Thursday, 20 June 2013

(10.00 am)

(Delay in proceedings)

(10.21 am)

THE CHAIRMAN: Good morning. I'm sorry to have kept everyone waiting for almost half an hour. I'm afraid something came up that had to be dealt with. I'm sorry, Dr Frawley, to keep you waiting in particular.

Mr Wolfe, shall we start?

DR THOMAS FRAWLEY (called)

Questions from MR WOLFE

MR WOLFE: Good morning, sir. You have provided to the inquiry one written witness statement, which is numbered WS308/1. It is dated 5 February 2013. We ask all of our witnesses whether they wish to adopt their witness statements as part of their overall evidence. I take it you would wish to adopt your witness statement?

A. Yes. If I may through you, chairman, there's just one minor amendment I would like to make or ask to be noted. In the account of my employment, I don't think I have accurately recorded the nature of my role between 1996 and 2000. Chairman, through you --

THE CHAIRMAN: Of course.

MR WOLFE: Is this page 3?

A. This would be page 3, indeed. What I would have wished

to insert there is, in 1996, the trusts came into being and then I had a different role, if you know, because the way I've described it, it look as though that was a continuum from 1985 to 2000.

Q. Of course that's otherwise addressed in your witness statement.

A. Yes, of course, sorry. On the next page it's clarified.

Q. Yes, and we'll no doubt look at that. Can I just go into your witness statement a little and look at your qualifications and career history. If we could start at page 2 of the witness statement -- so that's WS308/1, page 2 -- you set out your academic and professional qualifications: a BA from Trinity College, participation in the national graduate training scheme, certificate in health economics, and latterly your honorary doctorate from the University of Ulster.

Over the page then to where you referred us, page 3, and that is your career history. You are currently employed as the Assembly Ombudsman and the Northern Ireland Commissioner for Complaints?

A. That's correct.

Q. And you have held that role since September 2000?

A. 1 September 2000, indeed.

Q. And it's the role immediately before that with which we are most interested this morning, and that was your

role as general manager, sometimes described as chief executive, of the Western Board.

A. Yes. I should explain that because I sensed in one of the transcripts I read that it was rather frustrating, the chairman at one point, whatever Mr Frawley was called at the time. I think that the situation was that I had this sort of view that there could only be one chief executive and, as I understood it, it was the individual who ran the executive arm of the Department of Health, or the HPSS Executive as it was known, and I felt then it was -- the title that was appropriate to my role was that of general manager, so there wasn't any provenance to it other than that, chairman.

Q. Yes. And you have already alluded to this, in the first box on that page, where you describe that:

"[You] had overall responsibility for ensuring the Western Board fulfilled its statutory duties and managerial responsibility for all Health and Social Services and staff working in the geographical areas served by the board. [You were] accountable to the chairman of the board and, through him, to the board appointed by the minister. [You were] also accountable officer for financial resources allocated to the board."

A. That's correct.

Q. As you've said, there was, if you like, arising out of

a fundamental change in how health was provided and managed in or about 1996, a sea change, if you like, in your responsibilities, which we will look at.

You have provided us with your job description, but it's helpfully, I think, summarised at page 4 of your witness statement where you indicate there are four key areas of responsibility and the bullet points underneath at the bottom of the page highlight some of those individual areas that were key.

Within your job description, if I could just turn briefly to that -- if we could have up page 41 in this sequence -- at the bottom of the page, one of the key requirements under the heading "Partnership/working relationships with others", there was an onus on you to:

"Develop effective HPSS partnerships with trusts/independent contractors/other providers and the western Health and Social Services Council, et cetera."

So we're talking in the post-1996 era now, within your area there were three trusts, the Foyle, Altnagelvin and importantly, from our perspective, the Sperrin Lakeland Trust.

A. Correct.

Q. So there was an importance attached to the need to develop effective relationships with these bodies, specifically imposed in your job description?

A. I would go further. I would say probably, in my view, the success of the Western Health and Social Services Board actually was critically dependent on the success of the three trusts in delivering the quality of care and service that our population required. So it was about building a relationship that would, in my view -- and I believe in the board's view -- create a successful delivery system for the people living in the west.

Q. As you will be aware, we've been anxious to obtain some help from board witnesses just in terms of the nature of the relationships between the Western Board on the one part, the Trust on the other, and then the department in that period after 1996. It was March 1996 when the Sperrin Lakeland Trust formed; isn't that correct?

A. That's correct. I think, chairman, just for clarification, there was a shadow period before that when they, in a sense, to all intents and purposes were operating, but they still hadn't had the full panoply of authority invested in them until 1 April 1996.

Q. What we're most interested in is in relation to this whole concept of accountability, and the summary position is that pre-1996 -- and leaving aside this shadow point, we've got you on that -- but pre-1996 there was a unit of management which was directly accountable to the board; isn't that correct?

A. Yes.

Q. And then post-1996, the trusts were formed and assumed an independence of the board, which, as I understand the position, meant that they were not directly accountable to you and to your organisation.

A. Absolutely, chairman. I would describe it as an autonomy. They developed their own autonomy and they were then accountable to the department directly.

THE CHAIRMAN: Can I take you back to just before 1 April 1996? I want to ask you about how you react to the evidence that William McKee gave when he was giving evidence about what had happened in Adam's case, Adam having died in November 1995 in the Royal. By that time, the Royal was a trust, so it was a little while ahead of the Western Board area and the trusts being legally established. But what Mr McKee said was that at that time and until 2003, he, as chief executive of the Royal Trust, had no responsibility for the quality of care provided by the Trust. In 1995/1996, when you were the general manager of the Western Health Board, pre-trust, did you regard yourself as having any responsibility for the quality of care provided by the Western Health Board?

A. I would consider myself to have real and crucial responsibility for that, chairman.

Chairman, if I could elaborate on that. I suppose, to give you an example: in terms of medico-legal issues and so on, where there was clinical negligence and other things, we were directly involved in all of that, and equally, if you look at the complaints system as it was developed in 1996 -- and clinical decisions came under the remit of the Ombudsman -- at that time I would have had direct responsibility for responding to complaints and those would include complaints about clinical practice and clinical decisions, and therefore I would see a clear accountability at that time.

THE CHAIRMAN: I don't know if you had a chance to look at Mr McKee's evidence, but we've referred to it a couple of times over the last few weeks. His line seems to be that, until the 2003 order was passed, which imposed formal legal responsibility on the trusts for the quality of healthcare, there was no such responsibility on the trusts and, I think perhaps by extension, that means there would have been no responsibility on the boards before that.

A. I think if he was talking about formal legal, I wouldn't consider myself competent to necessarily see the absolute nuance of that, but I certainly, in terms of both the engagement I had with clinicians and the engagements with the issues that clinicians were

involved in, was not in any way reluctant to engage in discussions about clinical matters and clinical issues, and I would see that as part of my overall responsibility to be in a position to give account to the board for the performance of the whole system.

THE CHAIRMAN: The trust that he was specifically talking about, the Royal Trust, and he said that issues about quality of performance barely reached him, that they were in the remit in those days of the individual consultants who were responsible to their professional bodies and to the GMC.

A. Well, I would say, again, that there was a constant tension in that. I'm not in any way saying that doctors in the Western Board accepted or acknowledged the role or accountability to the management, but I would see it as an issue that we continued to pursue and one that I think, for example, Dr McConnell played a very key role in when you look at his responsibility in terms of appointment processes, employment arrangements and participation in interview panels where he would have been, with others, assessing the clinical qualifications and competence of people who were presenting to be employed in the Western area at that time. And I would have assumed that, once the trusts came into being, the chief executive of the trust would have had a similar

role sitting on a panel. So it seems to me, when you're at that stage deciding and contributing to the decision on who should be employed, you have a clear interest and responsibility in the performance of that individual once appointed.

THE CHAIRMAN: I don't want to try to summarise it too crudely or broadly, but do it take it from what you've said in the last few moments that you don't think you could be the general manager of a board without accepting that you have some responsibility for the quality of care provided in that area?

A. I would have no difficulty with that, chairman.

THE CHAIRMAN: Thank you.

MR WOLFE: Skipping back then to the post-1996 era, Mr Frawley, let's have up on the screen how you defined in your witness statement the nature of the relationships between board and trust. If we could start at 308/1 at page 6. You're saying that:

"As general manager of the board, [you] ceased to have any responsibility for the operation, management or supervision of the services provided by the Erne Hospital with the creation of the Sperrin Lakeland Trust in March 1996 [as you've said]."

A. That's correct.

Q. "At that time, the Western Board ceased to have any

operational management or supervisory responsibility for the three trusts which were established. In relation to the control of services [you say], as general manager I was responsible as accountable officer for the commissioning of services and the signing of service agreements as well as leading on the monitoring of the performance of the trusts under the service agreement."

If we could stop there. Can you illustrate, comparing and contrasting pre-1996 and post-1996, leaving aside the notion of control of services, which you've defined there? Let's talk in terms of adverse incidents. Pre-1996, as compared to post-1996, how would you have defined the change?

A. I suppose if I was trying to explain it to you, I would have seen myself pre-1996 very much in the role that Mr Mills was in post-1996, very much at the centre of establishing the process, becoming involved in the arrangements, the terms of reference, the people who would undertake it, the sort of time frames and the outputs we'd be looking for and then making sure that process was underway and was completed.

I had no such responsibility post-1996, so I was looking in on that from a distance, but with a direct and particular interest in the outcome of that review, investigation.

Q. Thank you. That's very clear. If we could move to a diagram I think you've provided. If we go over in the statement to page 11, please. This, in diagram form, explains to us, does it, the post-1996 arrangements? The line at the bottom between the board and the trust, that reflects the purchaser/provider relationship?

A. Yes.

Q. The board is commissioning services from --

A. The trust.

Q. So I think, as you say, over the page, page 12, that isn't a hierarchical relationship?

A. Not in any way. And in some ways, chairman -- and it might help the inquiry -- this is not an easy adjustment for someone who's been in an accountable relationship with the system. You suddenly, if I might use the metaphor, don't have the levers that you could pull before or the accountability relationships or the authority you could invoke before. You're now in a situation where you are, to some degree, in a more passive role awaiting and seeking the information without necessarily the same level of authority to have it delivered to you.

Q. What then of the department, Mr Frawley? There is plainly, in this drawing, a hierarchical relationship there into which the trust and the board separately

feed.

A. Yes.

Q. Can you help us with your understanding of the trust's obligations with regard to the department at that time?

A. Well, I don't know --

Q. Let's bring it to the year 2000.

A. Okay. I don't know whether this might help, through you, chairman, but it would be very much, the department was the principal and we were both, if you like, agents of the department. The board, with a particular set of responsibilities and functions to fulfil, in terms of the population served, the trust with a very specific role in terms of delivering services as specified by the board. And then we were directly accountable to the department for those specific functions we had: the trusts for the delivery of service to the individual patients; the board for the commissioning of services for the population served. So two very distinct accountability lines into the department, if that would help.

Q. Can I bring it down to adverse incidents again? Let me ask you this: was it your understanding at the time that, given the nature of the accountability arrangements that were in place, that the trust had an obligation to be reporting to the department where there

were adverse incidents?
A. Well, I would believe so. That was my view of it and that would have been exactly, if I may again refer back, the circumstance before the trust was established, that would have been the responsibility of the board to make those reports. I clearly then would see in the new relationship the trust's responsibility was to report those things to the department.
THE CHAIRMAN: But do I take it that, as with the board before, pre-1996, that what you reported to the department would depend on the seriousness of the incident?
A. Absolutely, absolutely.
THE CHAIRMAN: So the department doesn't want to be troubled with every incident?
A. Absolutely.
THE CHAIRMAN: But it does want and need to know about the serious ones?
A. Absolutely, chairman, and I've had, thanks to the efficiency of your secretariat, an opportunity to look at the evidence given by both Mr Bradley and Dr McConnell, and both highlighted rather well there would be a gradation of issues and clearly serious adverse incidents, I think as Dr McConnell emphasised yesterday, had the potential to have a publicity around

them or a controversy around them, clearly the judgment would be made that the department would need to be aware of that. And certainly, if it had an implication for the safety of services or for, I think, as again Dr McConnell alluded to, maybe an infectious disease or whatever it might be that would alarm the public, again it would be vitally important that the trust alert the department to those issues.
MR WOLFE: Let me jump back again to the board/trust relationship. You will have had an opportunity in preparation for today to consider the report furnished to the inquiry by Professor Scally.
A. Yes indeed.
Q. And I wonder could I put his interpretation of the post-1996 relationship to you. He says, interpreting the evidence that he has seen, that:
"The culture of management, some of the procedures in place and the communication pathways appear to have persisted into the period after the creation of the Sperrin Lakeland Trust."
And if I can, what he appears to mean by that is that in the context of adverse incidents, there appeared, at least on the trust side, to be an understanding that they were required to report to you, their commissioning body, serious adverse incidents.

A. I think I do want to say that I would have an absolute expectation that they would, as the commissioning authority, advise me if a patient that was within the population we were commissioning services for experienced an adverse incident or indeed an outcome, then I would want to know about that because that would have clear implications for the wider service that we were commissioning, potentially, or indeed for that specific patient. So I would have an expectation.
Equally, I would have, if I worked in the Northern Board that were commissioning services, and as I understand it, the trust would have provided services to some small part of Northern Ireland and equally they would have been advised if one of their residents had been affected. And I think that's just the standard of relationship we had. I had that expectation and I think, if you -- and you will, I think, chairman, have received from me a copy of the service level agreement. I wouldn't in any way claim that this was a finished piece of business, but we were working on clinical governance and we did highlight to all of the providers that we worked with that adverse incidents were a key part of the accounting relationship that we expect to see developed. I'm not --
Q. Sorry to cut across you, and I'll let you finish. As

you talk about the service level agreement in that context, let's turn to page 67. I think this is what you're talking about. This is the SLA that was signed off between yourself and Mr Mills in or about 1999. So it would appear to be the agreement that was current at the time of the particular adverse incident affecting Lucy Crawford. Help us if you can then. This is the section of the agreement dealing with clinical governance.
A. Yes.
Q. We are aware from other witnesses that the development of the systems and structures around clinical governance were at their infancy at this point in time and really didn't get up and running until late 2000 in shadow form and thereafter. So what was the board about or interested in in having this section included in the agreement?
A. Well, I think, as again in another document I shared with the inquiry as part of my evidence, we as a board were working with our sister boards in Northern Ireland to build a better understanding of what clinical governance meant for commissioners and purchasers of service. And clearly, out of that we were then trying to give life to those ideas in a practical way and clinical governance, as described in the service level

agreements, is the beginning of establishing those arrangements and what we're saying, if you like, at 5.2 is that, as we build the system, we want to begin to see the processes for recording the risk management programme, clinical audit arrangements, evidence-based medical practice and a supportive culture. All would be part of -- we would be looking for evidence of that as evidence that the providers we were contracting with were developing sound clinical governance arrangements.

Q. Yes. Just looking at that first bullet point at 5.2:

"To be effective, a clinical governance programme must include key elements such as processes for recording and deriving lessons from untoward incidents, complaints and claims."

A. Mm-hm.

Q. And as we will see in a moment, is that in, if you like, in principle the board imposing upon the trust, as part of this contractual arrangement, a requirement for the trust to be proactive in following up on adverse incidents, medical accidents?

A. Absolutely.

Q. And learning from them?

A. Absolutely.

THE CHAIRMAN: In other words, if you're commissioning a service from a trust and the trust has been sued or is

receiving complaints against it or has untoward incidents, you want to ensure that the trust learns lessons from those so that the service which you are paying for is improved?

A. Absolutely, and indeed I suppose fundamentally, as tragically emerged here, that if there is learning we need to identify it very quickly and implement it very quickly because the protection and the quality and the safety of the service can become part of that process.

THE CHAIRMAN: Sorry to interrupt, Mr Frawley, but what has come across repeatedly in the inquiry hearings over the last year is the reticence, particularly of doctors, to express in clear, unambiguous terms concerns and issues about other doctors or about themselves. And if there's one striking feature emerging from the inquiry, it is of doctors -- to put it, I think, kindly -- pulling their punches. Up to 2000, when you were actively involved in this -- and I know that your continuing position brings you into some contact with this -- was that recognised as a problem?

A. I think, chairman, it was. I think that that was always difficult. The reality was, I suppose and again rather sadly, and I suppose reflected in my appearance, I've been doing this since 1971, what I have seen -- and I think you might be critical of it in 2012 or 2013 -- I

mean, what we've seen is incredible progress in all of that from the time when I entered the Health Service in 1971, where the medical part of the Health and Social Care system was a very closed piece. The issues of clinical autonomy were absolutely preciously defended, clinical freedom was the recourse that everyone would go to in terms of a decision they made, and I think over time that has changed and I think there is oversight and there's scrutiny now on a level that most doctors would have found unthinkable, however limited you might now see it. But certainly there has been, I think, a transformation in that, but I think I would be the first to say, even in my new role, there still is a lot of ground to travel on these issues, yes.

THE CHAIRMAN: Thank you.

MR WOLFE: Mr Frawley, just translating what appears on paper to be an interest given contractual form in terms of an obligation upon the trust to keep its house in order in terms of clinical governance, getting information into your system then when things go wrong, that's what I want to move on to next. There seems to be two stages, and I want to look at this in two stages.

First of all, what happens when a report of an adverse incident comes in to your system, and then, secondly, what happens at the stage after that has been

further investigated by the trust, what happens at the board once it has been investigated?

Dealing with the first of those stages, you've told us in your witness statement that there were no formal procedures in place in or about 2000 for the reporting of untoward deaths by the trust to the board.

A. Yes.

Q. However, there was, nevertheless, an expectation that the trust would notify the lead professional officers at the board. And by that, you mean Dr McConnell and Mr Bradley; is that right?

A. That's right. And equally, I think, important to remember in an integrated service, if it was in a social care setting, the Director of Social Services would be informed if that was where that adverse issue -- so there were, if you like, three lines in, and there would be an initial contact, as happened in this case, with Dr McConnell, because this was a clinical matter and that is how it developed. Clearly, then there were other aspects to the issue and Mr Bradley became involved through the nursing line, and then I'm sure we'll come to it, I became involved then in May, in fairness -- and I want to confirm this -- both to Mr Bradley and to Dr McConnell, although I can't specifically recollect the moment they told me.

I certainly was aware from them there was an issue around an adverse incident in the Erne Hospital that was being examined.

Q. Yes. We'll descend into the specifics in a moment, but keeping it at this general or theoretical level, could I ask you: you have said in your witness statement again that if a report came in to the board, the onus would be on the professional leads to seek assurances that an investigation had been initiated?

A. Yes.

Q. Can I ask you this: Dr Kelly, who was the medical director at the Trust, the Sperrin Lakeland Trust, has said in the context of a report being made by the Trust to the medical side, the medical professional side within the board, that is to Dr McConnell, he would have had an expectation or an understanding of Dr McConnell's role that it was for him, that is Dr McConnell, to satisfy himself that the investigation being conducted was appropriate?

A. I think that obviously, as a professional lead, Dr McConnell would be involved in supporting the Trust in its arrangement to make sure that whatever emerged from the process would meet the needs of the commissioner in informing whatever next steps might be necessary. So in a sense, I would concede the point

made that Dr Kelly had a reasonable expectation that, if a process was embarked on and that Dr McConnell was aware of that process, that Dr McConnell was satisfying himself that the process would work and achieve the outcome he needed in order to inform the decisions the board may need to take going forward.

Q. And if we could just look at what Dr McConnell has said in definition of his own role. It's at 286/1, page 4. He says there at item (e):

"In such circumstances [those are circumstances where an unexpected and unexplained death has been notified to the board] my role within the board would be to notify the director of healthcare ..."

He's explained yesterday that that is a bit of a slip on his part because, as at April 2000, he was wearing that hat and the hat didn't transfer to Mr Bradley until late summer.

A. That's correct.

Q. "And through him, or directly if that was not possible, the chief executive [that is you] and the board, I would also advise what I knew of the circumstances, what action I was aware of being taken within the Trust and whether there was the potential for wider implications immediately apparent from the event in other settings, either within or outside the Western Board area.

"If I considered there were potential wider implications, I would notify my directors of public health colleagues in other boards and the chief medical officer or the department of the issues. At that time those responsibilities were derived from my own role/job description, and that of the Western Board and Social Services board and from a commonsense approach."

I take it you would have no disagreement with that broad description?

A. No, I would be content with that, chairman.

Q. Descending into slightly more specific territory, could I put up on the screen, please, Mr Bradley's account of what he would have deemed important for himself as a professional lead to do if notified of an adverse incident? That's at 307/1, page 3. Again, under (e) at the bottom of the page, it's a broadly similar question to that which was directed to Dr McConnell. What he says is:

"If a trust notified me of an unexpected or unexplained death, I would have asked the trust to explain what action was being taken to investigate the circumstances, and also ask if the coroner had been informed. I would have suggested that the trust considered making the department aware of the situation if the death was giving cause for concern, could have

implications for patient/public safety, or likely to be of public concern. I would have also requested that learning from the death or the circumstances surrounding the death would have been communicated to the board. I would also have shared such information with the director of public health and chief executive. I would seen this as the responsible approach to take."

So a degree of overlap between your two professional leads, but taking your understanding of their role within your organisation and perhaps by reference to your understanding of their job descriptions, thinking back, are these fair descriptions of what you would have thought that they might be doing if a report of an untoward death came in?

A. I don't have difficulty with either of them. Obviously, looking at it, and having the opportunity now to look at both alongside each other, clearly the approach that Martin Bradley indicates he would have taken is probably, in light of the events, the more effective approach.

But I think one of the issues that strikes me in looking at Dr McConnell's view is that what he was describing was the very early stage of -- there was no sense about the scale or the gravity of the circumstance that unfolded, I think. So I'm not sure at which stage

Martin Bradley would have taken this and how much information he would have needed to do this. The term "adverse incidents" is being used here, but really I think Dr McConnell in his description, as I understood it, was describing his initial interaction with the Trust. I'm not sure how much information Martin Bradley would have had in coming at it with this much more comprehensive response.

Q. In working through this checklist, let's deal with what the board might have expected the Trust to have done external to itself. We heard from Dr McConnell yesterday with regard to his understanding of what the Trust should have been doing in the direction of the department. So he's saying that the death of a young child in a hospital setting where, if you like, the background disease wouldn't have given you cause for thinking that the child should have died --

A. Yes.

Q. -- that is a matter of such significance or such moment that you would inevitably be thinking that the Trust should be reporting that to the department.

A. Yes, I think that's fair.

Q. And I think, just moving closer into Lucy Crawford territory, you tell us in your witness statement that you have no knowledge of whether this case was reported

to the department --

A. No, I don't.

Q. -- save to say, perhaps just repeating the point that you've said a moment or two ago, you said in your statement you would have expected this death to have been reported.

A. Well, I think that in the nature, as you've described it -- and I accept it was an unexpected death of a child in circumstances that one wouldn't have anticipated a death -- then that circumstance would warrant reporting to the department, yes.

Q. Would you have expected your own office or indeed your professional leads to have taken steps to ascertain or check that a report had been made to the department?

A. No, I wouldn't have because I go back to the relationship that had been fundamentally altered with the creation of trusts to make the point again: this is four years into trusts. This isn't a week or six months; they had a preparatory year, as I understood it, and my knowledge would say that trusts were evaluated very robustly, that the processes for appointing officers were robust, that the Trust had its own board, its own chairman, its own systems, and I think it wouldn't have been appropriate even for us to second-guess a trust and say, "Have you told the

department this?". One would assume that, at the level they were operating at, that they would have had that knowledge and understanding themselves. So I don't think it would have been for us to tell them what to do.

Q. So where Professor Scally in his report says he felt it appropriate that the Western Board should tell the trust or advise the trust to make a report to the department, where you draw issue with him is where he goes on to say that there was an onus on the board to ascertain that such a report had been made?

A. Well, absolutely. I mean, at another point -- and again you'll be much more familiar with Professor Scally's evidence than I am -- he indicates that Dr McConnell's authority on this matter was very limited and he couldn't say that the board had an accountability for this. I don't wish to misrepresent him, but that was my understanding of what he said at another point in his statement. So in that situation, I would have looked to the Trust to go to its principal and say, "We have an issue here that is a serious issue that we are examining", and notified the department of it in that way. It certainly didn't arise from me and I certainly would have clear support for Dr McConnell's point that it wasn't our responsibility to advise or inform or tell the department that this incident had happened or

indeed, as I saw it, and reflect on it now, to tell the Trust that it should take these steps.

Q. We will come on and look at what the board did or didn't do when the review report conducted and published by the Trust was available. Is it fair to say, Mr Frawley, that if an investigation report reveals to the board, through the Trust, a concern that is of wider significance than just -- and I don't mean this harshly -- one medical accident, if it's of broader importance potentially, that the board would have a role at that point, seized of that knowledge, to take steps to inform the department?

A. I would accept so and I would like also to think that if the evidence, having completed the review, suggested such a potential implication that the Trust would also have told the department and, in that circumstance, I would have no difficulty with the duplication of effort that might be involved in all parties who are aware of such a circumstance advising the department.

Q. A number of the other points that Mr Bradley mentioned.

He mentioned that, in his view, as a professional lead he would be wishing to establish from the Trust whether the coroner has been notified, and you think that that is an appropriate approach. Are you aware, Mr Frawley, what --

A. Sorry, could I clarify, chairman, with you? I think that's an appropriate approach, Mr Bradley's approach --
Q. Yes.
A. -- in clarifying whether the coroner had been informed?
Q. Yes.
A. Of course, I don't have any difficulty with Mr Bradley, but I certainly in all the time I've worked in the health service would not have -- and again, thankfully, I hadn't the experience of these sorts of situations, but I wouldn't have thought of the coroner at that point. I would have assumed that all of the clinicians involved, throughout the two hospitals -- and there was, as I've read this, a significant number -- that all of them would have understood a responsibility to inform the coroner. And it wouldn't have arisen for me or I wouldn't have reflected that "Oh, I must make sure the coroner ..." because I would have assumed that would have happened. That may not be an assumption that I should have made, but that is my assumption from all my experience that those clinicians were much better placed to make that judgment and would have known the procedure that was required of them in that situation.
Q. So you felt that such an assumption was safe on the basis that it was so self-evident in this case that a report would be made by both hospitals?

A. Absolutely, by both hospitals, yes. I wouldn't have for a moment considered that the coroner hadn't been informed.
THE CHAIRMAN: Sorry, if we go back then before the establishment of the Trust, when you're the general manager of the Western Board, so Altnagelvin and the Erne and so on, they're units within the board, right?
A. Yes.
THE CHAIRMAN: So if there was an incident at that point, if there was a death, an unexpected or unexplained death, you would not as the manager expect to have to follow up on whether there has been a report to the coroner, you would work on the assumption that the legal obligation lies on the doctors and you're entitled to assume that the doctors have fulfilled their legal obligation?
A. Absolutely, chairman.
THE CHAIRMAN: I'm afraid, Mr Frawley, the evidence, particularly in recent weeks in the inquiry, has been that the doctors didn't know their responsibilities. I've had a series of doctors who are entirely unfamiliar with their legal responsibilities under the Coroner's Act as late as 2000. I'm saying that not because your assumption is necessarily in any way outrageous or unfounded, but it's a major cause of concern for me that, in 2000, doctors didn't know their

obligations under the Coroner's Act.
A. Well, chairman, all I can do is join with you in that. I equally am dismayed, I would say, to be advised of that because that is an assumption I would make in terms of clinicians, both in terms of the level they were operating at and the seniority they were at. It would seem to me, again, self-evident that the coroner should have been informed.
THE CHAIRMAN: Thank you.
MR WOLFE: Mr Frawley, we've dealt with two of the items that might or might not have had to be said to the Trust by your officers and you have dealt fairly with those. Can I move on to what ought to have been happening within your house, within the board?
Dr McConnell, when he gave evidence yesterday, said that, echoing what he had already said in his statement and which I put to you:
"My own expectation, and presumably that of Hugh Mills, was that I would convey the information about the unexpected death to Martin Bradley and to the general manager of the board."
A lot of Dr McConnell's evidence, I think it is fair to say, suffered from his inability to touch upon documents to confirm just exactly the steps that he took at the time. I want to move on to look at the issue of

documentation with you in a moment, but do you have a recollection of being informed of the death in these relatively early days after it happened?
A. Chairman, through you again, you can imagine it's 13 years ago. Certainly when I read the note that Mr Mills had recorded of my meeting with him, where I said, I think in response, that I had already been made aware of this matter by Dr McConnell, I'm absolutely content with the accuracy of that record by Mr Mills that I would have -- that I did say to him that I had already heard of this matter. So in those terms I can say that Dr McConnell had made me aware of this adverse incident. And I think it's also accurate to say I would have had a recollection equally of Mr Bradley at another moment in time confirming to me that they were looking at this incident.
Q. How would you define your own role at that point when you're hearing for the first time that there had been this awful tragedy in a hospital from whom you commissioned services?
A. Well, I think by its nature it was concerning, but as with all these things, what you would want to do is to get as much information through your professional leads as you could in order to make an informed judgment about where the board should stand on this and what steps the

board should take. So in a sense, I was assured by the fact that both the leads that I would have wanted to be involved were involved and were aware of the situation and that we were now awaiting further developments from the Trust.

Q. Again, Dr McConnell yesterday, when he gave evidence, talked about the healthcare committee, which was one of the main sub-committees of the board; is that right?

A. I should maybe explain, chairman. There are a series of committees called statutory committees that compose the board in terms of, if you like, the organisational structure of the board. So you had a social care committee, you had a healthcare committee, you had an administrative services committee and then all boards also had an audit committee. Those were the formal committees. And the committee that would, if you like, on behalf of the board, have oversight of health matters would be the healthcare committee.

Q. He said yesterday:

"I would have expected to have reported that to the healthcare committee within one or two meetings of it happening as soon as I was in a position to adequately describe to them what had occurred and what we understood to be going on."

So he describes a process perhaps of gathering

information from the Trust, and there were, no doubt, regular contacts over those first few days and weeks. We know that Mr Bradley had conversations with Mr Mills, as did Dr McConnell. So the information is gathered, there's knowledge that a review is being conducted by the Trust, there's knowledge that a Dr Murray Quinn from the Altnagelvin Hospital was going to assist the Trust with that hospital of review, so it's now fit to go to the healthcare committee in Dr McConnell's eyes. Did you sit on the healthcare committee?

A. Well, yes, chairman. I just need to maybe take you back if I may, chairman. Two things to remember. The healthcare committee was a scheduled committee, so it was a committee that didn't come together at short notice; it was a committee that had a schedule of meetings each calendar year. And the way we tried to manage it, because we had very few board members, was that we would have a board meeting in one month and then at the beginning of the next month we would have the committee meeting. So the schedule of the meeting would be important and I don't have that to hand, chairman, so that you could see whether a healthcare committee actually happened during the period coming up to the report.

The further complication around this time of the

year was holidays and sometimes, because of the unavailability of members, you might not have a meeting in July and August, so again that's another complicating factor. Thirdly, I would say in this circumstance that in order to bring a matter to the board, we would probably -- at least my judgment as general manager would be is we want to bring much as the issue that has arisen, we would want to bring an evaluation of the issue that had emerged and clearly a recommendation from officers to the committee of how we wanted to proceed.

So it isn't just a matter of saying -- I don't think we could go to each committee with, "We have an adverse incident, these issues are now in play, this is what we know to date, we'll come back to you again". When we are going to a committee, we are going to make a formal decision on how we proceed as a board and therefore I would have wanted the review report as an example, as a first stage, to be available before I would make a judgment as to whether that was ready to go to a board meeting.

THE CHAIRMAN: In other words, if there was a review established which was expected to report, you might hold off bringing it to the healthcare committee until you had the report?

A. Absolutely, chairman.

THE CHAIRMAN: Because until then, all that you would be saying is that there's a review ongoing and we'll let you know when the report comes through?

A. Absolutely, chairman, and just to finalise that, you'd have members asking you questions to which you had no answers and I think eventually they'd say, "Why have you brought it here? You clearly don't have a complete understanding of what happened in this instance". So I think what you'd be wanting is that first review report and then make the judgment: was that fit for purpose in terms of a debate at a health committee?

MR WOLFE: It wouldn't be unusual in any sphere of life to bring an initial report before a committee, whether as a formal agenda item or whether under "any other business", simply to mark the fact that the board was aware of the issue, was monitoring the issue and will bring you -- the board members, committee members, I should say -- further information as it becomes available. And that seems to have been the flavour of Dr McConnell's evidence, and if I may say so. It seems to be a little different from your evidence, which is to say that your expectation would be that it would only appear before the committee as an item --

A. I don't want to contradict, chairman, through you, but as I remember the transcript I read last evening, there

was a discussion between yourself and Dr McConnell through you, chairman, where Dr McConnell was at least suggesting that he was describing the committee debate later in the process and that he didn't mean to indicate this earlier in the process, although that was overtaken by a debate around the search for the information and the search for the information. But I developed some sense in reading it -- I may have got it completely wrong -- that he didn't say that at that early stage it would have gone to the committee.

Q. Well, I have read you out what he said. He certainly did say that he wasn't meaning to suggest that it would have gone to the committee right away, but when I pressed him upon the significance of this, in the sense that he had been advising the Trust to be reporting it to the department, as being a very important or significant issue:

"By that token, should it not have been going to the committee within the Western Health Board promptly?"

And he said:

"It would certainly have been [his] expectation that it would be reported to the healthcare committee within one or two meetings of it happening."

A. One or two minutes [sic] -- I go back to the sequencing again, chairman, and I did explain that in that

circumstance I'm not sure what the sequence was, but it could be that there wasn't a health meeting, say, after May, there mightn't have been one until later, I'm not sure. I'm sure the inquiry can find that out.

Q. We can, of course, find that out. I'm not particularly concerned to descend into the detail of that. What I want to ask you is this: have you any recollection, when you continued to hold the general manager role before you left at the end of August, of this incident being brought before the healthcare committee?

A. I do not.

Q. We know, we have Dr McConnell's evidence, that having checked the records, the minutes, for the period 2000 to 2004, that this item or this incident doesn't appear on that record.

A. Well, again, absolutely. I've read that as well, chairman.

Q. But do I interpret your evidence correctly by saying that when this case had been investigated to the point where a formal report was available, that that formal report should have been shared with the Western Board and at that stage brought before the healthcare committee of the Western Board?

A. Absolutely.

Q. The formal communication or direct communication, is

perhaps the better word, between yourself and the Trust in relation to this incident came via Mr Mills at a couple of meetings; isn't that right?

A. That's correct.

Q. And you don't produce, Mr Frawley, a record or a note of those meetings?

A. Well, again, chairman, just to say, again, I left the board, as I say, in August 2000. I think anyone who worked with me in the board, certainly in my office, would know that my practice was to keep handwritten notes, very short, very brief, of these encounters, and I would then develop action steps out of those notes. Now, to be fair, they were written in a very rough hand way, I'm not sure whether, when I would hand them to my PA, sometimes they might be put on a dictation machine, sometimes they would be handwritten and they would be actions. Sometimes I would bring people in and they would action them verbally with me. So there were different sorts of outcomes or outputs from them, but they would have been taken. I don't know what happened with those notes, I asked for them, they were not there. I would not be surprised if they weren't retained because they would represent a whole range of things that I had discussed with the general managers or the chief executives of the trusts, and not just those

trusts but lots of other meetings I would have had with other trust chief executives and board chief executives.

Q. Did you, through your PA, open, if you like, a Lucy Crawford file pursuant to the information that was coming your way?

A. I did not, no.

Q. You have said in your witness statement more or less what you have said just now, that you were in the habit, at meetings, of making short notes; would they then have been typed up?

A. I wouldn't necessarily type the whole note up; I would type up the action that I had agreed to take or the commitment that had been made to me.

Q. Is it your expectation, doing the best you can with a subject matter that is 13 years ago, that you would have made notes arising out of your actions or thoughts following communication of these adverse incidents or this adverse incident to you?

A. As I say, what I would have been looking at was just -- I would have been getting a sense of what was happening and then I would think: what does that mean for us, what do we need to do know? So I wouldn't have been necessarily taking a detailed note of all the steps that had been shared with me, but I would have been taking more a sense of what do we need to do in that

circumstance?
Q. And as you note, of course, you left the board behind you at the end of August 2000.
A. Yes.
Q. Leaving behind you, presumably, all relevant business records with the board, taking only your personal records?
A. Absolutely. Again, as I left, I don't think I -- I certainly didn't take any papers or files or documents pertaining to board business. Again, one accumulates a huge amount of material. I would have left that to be disposed of or filed and recorded, as was appropriate. So I didn't take anything with me.
Q. There was a call for documents by Mr Gowdy in or about October or November 2004 as a prelude, as it turned out, to this inquiry. At that time, were you contacted by anyone to provide information or directions as to where your notes of the time might be found if there were to be any?
A. I received, chairman, a letter from the then chairman of the Sperrin Lakeland Trust -- I think it was a Mr Mullan at that time -- who said to me that I had been referred to in notes of Mr Mills that related to the work of this inquiry, and if I'd any papers relating to that, I should retain them because they would be needed by the

inquiry or they could be needed by the inquiry. I have a copy of that letter if someone wants to -- maybe I should have made it available already.
THE CHAIRMAN: We might take a copy of it before you leave.
A. I don't have it with me, but I could send it to you, chairman.
THE CHAIRMAN: Thank you very much.
MR WOLFE: How did you respond to that?
A. I responded that I didn't have any papers or documents that I had taken, I had left all materials behind me when I left.
Q. Let me turn back then to the meeting with Mr Mills --
THE CHAIRMAN: In other words, the only contact that you had about your notes or records wasn't from the Western Board but was from the Sperrin Lakeland Trust?
A. That's my recollection, chairman.
MR WOLFE: Happily, Mr Mills made a short note of his interaction with you on 3 May 2000, and he records, under "Any other business", that he raised the subject matter of Lucy's death with you. That wasn't, of course, the first time you'd heard of it, Mr Frawley.
A. That's correct.
Q. Did this add to your well of information?
A. Again, chairman, through you, you describe it as a well. I had a series of brief interactions with chief officers

who were indicating to me that this was ongoing, that they had, I think, you know, been engaged with the staff in Sperrin Lakeland and all Mr Mills shared with me was again that this matter was ongoing and that the review would be completed in due course, and I noted that.
Q. Yes. Maybe I assume too much when I said earlier that Dr Quinn had been appointed; had you been apprised of that fact?
A. I honestly cannot recollect that at all, no.
Q. Well, that answer may address the next question, but I'll ask it anyway. The evidence of Dr McConnell, at least in his statement to us, indicated that there was a concern which derived from his consideration of Dr Quinn's appointment that there may be a question mark over Dr Quinn's independence because he had -- well, first of all, he was working in the Western Board area as a consultant in the Altnagelvin Hospital, but some years previously had an attachment to the Erne Hospital. Again, just for completeness, were you aware of any sense of unease about Dr Quinn's appointment?
A. No.
Q. Very well. You, sir, issued an e-mail on 8 May 2000 --
A. Yes.
Q. -- to Mr Bradley and Dr McConnell. If we could have that up on the screen, please. Sir, I haven't brought

the reference for it out with me, but you will recall that e-mail.
A. I do, yes.
THE CHAIRMAN: It's witness statement 308/1, page 94.
MR WOLFE: Thank you.
It says:
"I am aware from brief conversations that you have received some background on the above from Hugh Mills. I think it is important that we get some definitive advice and I would be grateful if you could keep me apprised. Many thanks."
What was your intention in issuing that e-mail and, in particular, what did you mean by "definitive advice"?
A. Well, I suppose I was becoming a little bit sort of aware of the fact that Dr McConnell was having a conversation, Mr Bradley was having a conversation, there were these sort of miscellaneous conversations going on, and I thought it was very important that we began to sort of get a more complete and integrated picture of it all. And when I said "definitive", I meant clearly we need to get to an outcome here that comes to a definite conclusion about what happened in this situation.
THE CHAIRMAN: In other words, was this something to be worried about or not worried about?

A. Exactly.
THE CHAIRMAN: Because at that point, you've been told that a child has died, but the level of detail you have about that doesn't tell you how worried you should be about the circumstances?
A. Absolutely.
MR WOLFE: Do we understand the chain of events, Mr Frawley, as you getting, if you like, an update from Mr Mills at a meeting the week before, you then, perhaps mulling it over in your mind -- and this is the action you take arising out of that, and what then comes next, according to Dr McConnell, is that, reacting to this e-mail, he contacted, by telephone, Dr Kelly and asked for an update? And the update arrived in the form of a letter in mid-May? If we could have up on the screen, please, 036a-046-099. Perhaps if we go back a page. Keep both pages up.
This is directed to Dr McConnell from Dr Kelly, 15 May 2000. Were you provided with a copy of this letter?
A. Not that I can remember, chairman, no.
Q. What it promises on the right-hand page, towards the bottom, is -- they talk about the review that is being conducted with Dr Murray Quinn and it goes on to say:
"Next stage is full analysis of the investigation

report from Dr Anderson and Eugene Fee with a planned review meeting on the case with Murray Quinn."
If we go over the page, please, it indicates that an initial interview has taken place with the family and concludes by saying:
"I will, of course, have more details as the full investigation/reports comes online and will be happy to share all the details with you in due course."
So at least so far as Dr McConnell is concerned, he is now getting more information about what the Trust has been doing over the previous four weeks since the death and there is the, if you like, promise at the end of it of a review report, the details of which will be brought to the attention -- when available.
A. Yes.
Q. Dr McConnell's recollection is that he then feeds that information in to you because you have asked to be updated via your e-mail. Can you help us at all with that?
A. I genuinely can't, chairman. I can't remember the specific letter. Again, he may well have sent it to me, I didn't see it. I suppose the only comment that might be helpful or not is that the definitive advice I was looking for was the review when it was completed and when it would be available because this is an update of

steps that are ongoing.
THE CHAIRMAN: Just to get it clear, Mr Frawley, are you saying that you didn't see this letter or you don't particularly recall seeing it?
A. I can't recall seeing it, chairman.
THE CHAIRMAN: But from what you are saying now, if you had seen it, you would have been reassured that there was some review going on, but you are still waiting to see what the outcome of the review was?
A. Absolutely.
THE CHAIRMAN: Okay.
MR WOLFE: Can I just ask you, Mr Frawley -- and we all appreciate the frailties of recollection and memory, but thinking back to that time, was there a sense of anxiety within the board that this death had happened and that it was something that you as a commissioner, your organisation as a commissioner of services, needed to get to the bottom of?
A. I think that's fair comment. I think what -- and again, this may have been covered in other evidence. There was a fragility in terms of the service in Sperrin Lakeland. By that I mean that what you have is a very small pool of consultant staff, they are delivering a full panoply of services, they are 80 miles the centre in terms of Belfast, they are 60 miles from Derry, and therefore

you have a community down in Fermanagh that's very dependent on that service and people from Omagh as well and, as I've said before, people from other parts of the Southern and Northern boards also coming into that, and you have a very limited resource. So if you're now in a circumstance where there is uncertainty about the quality or safety of a service, then you really do need to get to the bottom of it and make some very difficult judgments going forward.
Q. Moving along the timeline then, your next contact with this issue, so far as we can make out, is a meeting with Mr Mills on 14 June.
A. Mm-hm.
Q. And again, no note emerges from the board, but Mr Mills has maintained a note. It appears that he is telling you at that meeting that new information is emerging from Dr Asghar and another staff-grade paediatrician pertaining to, if you like, the practice or competence of the consultant paediatrician who had cared for Lucy Crawford. Do you have an independent memory of that meeting?
A. I don't, genuinely. I think, again, just to point out, as I think has been pointed out in my evidence, and I think acknowledged by Mr Mills, these meetings were about a whole range of issues, they weren't convened to

give me an update specifically on what was happening. This could have been, you know, a two-page agenda, some small items, some very significant items that were ongoing. They were an information-sharing opportunity, they were an opportunity to test some of the developing challenges we had, et cetera, et cetera. So they covered a whole range of things, and within it then there was this brief update on further developments on this. So I didn't register -- I just felt that obviously the review is continuing and this is yet another aspect of that.

Q. The significance perhaps of the fact that we're talking about this at all is not necessarily the information that was imparted during the meeting, which may not have been terribly significant, but it reveals, does it not, that the Trust felt obliged or required to keep you in the information loop on this developing issue?

A. Well, again, I think, chairman, having opened up the debate by telling us, having in a sense engaged with Dr McConnell, engaged with Mr Bradley, there was a sort of level of involvement that just was continued in terms of the ongoing -- I don't know whether the word "obliged" would be the appropriate word in that circumstance, but certainly we had indicated that we wished to be aware -- again for the rationale

I explained some time ago -- as the commissioner what was happening and Mr Mills was just appraising me of a matter that was clearly very significant for the Trust at that time.

THE CHAIRMAN: This rather looks like a step up in the seriousness, doesn't it? Because reading it from this remove, it looks as if you're not just being told about the death of one child, it looks as if you're being told something about more concerns emerging from another doctor? So that would have increased your anxiety to know what exactly was going on.

A. It does do so, but again it's within the context of the Trust's review, which is still not completed, and, as far as I was concerned, that was the key moment for us where we had a complete review of all the aspects and this, no doubt, would have been part of it as well, against which we could make an informed judgment about, as I said again before, what we would do now.

MR WOLFE: We know that the final review report produced by Messrs Fee and Anderson, the coordinators of the Trust review, is dated 31 July 2000, four weeks prior to you leaving your post in the Western Board. I think you've told us in your witness statement that you had annual leave to take in or around that time, straddling late July into early August. I think you've told us,

Mr Frawley, that you have no recollection of seeing the review report.

A. No, none whatever.

Q. Do you have any recollection of discussing the review report?

A. No.

THE CHAIRMAN: How would you expect that report to come to the board?

A. Well, chairman, again this would have been the model -- even in the directly-managed period of the board's existence, in other words pre-1996 -- I would have had and expected a discrete report with a letter, which might read something like: dear Mr Frawley, I enclose a copy of the completed review of the circumstances affecting the death of Lucy Crawford. Maybe then in the letter a little summary of the conclusions and the recommendations, but certainly that would have been inside the report itself from my point of view. And that would have been formally posted and sent "personal and confidential" I would go so far to say. It was a significant and important moment. And I find it very surprising that -- and I think this was commented on by Mr Bradley yesterday -- that we have notes and records of all kinds being kept at every moment in this process and yet there is no formal moment at which this is

submitted to the board as an interested party that I can see and that I have any record of seeing.

THE CHAIRMAN: Thank you.

MR WOLFE: Can I take you back to something you said in your witness statement? It's WS308/1, page 8. You'll recall towards the start of my questioning this morning, Mr Frawley, that I introduced, if you like, a two-stage process. We're now at the second stage where a report is available and I have your answer that you didn't see it or discuss it. But what you say about the second stage is at the third bullet point:

"Where the investigation and its conclusions resulted in the preparation of a formal report, I would have had an expectation that the report would be shared with the board in order to enable the board to consider whether the board needed to initiate any action in light of the report. In making such a judgment, I would seek the views of the relevant professional leads in the board on whether the findings, conclusions and recommendations proposed by the Trust were a proportionate and appropriate response to the incident that had been investigated."

So what you're saying there is, in principle, if that report had been sent to either yourself or your professional leads, you would expect --

A. I would go so far as to say I would have expected it to be sent to me; I wouldn't have expected it to be sent to the professional leads. I would see it as my role. They may well have been copied into it, but I would certainly then send it to them and we would have a round table to evaluate the content and the conclusions and the next steps, if you like.
Q. So however it came to the board, and you would have expected it to come to you, and I have that, you would have expected that then to lead on to a process within the board such as you have described?
A. Absolutely.
Q. And just turning to what Dr McConnell said yesterday, I put that description of the second stage as it emerges from your witness statement and asked him whether a discussion such as that did emerge from yourself as general manager. He said:
"I'm quite sure that -- I cannot definitively say, but I'm quite sure that it would have. We had regular review meetings. There would have been issues that would have been put on the agenda for those and I'm sure that, on foot of the e-mail that he had sent [that's the May e-mail, Mr Frawley], on foot of that e-mail Martin and I, he would have sought an update from one or both of us."

You were bound to be seeking updates from your professional leads.
A. Well, I mean, again, I would see updates on the basis that there was something new to tell me. At the end of the day I just didn't seek updates for the sake of them. These were very senior people with great experience. I would look to them to make the judgment as to whether something new and definitive had emerged that they wanted to share with me. We certainly -- we worked very closely, we would encounter each other two or three times a day in terms of different times of meetings or indeed having a cup of coffee or whatever it was, so no doubt if there were developments they would share them with me.
All I'm saying is that a report of this kind isn't about an update or a moment; it requires people to sit down with it and say, "Right, from your point of view, does this address the issues that you were concerned about? From your point of view ...", so that we get a collective position. And it goes back to the heart of your earlier point, which is: had such an event happened, then you would have been in a position to take a position and go to the health committee with it and say," This is the conclusion we've reached, these are the next steps", or, "We are reassured this matter was

a one-off or an explanation has been developed, which is as follows, and we are satisfied with it", and we would move on from there.
Q. That's helpful. You would have had in mind, again, a two-stage approach. You speaking to your professional leads with the report in front of you around a table, establishing, if you like, or critiquing --
A. Yes.
Q. -- the review report produced by the Trust to see if there's anything missing --
A. Correct.
Q. -- anything that requires further action --
A. Absolutely.
Q. -- and then take it on to the healthcare committee --
A. Yes.
Q. -- to inform them?
A. Yes.
Q. And during your time with the board, you're saying that that didn't happen in the context of Lucy Crawford?
A. Again, chairman -- I may have got this wrong -- that is exactly what I'm saying because I have no recollection whatever of any such report. I have no recollection of -- certainly we hadn't the meeting that I would have wished to have and certainly we were not in a position then to formally take a board position and move on.

THE CHAIRMAN: Can I confirm this: when it would go to the healthcare committee, it would go with a specific agenda item?
A. It would, an issue of this nature, yes.
THE CHAIRMAN: So when Dr McConnell confirms that the minutes of the healthcare committee from 2000 to 2004 have been checked and there's no reference to Lucy in those minutes, that suggests that this just never happened?
A. Well, I am absolutely satisfied, chairman, if I could -- because I note from yesterday's discussions -- again, thanks to the staff who shared these transcripts with me -- there was some debate. The administrative system, which was my responsibility -- so I'm speaking on my own behalf, you could argue -- and the secretariat were extremely conscientious and I have no doubt that in the record keeping, if it was in the minutes, it would be on the record and it would be available to you.
THE CHAIRMAN: Thank you.
MR WOLFE: It's stating the obvious perhaps, Mr Frawley, but when Dr McConnell received the report and he's uncertain, I think it's fair to say, of when he received the report and in what form he received it, I think to the best of his knowledge he didn't receive the various appendices that attached to the report, but the question

is: it's stating the obvious to say, if you were still in post, the report should have been brought to your attention?

A. Absolutely, whoever was the chief executive. Now, I do know there was a sort of interregnum because after I left, there wasn't a chief executive, I think, for maybe six weeks. Chairman, again, the record would show that, until around -- I think the interview might have been around October, and the person appointed around that time. So there may have been a two-month period but I think someone was acting to fulfil the functions of the general manager.

Q. Just while we have it on the screen, you talk about:

"Seeking the views of your professional leads with regard to the findings, conclusions and recommendations proposed by the Trust to determine whether they were a proportionate and appropriate response to the issue being investigated."

One of the points that Professor Scally makes in his report -- and help us if you can on this. One of the things he says is that when you have a report like this about a serious adverse incident and where no clear conclusions emerge with regard to the cause of this child's death you, as a board, should be seeking to advise the Trust that they ought to go on and carry out

a broader review, perhaps involving the other care providers in this case, who were the Royal Belfast Hospital for Sick Children. That's the kind of recommendation he thinks should have emerged from a board's consideration or critique of this review report.

A. I would completely accept that. I don't think one could just settle for "This is unexplained". I think we would need to go further to absolutely exhaust every possibility in order to get an explanation of what happened.

Q. Could I bring you to one final point, Mr Frawley? If we could have up on the screen 308/1, page 35? What I'm interested in exploring with you is this -- and I realise that it's hypothetical in this case: suppose, for the sake of argument, that the board obtained a report from the Trust, which pointed up the inappropriate use of Solution No. 18, a particular fluid, in the management of a child's replacement fluid needs; might that be something that you on the administrative or managerial side would need to take advice on?

A. That would be so. I think we would need clinical advice. I suppose the thing I would say -- and whether it's helpful to the inquiry or not -- I would have liked

to ... If that had happened and that had emerged from this inquiry, I would assume that the Trust would immediately have notified its principal, the department, that this was now an issue without the board ever having to go to the department to confirm it.

Q. Yes. Well, getting to that stage then, based on this hypothesis, if that conclusion emerges clearly to you as a board and if it's viewed as a matter of broader application or broader danger perhaps, is the board a vehicle for getting that message out?

A. I think it's one vehicle. I think you have to recognise that the centre of the Health and Social Services system is the Department of Health. The boards would have a, as you've said, area that they're engaged with, they have opportunities to contact other boards, but the overview of the whole system is at departmental level and therefore the critical thing would be, one, of course, to make sure that they were aware of this, but it really does seem to me that the urgency of the centre being aware of it and the centre then taking the action that every aspect of the Health and Social Care system in Northern Ireland, and indeed other jurisdictions, if appropriate, is given notice that this is a risk and this is a problem. That's the crucial thing.

Q. Yes. But nevertheless, the board could take steps to ascertain that the department is seized of this information?

A. Absolutely. One would want to confirm that they have been told and that they are aware of it, and even at this point, even though I've said other things in the past, I think when this became clear, then it was essential that the board would confirm with the department they were aware of this and that steps had been taken to notify the relevant parties.

Q. And you have set out on this page the kind of factors that might be taken into account by the board when seeking to assess whether the incident has broader implications.

A. Absolutely.

Q. Could I bring you to just one final document in this context? It's a paper that you appended to your witness statement and I'll take you to page 63, if I could. Number 5, you look at the issue of the interaction between the health board and the department, in particular:

"How information comes to the attention of the board that may impact on the future care of patients within other health boards and how that's disseminated to the DHSS."

What you say is:

"At the time of the incident, the usual mechanism would be for the medical director of a trust within our geography, where an incident had occurred, to contact the director of public health."

So that in essence is Dr Kelly reporting to your Dr McConnell --

A. Mm-hm.

Q. -- albeit, in this instance, Mr Mills took up the reins and reported to Dr McConnell? Of course, this must depend on the nature of the incident that's being reported in, but you're saying that:

"The director of public health would then have circulated the information to the relevant medical directors locally, advised director of public health colleagues elsewhere in Northern Ireland and advised the chief medical officer either urgently, if needed, or, if more appropriate, at the next regular meeting about the issues concerned."

So do we view that answer, that information, Mr Frawley, in this context: when there is certainty, perhaps after a review report is available about what has happened in a particular case, that those are the kinds of steps that your director of public health might take?

A. Yes.

Q. Perhaps overlapping or in addition to what the Trust might be expected to do?

A. Well, again, I think that's right. I think that it is obviously meeting their responsibility in that circumstance. Again, chairman, it would be helpful to me if I had the context for this particular document. I know it was a paper probably you are indicating I sent.

Q. Yes, indeed.

A. Does it refer to something I said in my statement?

Q. No, it's wide-ranging. If I just give you the first page of it. Page 49 is the first page of it. It is a wide-ranging document, Mr Frawley, that you have sent in to us on the back of your statement to help us understand the nature of the triangular relationships.

A. Yes. I do want to explain, chairman, if I should, the context of that was, again, a call for documents by yourselves in 2004, and this was a paper produced by the Western Board at that time. Each of the boards, I think, in responding to you, produced a document describing their functions, purposes and so on, and this was a document written in 2004. So it is important that it's that context -- I was just indicating that it was the most comprehensive description of these functions

and responsibilities that was available to me, so I included it for you.

THE CHAIRMAN: Thank you.

MR WOLFE: Could we just go back to page 63? We have it in front of us, number 4 at the top of the page. I wonder, could you help us with your experience? You talk about here the procedure in place within the board for disseminating information learned as a result of coroner's inquests or other events both to the trusts and to colleagues or other health boards in Northern Ireland. You say:

"The board may become aware of information from coroner's inquests or other events, which might impact on the future care of patients through ..."

And there's a list of things given. You says:

"There seems to have been no standard method used by coroners to communicate relevant issues to boards at that time."

A. Well, again I want to make the point that this was produced under the auspices of the new regime and I don't want in any way -- in terms of -- and either take credit or ... I mean, I enclosed it because I thought it was comprehensive. So this would have been written at the time. This is 2004, so the clinical governance arrangements and the other arrangements are

developing all the time and clearly the circumstance that is recorded here:

"There is no standard method used by coroners to communicate relevant issues to boards."

Yes, that was the understanding in 2004.

MR WOLFE: I think we can leave it there. I have no further questions.

THE CHAIRMAN: Anything from the floor? Mr Lockhart?

MR LOCKHART: Just one clarification, chairman. Yesterday, an issue arose regarding documentation and you very helpfully provided the steps taken by the inquiry. I just want to reassure the inquiry that we've also taken certain steps overnight and I hope to have a letter with the inquiry. I had in fact hoped to have it by 11 o'clock which, post-May, sets out the subsequent steps that were taken to try and locate these documents.

THE CHAIRMAN: Thank you very much. But you have no questions for Mr Frawley?

Mr Frawley, thank you very much for coming. Your evidence is over. If you want, you don't have to say anything more, but if you want to raise anything or make any comment which you haven't been given the opportunity to, this is now the opportunity.

A. Thank you. The only thing I would want to say, I think,

chairman, is just to, if I may, with your permission, express my sincere sympathy and condolences to the families affected by these awful events and to acknowledge, as others have done, that it doesn't reflect very well on the Health and Social Services system that I was working in.

THE CHAIRMAN: Thank you very much, Mr Frawley.

(The witness withdrew)

Ladies and gentlemen, let me tidy up a few bits and pieces. Mr Quinn, you and Mr Green were going to come back to me with some issue in Claire's case.

I understand, from a separate discussion which we had about another issue altogether, that that will be with me on Monday; is that right?

MR QUINN: It will.

THE CHAIRMAN: We will develop it then, but I'm very anxious to tidy up all the outstanding issues. Apart from the fact that the hearings will be over by Hallowe'en, I have to write a report. There are families who have been waiting. Adam's mother has been waiting for a report. It will be well over a year by the time it reaches her from the time of the hearing into Adam's part of the inquiry ended. And I'm sure the other families are equally anxious. It's one thing to hear the evidence coming out, but insofar as the completion

of the inquiry is concerned, it doesn't end with the oral hearings; it ends with the report being published.

MR QUINN: There's also the issue of child W2. I will take instructions from the Roberts family on that point and address that on Monday as well.

THE CHAIRMAN: One possibility is to ask some more questions in writing of Dr Webb.

MR QUINN: At the moment that seems to be the best way forward, but I will clarify that with the family. Those suggestions were put to them and I will come back to them on that.

THE CHAIRMAN: Thank you very much.

MR GREEN: If it's any comfort to you, sir, on the first issue Mr Quinn and I are pretty much in broad agreement.

MR COUNSELL: I wonder if I can come back on the second issue on behalf of Dr Stevenson, who was peripherally involved in that issue, just to enquire whether there is to be further disclosure. I think that is where we were, at one stage, of redacted documents.

THE CHAIRMAN: I think you should have W2.

MR COUNSELL: I don't think we have. Maybe I can take it up.

THE CHAIRMAN: If you don't, we can tidy that up before lunch. If you don't, it can be provided, Mr Counsell.

On Monday, I think the idea is that we deal with the

evidence of Mr Doherty; is that right?

MR WOLFE: Yes, he will be a very short witness.

THE CHAIRMAN: Then we go into the evidence of Miss Dennison from the coroner's office, which will lead us on Tuesday into the evidence of Dr Curtis. So we'll deal with Mr Doherty first on Monday, then we'll deal with the senior coroner and two other people who have relevant evidence to give from the coroner's aspect.

Dr Carson is returning to complete his evidence on Wednesday. And then Professor MacFaul this day week, and that leads us finally, on Monday the 1st, into Professor Scally and, on the Tuesday, we'll have the two pathologists together, Professor Lucas and Dr Gannon.

That will bring an end to this segment of the inquiry. So unless there's anything else, ladies and gentlemen, I will adjourn until 10 o'clock on Monday morning. Thank you.

(12.10 pm)

(The hearing adjourned until 10.00 on Monday 24 June)

I N D E X