- Mr Green hasn't, as it were, contested very much in relation to what I've said in my conclusions section. So therefore, we're on all fours in relation to getting the document tested in some form, and yes, there is a problem, there may be a problem, but given that the paper that I relied upon was written over three years ago, this science may have moved on. So with respect, sir, the first question might be: can it be tested at all?

THE CHAIRMAN: Because the gist of that paper is that there aren't reliable techniques.

MR QUINN: That's correct.

THE CHAIRMAN: So the request could only be developed if

there are now reliable techniques which are not referred to in the paper from May 2010?

MR QUINN: Precisely, sir.

THE CHAIRMAN: While I have no hesitation at all about questioning Dr Webb further than he has been questioned before, I'm really quite hesitant about this, and I will think about this overnight in view of the exchanges today. That's about the ink testing.

I have to say, I'm even more concerned about the ESDA testing. For the ESDA testing to be a runner at all, we have to know what the sheet below the relevant page is.

MR QUINN: May I respectfully submit that we are not experts in this field. We all think of ourselves as experts to some degree because we've all been in trials where these methods have been disputed and argued about and given evidence on. But my first line of attack, as it were, on that paper would be to ask the experts, and what normally happens by way of legal services consent is that (a) the experts are asked, one set of agreed experts is picked, their expertise is enquired about in relation to whether they can prove or provide expertise in relation to that subject.

Once they say, yes, they can be of use on that subject and then we could ask how much it would cost.

THE CHAIRMAN: I'm sorry, the point is that this typically arises in a criminal case where there's an argument over what police say they have noted in terms of a confession by a defendant.

MR QUINN: Correct.

THE CHAIRMAN: What has sometimes been established in the past is that notes have been added to or altered or page 1 has been completely rewritten to include something which incriminates the defendant, but a trace of that cannot be found on page 2 and that supports the defence thesis, which is that the defendant did not make the admissions and the notes have been rewritten to establish guilt. On that scenario, you know what page 1 is and you know what page 2 is. We know in Claire's case what page 1 is. I think the question is whether we know what page 2 is.

MR QUINN: Yes.

THE CHAIRMAN: And what I would like to be done in the next 24 hours -- I'm sure Claire's notes and records aren't here, Mr McAlinden, I'm sure the originals aren't here.

MR McALINDEN: They were returned to the Trust.

THE CHAIRMAN: I wonder could those notes be taken back from the Trust, or at least brought here by you or somebody on behalf of the Trust over the next day or so --

MR McALINDEN: Yes.

THE CHAIRMAN: -- to see if it is possible to assert with any degree or establish with any degree of certainty what the pages below the relevant entry in Claire's records are?

MR McALINDEN: Yes.

THE CHAIRMAN: Because I think it seems to me at least that the potential value of sending a collection of medical records stretching over a number of pages for ESDA testing -- I suspect the first question that the examiner would ask for is, "What was the page below the relevant page?" If that can't be answered, it makes the whole process far more difficult.

MR QUINN: And I did submit that in my paper. I provided a number of scenarios where it might not be relevant at all. So perhaps the first test is what you suggested, chairman.

THE CHAIRMAN: Then let's start that process, if we can, over the next day. If it's at all possible to bring them back tomorrow for the parties to look at to see how close we can get to establishing what the page is below the relevant page.

MR McALINDEN: It might be necessary to ascertain how medical records are actually produced in the hospital because it might well be that there are a blank stack of clinical records and individual pages taken by

a clinician who then makes an entry and then these pages are then collated together in the file. So it might well be that there --

THE CHAIRMAN: [Inaudible: no microphone] just taken off a pad?

MR McALINDEN: -- as opposed to forming a page in a pre-organised booklet.

THE CHAIRMAN: I will consider making further enquiries about this, but I need to have a clearer basis so that I can decide that this is actually worth referring to an expert at all.

MR QUINN: I understand that.

THE CHAIRMAN: We're here tomorrow and then we're here on Monday and Tuesday. I would like to get this issue sorted out within that timescale because obviously we need to get this off. If it could be brought tomorrow for these discussions to take place, and if it can't be brought tomorrow, at worst it will be brought on Monday.

Is there anything further today?

MR QUINN: Nothing further.

THE CHAIRMAN: Then we'll start with Dr MacFaul tomorrow at 10 o'clock. Could I tell you now that on Monday, for various reasons, which are not personal to Professor Scally, we're going to have to start at 9 o'clock. Okay? Thank you very much.

(1.08 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X