1 Monday, 4 November 2013
2 (9.30 am)
3 THE CHAIRMAN: Good morning, everybody. Thank you for
4 coming a bit earlier today. Unfortunately, I have to be
5 in Belfast this afternoon, so we're going to sit until
6 about 2 o'clock. We won't take a lunch break, but we'll
7 take two breaks of about 15 minutes or so between now
8 and 2 o'clock. Hopefully that will give us all the time
9 we need to get through Mr Hunter's evidence and the
10 evidence of Dame Professor Judith Hill.
11 Ms Anyadike-Danes?
12 MS ANYADIKE-DANES: Thank you very much. Good morning. If
13 I call Mr Hunter.
14 MR JOHN HUNTER (called)
15 Questions from MS ANYADIKE-DANES
16 MS ANYADIKE-DANES: Mr Hunter, have you attended any of the
17 sessions that have already been heard?
18 A. No, I haven't.
19 Q. You've made one witness statement for the inquiry;
20 that's correct, isn't it?
21 A. Yes, that's right.
22 Q. Do you have it there with you?
23 A. I do.
24 Q. It's dated 30 September of this year and the reference
25 series is 349/1. I'm going to ask you if you adopt that

1 statement as your evidence subject to anything else you
2 may say in the hearing today.
3 A. Yes, I do.
4 Q. Have you made any other statements in relation to the
5 work of the inquiry?
6 A. None at all.
7 Q. Thank you. Then if we just look briefly at your
8 experience. It's set out on the second page of your
9 witness statement, 349/1, page 2. We see from there
10 that in 1985 to 1988 you were the Director General of
11 the International Fund for Ireland. Then you came into
12 the Department of Health as an undersecretary in 1988
13 and you worked in that capacity until 1990; is that
14 correct?
15 A. That's right.
16 Q. Then, in 1990, you became the first chief executive of
17 the Management Executive; is that right?
18 A. That's correct.
19 Q. And you stayed in that post until 1997?
20 A. It was in fact 31 December 1996 that I left that
21 position.
22 Q. Thank you. Since then, you haven't really been involved
23 in the work of the Health Service; is that right?
24 A. That's correct.
25 Q. You went on to be Director of Personnel at the

1 Northern Ireland Court Service?
2 A. No, sorry, Northern Ireland Civil Service.
3 Q. I beg your pardon, Civil Service. You had two posts as
4 Permanent Secretary; is that right?
5 A. Yes.
6 Q. One with Department of Social Development and the other
7 with the Department of Finance?
8 A. That's right.
9 Q. Thank you. So you've really operated at a senior level
10 in the Department of Health for about nine years?
11 A. Yes.
12 Q. 1988 until the end of 1996?
13 A. That's right.
14 Q. I wonder if you could help us with one thing, which is
15 the structure as it was then for you. If we pull up
16 323-027d-001. (Pause). No, it's not going to come up.
17 Well, it will come up hopefully in due course. Why
18 I'm putting it to you is it's an extract we received
19 from the department, which is titled "Health systems in
20 transition", but the reason why I'm asking you to look
21 at it is because it sets out the organisation of the
22 Department of Health and Social Services and Public
23 Safety. It has at the top the Minister for Health, then
24 immediately -- here we are. Immediately below you see
25 the Permanent Secretary and then a number of groups of

1 which the far right are the chief professionals and then
2 linked into that chief professional groups you see how
3 the chief professionals are. What I wanted to ask you
4 is: where did the Management Executive fall in that
5 structure?
6 A. The structure that you've shown post-dated the
7 Management Executive.
8 Q. Ah.
9 A. That was the structure at the time of devolution
10 whenever the reorganisation of functions led to the
11 department being renamed DHSSPS to include the Fire
12 Service as the public safety element.
13 Q. Yes.
14 A. So the Management Executive doesn't appear on that
15 organisation chart that at all. The Management
16 Executive was absorbed into the department following my
17 time as the chief executive at the time of devolution.
18 Q. Let's see if this helps. It's witness statement 348/1,
19 at page 8. If we just concentrate on the bottom bit of
20 the organisational chart, we see the Management
21 Executive to the middle but slightly to the right;
22 is that correct?
23 A. That's right, yes.
24 Q. That really is setting it in some relation or pattern,
25 but also dealing with its role, but I was trying to see

1 where it fitted in with everything else of the
2 department. So we can see there that it's obviously
3 linked to the professional staff and linked to the
4 Permanent Secretary, but it doesn't give a very clear
5 indication of where it stood in the overall
6 organisation.
7 A. The best way I think I can describe it is that at the
8 time the Management Executive was established, it was
9 established primarily to oversee the management of the
10 HPSS in parallel with the policy part of the Department
11 of Health, which looked after the development of
12 policies for health and social care provision. Both
13 parts were then underneath the ultimate authority of the
14 minister in the department itself. I had
15 a relationship, in terms of management, my own personal
16 management performance, to the Permanent Secretary, but
17 the Management Executive had a separate line as shown
18 in the organisation chart to the minister in regard to
19 accounting for the HPSS.
20 Q. Does that mean you didn't report to the
21 Permanent Secretary?
22 A. I reported to him in management terms, internal to the
23 department, and indeed given the nature of the
24 relationship, I kept the Permanent Secretary aware of
25 everything that was happening on the Management

1 Executive front. But technically, I was the accounting
2 officer for the HPSS and, in that capacity, was
3 responsible for the resources made available through the
4 parliamentary budgetary process for HPSS expenditure in
5 Northern Ireland. That did not go through the
6 Permanent Secretary.
7 Q. I understand. But because you did report to the
8 Permanent Secretary, was the Permanent Secretary also
9 responsible in any way for the work done by the
10 Management Executive?
11 A. The Permanent Secretary had an overall responsibility
12 for the department as a whole, and if he had felt that
13 the Management Executive under my leadership was failing
14 to discharge its responsibilities effectively then
15 I have no doubt that he would have intervened.
16 Q. Thank you. Subsequently, when the structure changed and
17 it became, as you've pointed out, Department of Health
18 Social Services and Public Safety there was four -- and
19 your Management Executive became reabsorbed.
20 A. Exactly.
21 Q. There was an entity called the HPSS Management Group.
22 Did that carry out any like tasks as the Management
23 Executive had carried out?
24 A. I'm not aware of what it would have -- of what that
25 would have done.

1 Q. I can pull you up an organisational chart to see whether
2 that would help you. 323-027e-003. You can see where
3 the management group is there to the far right.
4 A. Yes.
5 Q. All of this now under Mr Gowdy as the
6 Permanent Secretary. Mr Simpson, who succeeded you as
7 the Chief Executive when you retired in 1997, he's there
8 as the deputy secretary for the management group. Does
9 that indicate perhaps that that management group was
10 carrying out like functions or can't you really help us
11 with that?
12 A. I think I can help you. I think the way in which that
13 organisation structure was created gave Mr Simpson as
14 the deputy secretary authority over the various issues
15 which fall within the range of duties shown on the
16 organisation chart. But he would have been directly
17 accountable to the Permanent Secretary for their
18 discharge.
19 Q. I see. And if you can see how along that -- just the
20 level just below the deputy secretaries, almost in the
21 middle, you can see that there's a Health Service Audit
22 Section; can you see that?
23 A. Yes, I can.
24 Q. When you were acting as chief executive, was there
25 a group like that or anybody like that tasked with that

1 role?
2 A. No one.
3 Q. But you performed that function to a degree?
4 A. Yes.
5 Q. Thank you.
6 THE CHAIRMAN: Can we go back, Mr Hunter, to your arrival in
7 1990? That was when the Management Executive was
8 formed?
9 A. That's right.
10 THE CHAIRMAN: Okay. So before that, there was no
11 Management Executive. So insofar as the establishment
12 of the Management Executive was the result of a split
13 between the policy aspects of the department's work and
14 the management aspects --
15 A. That's right.
16 THE CHAIRMAN: So the management is taken out of -- well,
17 not out of the department, but it stays within the
18 department, but under the body which you led?
19 A. Yes.
20 THE CHAIRMAN: What was the theory behind that?
21 A. The theory was that there was a political theory, the
22 political theory was that the management of the
23 Health Service required a special focus, which perhaps
24 it hadn't received before, in that policy considerations
25 had dominated, at least to a significant extent, the

1 work of the department. And a feeling that in pursuit
2 of greater efficiency, cost-effectiveness, et cetera, it
3 was necessary to have a stronger focus on management
4 issues within the Health and Social Services, and that
5 could be achieved through the creation of a group within
6 the department with a specific responsibility to that
7 end. And that particular development followed or
8 proceeded in tandem with similar developments in the
9 rest of the United Kingdom.
10 This was a time of direct rule and ministers from
11 Westminster who were responsible in Northern Ireland
12 followed the lead that their counterparts in Westminster
13 had developed. So setting up an executive was an issue,
14 an initiative that was similar to those taking place in
15 England, Scotland and Wales.
16 THE CHAIRMAN: Thank you.
17 MS ANYADIKE-DANES: Just before you became the first
18 Chief Executive, you were of course the undersecretary,
19 as we have seen, from 1988 to 1990. So you would have
20 been there when all that discussion was going on and the
21 planning for the formation of the Management Executive.
22 A. That's right, and in a sense, if it would help, the role
23 that Mr Simpson then played under DHSSPS was really the
24 same role that I had played prior to 1990.
25 Q. I see. So it reverted to --

1 A. In a sense it reverted, yes. Obviously there were
2 changes which emerged over time, but essentially it
3 reverted to that previous model.
4 Q. So does that mean that with the addition perhaps of a
5 greater focus on the management end, you were
6 essentially doing what you had been doing previously as
7 an undersecretary?
8 A. That's right, yes.
9 Q. Thank you.
10 A. But with ... well, at one level, organisationally -- in
11 terms of accountability there was a very significant
12 difference in terms of my responsibilities.
13 Q. I understand that. Just as in the way that you were
14 aware of the developments happening in the rest of the
15 UK that brought about the initiative for the Management
16 Executive, were you aware as to what was happening
17 in the rest of the UK in terms of the focus on quality
18 of healthcare and so on?
19 A. Yes, I was. We met regularly as chief executives of the
20 four Management Executives and we received a constant
21 flow of documentation, particularly from England, in
22 respect of initiatives that were being taken there.
23 Q. I wonder then if you can help us, because where we're
24 really now moving into is your more specific role as
25 Chief Executive. If I pull back up the chart we had

1 before, which is witness statement 348/1, page 8, this
2 is an extract from something that Mr Elliott, who was
3 the Permanent Secretary when you were Chief Executive --
4 he sent this to the inquiry to try and assist in setting
5 out what the role of the Management Executive was, and
6 therefore to some extent what your role was. One can
7 see there in paragraph 2.1 when it was established and
8 then we see the focus at paragraph 2.2:
9 "Underlying all its activities is the fundamental
10 goal of promoting the health and social well-being of
11 the population of Northern Ireland."
12 And was it thought that that would be better served
13 through the management of the systems that are put in
14 place as opposed to just the formation of policy?
15 A. I think there was a combination of beliefs. I think the
16 policy side clearly had a critically important role to
17 play.
18 Q. Of course.
19 A. And the management side was, as it suggests, focusing on
20 the delivery of an efficient, effective Health Service
21 to the people of Northern Ireland.
22 Q. So to ensure that the gains that it was hoped would be
23 received through the policy were actually achieved
24 through the proper implementation of that policy?
25 A. That's right, yes.

1 Q. And then if we look at paragraph 2.3, it sets out
2 certain ways in which it was intended that the
3 Management Executive would achieve that objective. One
4 is:
5 "To develop the management strategy and the service
6 culture necessary to secure quality health and social
7 services."
8 If we pause there, because the inquiry's heard quite
9 a lot about culture. Used in that way, what was meant
10 by "service culture"?
11 A. It's difficult to reflect back with a gap of 20 years --
12 Q. I'm sure.
13 A. -- but I believe at that time we wanted to encourage,
14 through our actions, the Health Service to deliver
15 a cost-effective, high-quality service. And to do that,
16 we wanted to create the conditions within which
17 a quality service culture could flourish.
18 Q. From your perspective, what sort of cultural change do
19 you think that would require at the trust and, perhaps
20 even lower down, at the hospital end?
21 A. At the time, we believed that one of the ways by which
22 we could achieve that would be addressing issues of
23 concern to the public and, because of that, of interest
24 to politicians. The kinds of issues we were looking at
25 were issues of waiting times in A&E departments, waiting

1 lists in acute hospitals, particularly in the
2 orthopaedic, the cardiac surgery field, issues around
3 accessibility to care. I recall at the time, for
4 example, that patients were travelling from different
5 parts of Northern Ireland to the Belfast hospitals for
6 dialysis and decentralisation of dialysis services was
7 one of the issues we looked at.
8 We were also encouraging higher levels of throughput
9 to address generally the issue of waiting lists. And
10 we were looking at issues of capital investment to see
11 if we could facilitate some of these improvements that
12 we wanted to see. But as I've reflected on it, it
13 struck me that most of the issues we were engaged with
14 were looking at population issues: how do we improve the
15 quality of the service that is generally available for
16 the population of Northern Ireland through such
17 management initiatives as waiting list management,
18 et cetera?
19 Q. And did that require, in bald terms, making the trusts
20 adopt or encouraging them to adopt a better management
21 of their own resources, whether that was their people,
22 their professional staff, the monies that were made
23 available to them or their physical assets?
24 A. Essentially, that was the role of the commissioner, to
25 work with the trusts in terms of defining the level of

1 service which was reasonable to expect a hospital to
2 provide across the whole range of activities of the
3 trusts.
4 Q. Then if we look down to that second bullet under there
5 as the other way --
6 THE CHAIRMAN: I'm sorry, just to avoid any doubt: when you
7 talk about the role of the commissioner, the
8 commissioner is the area health board, is it?
9 A. That's right, yes, it is. It is, sir.
10 MS ANYADIKE-DANES: And we see there the setting of precise
11 objectives and targets for boards and monitoring their
12 progress.
13 So you would set the targets and the objectives that
14 you wished the boards to achieve with the trusts --
15 A. Mm-hm.
16 Q. -- and part of your role was going to monitor that to
17 make sure that was happening?
18 A. That's right.
19 Q. And then if we go to the next column of that, at 2.4, it
20 says that:
21 "The Management Executive has a clear responsibility
22 to provide corporate leadership and direction to the
23 HPSS."
24 What was the leadership role that you thought was
25 involved?

1 A. Firstly, it was to develop the management plan for the
2 HPSS, and I think this particular page may have come
3 from the first management plan that the executive
4 produced. So it was to give leadership in terms of
5 strategic leadership for the HPSS. It also worked
6 closely with Health and Social Services boards in terms
7 of their accountability to the department or the
8 executive.
9 Q. Yes.
10 A. And we held annual accountability review meetings where
11 we discussed progress in delivering the objectives and
12 targets that had been set. The objectives and targets
13 weren't set without regard to the interests of the
14 boards concerned; the objectives and targets would have
15 been discussed with the boards beforehand before they
16 were promulgated by the executive.
17 Q. I can see that's the direction, but you say that's also
18 how you set the leadership for what was to happen
19 in that way?
20 A. Well, yes. I think integral to leadership in the HPSS
21 context is setting clear strategies, targets and
22 objectives. Now, we developed leadership in the
23 personnel field by engaging in programmes of management
24 development with the leaders of both trusts and boards,
25 so if it's personnel leadership you are thinking about,

1 then, yes, we did try to develop arrangements which
2 would improve the skill base within the HPSS.
3 Q. I see also the approach is to be informed by appropriate
4 professional advice. Well, you had that professional
5 group of the CMO, the CNO, CPO and so forth. So you had
6 professional advice available to you?
7 A. In fact, the Management Executive had a board, the
8 Management Executive Board, and that board, which met
9 regularly -- it was monthly -- to consider issues
10 affecting the management of the HPSS, had professional
11 membership. The Chief Nursing Officer was a member, the
12 Deputy Chief Medical Officer was a member, not the CMO
13 but the DCMO was a member of the group, but again the
14 DCMO and the CMO kept each other in very closely in
15 touch with what was happening.
16 Q. So that was linked in to the professional group that was
17 there at the disposal of the department generally?
18 A. Exactly.
19 Q. And then it says that one of the things you were trying
20 to do was:
21 "To build formal quality assurance mechanisms and
22 outcome measures into the HPSS at all levels."
23 A. Yes.
24 Q. And that's part of what you were going to be overseeing
25 and monitoring, that they were working.

1 A. Yes, that's right.
2 Q. I think you might have referred to the first plan.
3 I won't go into it in detail, but we'll have a look at
4 one of the plans later on. It talks about developing
5 a three-year management plan.
6 A. Yes.
7 Q. And you also encouraged the boards and the trusts to
8 develop their own plans?
9 A. Yes.
10 Q. In fact, they had to.
11 A. They had to, yes. It was an essential tool in regard to
12 the accountability arrangements.
13 Q. All of this was thought to drive towards higher quality.
14 The reason I mention the word "quality" is because
15 that's become an important theme for the inquiry, to see
16 what role that played for the department. Would you
17 agree with that?
18 A. Very much so, yes.
19 Q. And indeed, the internal market, as we have heard, that
20 was created for health with the separating off, as the
21 chairman asked you, of the purchasers of the service,
22 the boards, from the deliverers, the trusts, that was,
23 in part, to improve quality?
24 A. It was, yes.
25 Q. You've mentioned the professionals whose advice you had

1 access to. The Chief Medical Officer was asked about
2 her role and in her witness statement -- we don't need
3 to pull it up, but her witness statement is 075/2,
4 page 2. She describes herself as having responsibility
5 for advising the minister and the department on matters
6 relating to public health. She said that she
7 established and chaired working groups of Health Service
8 professionals in developing policy advice for the
9 minister and the department on various issues and she
10 was expected to provide an effective bridge between the
11 minister and the medical profession.
12 Can I ask you, in that role of providing advice to
13 the minister and the department, did she also or did you
14 see it as part of her role that she would provide advice
15 to the Management Executive?
16 A. Yes, it was, in my view, her role to provide advice to
17 the executive. But not necessarily through attending
18 executive board meetings. I mean, it came through the
19 Deputy Chief Medical Officer. But I would have also
20 had, in the course of my normal business, many
21 opportunities to talk to her about particular issues
22 affecting the Health Service.
23 THE CHAIRMAN: Just give us one or two practical
24 illustrations -- I know I'm asking you to think back
25 20 years, Mr Hunter -- in terms of the sort of things

1 that you might have spoken to her about?
2 A. Yes. One that springs to mind was that in looking at
3 how we monitored healthcare, I would have consulted her
4 on the information systems that we were using in the
5 executive, and indeed seeking to develop in the
6 executive at the time, particularly where they tranched
7 on medical matters. For her part, she would have
8 involved me in some of the discussions at her specialty
9 advisory committees when she wanted the committee
10 briefed on management issues, which might affect the
11 operation of the hospital service.
12 THE CHAIRMAN: Okay.
13 A. So there was a bilateral series of conversations
14 throughout the time that I was the chief executive.
15 THE CHAIRMAN: Thank you.
16 MS ANYADIKE-DANES: That's actually just where I was going
17 to take you to. So for example, you are dealing with
18 management with an objective, really, of value for
19 money, so increasing the quality of the service and also
20 reducing unnecessary expenditure if that could be done.
21 In order to monitor that that was working, you might
22 have had discussions with her as to what the trusts' own
23 monitoring systems were, what was her experience of them
24 was, so you could see how best able they were to deliver
25 you with the kind of information that you might want to

1 have or have access to.
2 A. Yes.
3 Q. Could you have had those sorts of conversations with
4 her?
5 A. I don't recall conversations of that nature. Perhaps to
6 give a specific illustration that might help --
7 Q. Well, in due course, perhaps something like clinical
8 audit, the extent to which auditing was taking place
9 in the trusts, which they might have to satisfy the
10 boards they were doing, but you yourself may have an
11 interest into how well the management systems are being
12 developed in the trusts so that the output of that
13 assists you in knowing where you stand with the
14 department's policy?
15 A. Yes. We commended clinical audit, medical audit. We
16 expected it to be introduced in the hospitals in
17 accordance with the circulars that we'd issued. I can't
18 recall the exact context for that.
19 Q. I understand.
20 A. And we would have expected the medical group in the
21 department to keep us abreast of any developments on
22 that front which might have emerged.
23 Q. So that's the sort of thing you might discuss with her?
24 A. Yes. Actually, I think the issues we would discuss with
25 her were more in the nature of service provision. For

1 example, we would have discussed where exactly
2 particular hospital services might be provided. When it
3 became clear that a particular specialty could not be
4 provided across every acute hospital in the Province for
5 reasons of efficiency and effectiveness, we would have
6 discussed with her where those services might have been
7 provided in terms of the infrastructure for the
8 development of health and social care.
9 Q. Like paediatric surgery, for example?
10 A. Exactly, and we would have seen that as the mechanism
11 for driving up quality because if you attempt to deliver
12 a specialist service across a large number of small
13 hospitals the expertise may not be available to be able
14 to properly resource that service and maintain a high
15 quality. So when we wanted to concentrate a service,
16 that would come through discussions between us.
17 Q. Or you might not have sufficient throughput of that kind
18 of condition --
19 A. Exactly.
20 Q. -- for the clinicians to maintain their expertise?
21 A. Exactly.
22 THE CHAIRMAN: In a sense, it's 20 years ago, but the same
23 debates that are happening today, except the terms of
24 them have changed from time to time?
25 A. And sometimes the terms are the same, unfortunately!

1 THE CHAIRMAN: Because you have waiting lists, waiting
2 times, where the services will be provided --
3 A. That's right, exactly.
4 MS ANYADIKE-DANES: Now that we've touched on quality,
5 I wonder if I could pull up this, which is an extract
6 from the Patients' Charter. 306-085-003.
7 So the Patients' Charter is quite a lengthy document
8 and I'm sure you're familiar with it. It came in
9 in March 1992 when you were already chief executive.
10 A. That's right.
11 Q. This is just the foreword, which seems to capture
12 what was being said, and it's signed off by the
13 Parliamentary Undersecretary of State. It concludes
14 with the statement that:
15 "As the minister responsible for the health and
16 personal social services in Northern Ireland, this
17 charter is my personal pledge to all citizens that
18 services in Northern Ireland will continue to match the
19 very best available in the rest of the United Kingdom."
20 THE CHAIRMAN: Just before you ask, with all due respect to
21 the minister, is that a pledge that couldn't possibly be
22 attained?
23 A. It would be very difficult to attain it.
24 THE CHAIRMAN: It's an aspiration?
25 A. It's an aspiration, yes.

1 THE CHAIRMAN: But to describe it as a pledge that the
2 Health Service in Northern Ireland will match the very
3 best available in Great Britain, it just doesn't add up?
4 A. It doesn't.
5 MS ANYADIKE-DANES: Even to be able to inform the minister
6 as to where matters stood, let's put it that way,
7 in relation to trying to deliver such a pledge or even
8 trying to realise such an aspiration, how would you know
9 what was happening in terms of the standard of service
10 in Northern Ireland as compared to the rest of the UK?
11 How would you monitor that?
12 A. At the time the charter was produced, there were, as
13 I have said earlier, significant concerns over waiting
14 times and waiting lists, and I think it was those issues
15 which drove the Parliamentary Undersecretary of State to
16 make this pledge in the belief that citizens in
17 Northern Ireland would not have to wait longer than
18 citizens in the rest of the United Kingdom. So
19 I believe the intent behind that was to demonstrate that
20 we could match the targets which were being set
21 elsewhere for service delivery, but, reading it as
22 it is, it's clear that we could not monitor the
23 performance of the services in terms of the quality of
24 individual patient care against that being available
25 elsewhere in the United Kingdom.

1 Q. But ultimately, was it expected that it would be your
2 unit, the Management Executive, who would be monitoring
3 and evaluating the improvement, as it was intended to
4 be, of quality in the Northern Ireland hospitals?
5 Is that what would fall to you ultimately?
6 A. It would fall to the executive.
7 Q. So even if you couldn't exactly see how you compared in
8 any detailed sense with what was happening with the rest
9 of the UK, at least monitoring the change and the move
10 towards improved quality in Northern Ireland, that's
11 something that your unit would have to be doing?
12 A. Yes, and I believe we did so through comparing
13 performance times on waiting lists, waiting times,
14 et cetera. Those were the issues we were focussing on
15 as an indication of the performance of the health
16 services in Northern Ireland because those were the
17 indications which were being, in our view, used
18 elsewhere in the United Kingdom and where there were
19 baseline comparisons that one could make.
20 Q. Those are discrete elements of care?
21 A. Yes.
22 Q. But in terms of the quality of the actual care as
23 opposed to how quickly you got into the hospital, who
24 was monitoring any improvement in quality standards?
25 A. I'm not aware of anyone in the UK monitoring

1 improvements in the care of quality standards at that
2 time in a systematic way.
3 Q. Yes. Well, if we leave the rest of the UK aside, I'm
4 only asking you this because of this aspirational
5 pledge, if I can put it that way. Was anybody doing
6 that here or even attempting to do that here in
7 Northern Ireland through your unit?
8 A. Not directly through my unit. Our belief was that by
9 supporting the clinical audit we were looking at how the
10 professionals within the Health Service could more
11 systematically review clinical practice and, through
12 that, quality of care.
13 Q. Yes. You'd be aware that there was a development in the
14 rest of the UK towards clinical governance?
15 A. I wasn't aware of that term until reading the papers,
16 2003, with the duty of care.
17 Q. Yes.
18 A. So I wouldn't have thought of it in terms of clinical
19 governance.
20 Q. Yes, but if one moves away from the actual term
21 "clinical governance" and thinks about what the
22 objective was, the objective was that you would have, in
23 a more multidisciplinary way, information at your
24 disposal to talk about improvements in the quality of
25 care. Audit may be a tool towards achieving that, but

1 was not clinical governance in and of itself.
2 A. Yes.
3 Q. But you'd have appreciated there was a move to find ways
4 in which you could improve the overall quality of care
5 being provided in hospitals?
6 A. Yes, in a generalised sense that's the case and part of
7 the initiatives that were being taken at the time were
8 to develop hospital information systems, which would
9 ultimately provide better measures of improvements in
10 hospital care.
11 Q. Exactly, hospital information systems, precisely. For
12 example, there was a paper that the NHS put out from its
13 own Management Executive, the publication of "Improving
14 clinical effectiveness", and that came out
15 in December 1993. You would be aware of these sorts of
16 initiatives?
17 A. I would have, yes.
18 Q. And there was then the Clothier report coming out of the
19 Allitt inquiry in 1994, and there a great emphasis was
20 being made to a quick route to ensure that serious
21 matters -- this is serious failings in care -- are
22 reported in writing to the chief executive of the
23 hospital and also to find a more centralised route so
24 that those who are managing as you are can see across
25 the board what are the trends, if there are trends, in

1 failings and the trends, if there are those, in
2 improvements. So you were aware of those sorts of
3 initiatives in the rest of the UK?
4 A. Yes, I would have been.
5 Q. I'm not sure if you're aware of this, but coming out of
6 the Clothier report there was a letter to the
7 NHS Executive regional directors from corporate affairs
8 NHS Executive, which is effectively your section, but
9 just in the rest of the UK, instructing those
10 NHS Executive regional directors to put in place
11 arrangements for the notification of serious untoward
12 incidents. You'd be aware of that sort of initiative?
13 A. I would have been aware of that, yes.
14 Q. And also, there were similar issues appearing in
15 a White Paper that was published in 1997, "The new
16 NHS: modern and dependable"; you'd know about that?
17 A. Well, no, because I left in December --
18 Q. Yes, you had left when it was published, but surely the
19 work that was going on towards the production of such
20 a White Paper would have been happening during your
21 time?
22 A. The work would have gone on, yes.
23 Q. So you would be aware of that even though you were not
24 in post when it was actually published?
25 A. It wasn't always the case that Whitehall briefed us

1 fully on developments in the NHS in England.
2 Q. Then if we leave out that particular paper, you have,
3 I think, agreed that you were aware of those sorts of
4 developments?
5 A. I would have been. I said I can't recall those
6 developments, but I should have been aware of them
7 during my time as chief executive.
8 Q. Then what was happening in Northern Ireland alongside
9 those? Because all those developments I've put to you
10 are in the sort of mid-1990s. What was happening in
11 Northern Ireland?
12 A. Well, all I can recall is that we were attempting to
13 follow initiatives that had been taken in Whitehall and
14 to apply them appropriately in the Northern Ireland
15 context. But I can't recall the detail of action that
16 we took or consideration that we gave to any of those
17 particular reports.
18 Q. Was that development regarded as important in
19 Northern Ireland?
20 A. I think so, yes. I can't imagine why we would have felt
21 it would not have been important to follow up such
22 initiatives.
23 THE CHAIRMAN: Is this something that's easier to look back
24 on some years afterwards to see how it developed than
25 working through it? You've got a paper coming out in

1 1993 and then another one in 1995, so the pattern isn't
2 quite so clear as it would be now with hindsight?
3 A. I believe that would be the case, yes.
4 THE CHAIRMAN: But you would be aware, until you left
5 in December 1996, that things were changing?
6 A. Oh yes. I mean, I was very conscious that there were
7 developments within health and social care that were
8 moving towards what we now call clinical governance.
9 THE CHAIRMAN: And Dr Carson described it some time ago now
10 at the inquiry as really, for the first time, the
11 involvement of the medical professionals in management
12 so that they -- traditionally they had not been involved
13 in hospital management.
14 A. Yes.
15 THE CHAIRMAN: But what we're looking at and what
16 Ms Anyadike-Danes is asking you about shows the start of
17 doctors and, for that matter, some nurses becoming
18 involved in management. Do you recognise that as
19 something which was beginning to emerge in the early to
20 mid-1990s?
21 A. I do. I do recognise that emerging in that time.
22 I suppose the most clear examples I can recall, apart
23 from the clinical audit which I've mentioned already,
24 would have been the development of CREST, the Clinical
25 Resource Efficiency Support Team, which looked at

1 guidance. And I'm also conscious of the interest that
2 the Royal Colleges would have had at the time in
3 developing clinical guidelines. But that would have
4 been on the professional side of the department and
5 wouldn't ... at that stage, I regret to say with
6 hindsight, would have been seen as part of the interest.
7 In a direct sense of the executive, that would have been
8 seen as the professional side of the department carrying
9 forward its proper responsibilities within a framework
10 of what's been described as clinical autonomy.
11 THE CHAIRMAN: So it look a while longer for the two sides
12 to come together --
13 A. In a way which delivered the outcomes we wanted, yes.
14 THE CHAIRMAN: Thank you.
15 MS ANYADIKE-DANES: I'm going to put to you in due course
16 some comments that have been made on the pace of that
17 change in Northern Ireland, the comments that have been
18 made by the inquiry's expert, Professor Scally. But
19 I wonder if you could help us with this: he referred to
20 this instruction, as it were, coming out of the
21 Clothier report that went to the NHS Executive regional
22 directors, telling them to put in place arrangements for
23 the notification of serious untoward incidents so that
24 they would know at that level, that regional level, the
25 serious untoward incidents in the hospitals in their

1 territory, and that that information therefore could
2 become available nationally, and from that, as I said
3 before, one can see the trends and so forth, and that
4 drives policy: you know how effective your policy is,
5 where changes need to be made, and so on and so forth.
6 A whole raft of management decisions and policy
7 decisions can be made on that.
8 So that is a letter that went out in, as I've
9 said, May 1995.
10 A. Mm-hm.
11 Q. Can you think, before you left in 1997, whether there
12 was anything comparable at all that went out in
13 Northern Ireland to ask for serious adverse incidents to
14 be notified in some central way so that one can see the
15 extent of them and the pattern of them?
16 A. I cannot recall any initiative that the executive took
17 at that time.
18 Q. Was there any impediment to it doing similar?
19 A. I can't think there should have been any impediment.
20 THE CHAIRMAN: Well, one reason -- let's explore this for
21 a moment -- why you might not need to write in
22 equivalent terms would be if you were satisfied that
23 there was already an effective and working
24 Northern Ireland system, whether or not the serious
25 untoward events did come to the attention of the

1 Management Executive and the department. Was that the
2 case?
3 A. Well, I believe that the information channels at the
4 time would have provided information on serious
5 incidents. But had I been faced with providing an
6 absolute assurance that that mechanism would operate in
7 each and every case I would probably, at the time, have
8 concluded that there should be a more formal mechanism
9 for achieving that.
10 THE CHAIRMAN: Thank you.
11 MS ANYADIKE-DANES: Some of the benefits, as you've said, of
12 having a more formal mechanism might be that there's
13 a degree of standardisation so that you know what one
14 place decides is a serious adverse incident somewhere
15 else does and you know with regularity that those things
16 would be reported and you can build a database that can
17 be relied upon and upon which to make decisions and so
18 forth.
19 A. Of course.
20 Q. And then of course you can check it. If that is what
21 the system is, you can check it's operating in the way
22 that it has been designed to operate.
23 A. That's right.
24 THE CHAIRMAN: Just sticking on this, because I think you'll
25 understand that this is one of the concerns that the

1 inquiry has, we've been told that, I think in your
2 statement and in other statements such as Mr Gowdy's,
3 that the belief was that there was something in place
4 which would lead to serious untoward incidents coming to
5 your knowledge.
6 A. That's right.
7 THE CHAIRMAN: What I don't have quite clear from the
8 information we have is this: who would they come to?
9 Can I assume that they would come to the Management
10 Executive because the Management Executive had the
11 specific priority of ensuring the effective delivery of
12 the service and the effective use of resources? So if
13 there was a serious event in the Royal or the Erne, for
14 that matter -- it doesn't matter where it was -- would
15 you have expected that report to come in to your
16 Management Executive?
17 A. No, I would have expect it had to come in through the
18 professional channels of communication in the first
19 instance.
20 THE CHAIRMAN: If we pin this down, does that mean you would
21 expect it to come in, what, through the CMO?
22 A. Through the CMO, yes.
23 THE CHAIRMAN: Right. Who would it come to the CMO from?
24 A. It could come either directly from the hospital
25 concerned, from the medical director, Medical Staff

1 Committee chairman, or it could have come through the
2 Director of Public Health as the key person in this
3 regard in respect of the commissioning responsibilities
4 of the board.
5 THE CHAIRMAN: The Director of Public Health of which there
6 were four?
7 A. There were four.
8 THE CHAIRMAN: One for each board?
9 A. That's right.
10 THE CHAIRMAN: So it could come in directly from the
11 hospital which, during your time, became trusts, or it
12 could come in through the Directors of Public Health?
13 A. That's right.
14 THE CHAIRMAN: And then what would you expect the CMO to do
15 with that information?
16 A. I'd expect the CMO to alert the -- me, as
17 chief executive, to the existence of the problem, and
18 indeed to alert the minister to the particular issue,
19 and for there to be discussions within the department as
20 a whole, given that there could be policy issues
21 surrounding it, as to the appropriate action to take.
22 It could also come through, I'm reminded, the
23 coroner's -- obviously a coroner's report.
24 THE CHAIRMAN: And can you remember -- I'm afraid that the
25 reason I'm asking is because we have some unfortunate

1 examples in this inquiry of that system not working.
2 A. Yes.
3 THE CHAIRMAN: Can you, without going into names, if these
4 aren't public events, remember instances where that
5 system did work, that you did become aware of serious
6 untoward events?
7 A. I've sought to explore that particular issue in
8 preparation for the inquiry, and beyond incidents
9 affecting medical equipment, which would have come
10 through the estates side of the Management Executive,
11 I can't recall an instance where that arose.
12 THE CHAIRMAN: But there was a specific route and procedure
13 for the medical equipment problem?
14 A. There was, exactly, yes.
15 THE CHAIRMAN: Right. You'll understand that leaves me with
16 a concern that it may be that this system which you
17 expected to operate or thought was operating just wasn't
18 operating.
19 A. That's right.
20 THE CHAIRMAN: Okay.
21 MS ANYADIKE-DANES: I'm going to return to some of that in
22 a little while when I take you through how some of these
23 systems that you established were actually structured.
24 But I wonder if I can take you to this place, just
25 finalising this pace of change point, because it has

1 proved to be an important issue.
2 You were aware that there was a Central Medical
3 Advisory Committee, there were a series of committees
4 which, if I can put it this way, acted as a radar. And
5 one way that they acted as radar for the CMO to know
6 what was happening, they brought her issues, she brought
7 them issues, and in that way could bring you points as
8 well.
9 A. That's right.
10 Q. But in any event, this particular meeting, the Central
11 Medical Advisory Committee meeting of 2 December 1998,
12 they are talking about this question of change. We can
13 pull it up quickly now. 320-006-005. It's just under
14 a year after you had left, but it's obviously reflecting
15 things that may have been current at the time just
16 before your departure. You can see there that
17 Dr Clements is referring to the "Fit for the future" and
18 the White Paper that I put to you, and he says:
19 "This area must be progressed quickly and decisions
20 on the way forward could not be delayed because of the
21 setting up of the new Assembly."
22 That's an issue that arose and perhaps explained why
23 there was less pace in what was happening here. But the
24 point that he's making is this issue to do with being
25 able to correctly identify the quality of care and make

1 decisions on that, the systems for that that were being
2 discussed in the United Kingdom and that White Paper of
3 1997, those decisions couldn't can be delayed in
4 Northern Ireland. Before you left, were you aware that
5 there was an urgency that we did need to move forward
6 towards more formal systems for assessing quality?
7 A. I was certainly aware of the importance of developing
8 the range of initiatives that had been taken, as indeed
9 have been referred to in that particular document.
10 It would have been my desire, as it was I'm sure my
11 successor's, to continue that work and to develop it,
12 and with a consciousness of the importance of it and
13 therefore the need for urgency. We were, I suspect
14 then, as well as when I was involved in the executive,
15 proceeding in tandem as best we could with the
16 developments in Westminster. Discussions with
17 clinicians in regard to these types of issues were
18 taking place on the back of discussions in Whitehall
19 with central clinical bodies representing the UK as
20 a whole. So we would have been piggybacking, in
21 a sense, on what was happening elsewhere in developing
22 our own local initiatives. So there would have been an
23 urgency about it and I would have shared that urgency.
24 Q. Thank you. And then just finally, that government
25 paper, "Putting it right", that I mentioned to you, that

1 was of course a Northern Ireland response and that was
2 the subject of debate in the Assembly on
3 14 December 1998, again after you've gone, but this is
4 all referring to a period which would have been relevant
5 to your time of office. What Mr John MacFaul says, who
6 was then the Parliamentary Undersecretary at the
7 Northern Ireland Office, he says:
8 "It is a sad fact that the quality of some of our
9 services is simply not as good in Northern Ireland as
10 it is in other parts of the United Kingdom."
11 So there was a recognition that the aspiration that
12 the chairman had referred to in the March 1992 charter
13 was not being met, and that was being openly recognised.
14 He goes on to say:
15 "And we must address this urgently. We have to do
16 better and ensure that our services are second to none
17 and this means change."
18 So would you accept that general tenor, that there
19 was an imperative to do something? One of the issues
20 will be why, as the inquiry's expert believes, it didn't
21 happen as quickly as it ought, but do you accept the
22 general tenor that there was a need to move and to
23 change?
24 A. Yes, yes, I do. I would say that the need to move and
25 change was a continuous one. Ministers come in and make

1 pronouncements, reflecting their own particular
2 perspective on issues. I'm not aware of any particular
3 incident which would have led Mr MacFaul to make the
4 statement that he did, but I would see it as
5 a continuous process of change and improvement and not
6 the discrete one which perhaps his comments suggested.
7 Q. I think in fairness to him it's because he was
8 introducing the consultation paper "Fit for the future",
9 and that consultation paper set out six key themes, one
10 of which was placing an emphasis on improving the
11 quality of services and the other:
12 "Ensuring the development of a system which delivers
13 fair access to high quality services for everyone."
14 So if you're going to emphasise improving the
15 quality of the service then you need to know how you're
16 going to monitor that and measure that --
17 A. Yes.
18 Q. -- and to ensure that that is happening, and I think
19 that's part of the impetus for him requiring the change.
20 A. Mm, yes.
21 Q. I don't think anybody ever thought that Northern Ireland
22 didn't want to have a high-quality health service at any
23 point in time.
24 A. Yes.
25 Q. If I then turn more specifically to the quality of care.

1 Professor Scally has said in his report for the inquiry,
2 and I think maybe I should pull this up so you have it
3 conveniently to look at, it's 341-002-003. He says at
4 paragraph 3:
5 "There is little evidence in the available
6 documentation to indicate that there was a firm
7 expectation that either Health and Social Services
8 boards or trusts would be subject to any systematic
9 monitoring of the quality of care provided to patients
10 or in respect of their handling of adverse clinical
11 events."
12 And he refers to the key document, which is the one
13 that came out of your office, the Management Executive,
14 dated 1 October 1993, and it set out the accountability
15 framework for trusts. I'm sure you're very well aware
16 of that.
17 A. I did sign that document.
18 Q. Yes. So he refers to that and it says, relating to the
19 accountability framework for trusts:
20 "Does not display any interest in patient care
21 issues and they are not included in the five key items
22 listed in relation to monitoring the performance of
23 trusts."
24 We can pull that document up. It starts at
25 323-001a-002. Perhaps if you pull the next page

1 alongside it. You can see from there, and you are aware
2 of the document anyway, the first thing was to set out
3 the relationships between -- let me give you that again.
4 It's 323-001a-003.
5 First of all, it's the relationships. If one looks
6 under paragraph 3, one can see that part of what these
7 are to deliver is:
8 "To secure improving performance, raising standards
9 and enhancing quality."
10 So that's what you're wanting to achieve in that
11 particular set of relationships?
12 A. Yes.
13 Q. And it also talked about the separation of the
14 purchasing and providing roles.
15 A. Yes.
16 Q. Then under paragraph 4:
17 "The trusts are accountable to ..."
18 Well, the general public, obviously, to whom they
19 provide the services to the purchasers or the
20 commissioning boards because they have an agreement with
21 them as to what services they will provide and in what
22 manner, presumably. And then, the third:
23 "To the Management Executive for the performance of
24 their functions, including the delivery of objectives."
25 So the trusts were accountable to you?

1 A. Yes, they were. They were accountable. Also, though,
2 as the document says, to boards for the services that
3 they were commissioned to provide.
4 Q. Trusts were accountable to the Management Executive?
5 A. Indeed, the ultimate accountability was to the
6 executive.
7 Q. And they were accountable to the Management Executive
8 for their functions and their functions are, of course,
9 the delivery of healthcare --
10 A. Yes.
11 Q. -- within their area.
12 A. Yes.
13 Q. Then if one goes on to 004 and pulls up 004 and 005, in
14 004 you begin to see here set out what the trusts are
15 expected to contribute to the achievement of corporate
16 objectives. Included in that they have to be committed
17 to the implementation of the charter for patients and
18 clients that we have just seen.
19 A. Exactly, yes.
20 Q. So that's quality pretty front and centre there. And:
21 "Work within the framework of relevant central
22 guidance and policies."
23 And then, if we are going over the page, we see the
24 strategic direction and business plans that they had to
25 submit. Then if one looks at paragraph 10:

1 "The Management Executive will use the business
2 planning process to secure accountability to the
3 chief executive, and hence to ministers, for the use of
4 public funds and assets."
5 So they were going to be pressed on their business
6 plan and you were going to assess that business plan to
7 see the extent to which that could deliver what they
8 were supposed to be doing?
9 A. That's right, yes.
10 Q. Then if one goes over to 006 and 007, we see
11 "monitoring", and that's the Management Executive again.
12 This, I think, is where Professor Scally takes his
13 reference from. This is what was being considered
14 important and what the Management Executive was
15 particularly going to monitor. I'm not saying that was
16 all you were going to monitor because it says "focus
17 on", but this is what's been identified as of primary
18 importance. The first is:
19 "The performance against targets and objectives
20 in the business plan."
21 And then:
22 "The performance in relation to statutory financial
23 obligations, obviously. The contribution via
24 contracting to achievement of service priorities."
25 And then:

1 "The application of funds and adherence to statutory
2 obligations."
3 What Professor Scally is saying is -- he doesn't see
4 patient care issues expressly stated in those matters
5 that you are going to focus on for the purposes of
6 monitoring.
7 A. Yes, I would see those as falling within some of the
8 five areas, particularly the performance against targets
9 and objectives, because they would, for example, have
10 related to the charter for patients and clients and the
11 achievement of objectives set out therein, which did
12 directly impact on the quality of service.
13 Q. Yes, I see that. I think -- and it's helpful to have
14 your view on this because he may be giving evidence
15 later on so it would help him to hear how you see it,
16 but I think what he is saying is there's no explicit
17 reference, other than indirectly through the charter for
18 patient care, to monitoring the quality of care.
19 A. Yes.
20 Q. If I distinguish that, because patient waiting lists,
21 yes, that does affect the access to care and therefore
22 that can affect the experience of care and indeed, for
23 that matter, the course of your condition, but it's not
24 the quality of care in the sense of "Are we having more
25 adverse incidents because people are less well trained

1 than we want them to be?", that sort of thing.
2 A. That's right, yes. That certainly is the case. I think
3 if we'd included a reference to that, it would have been
4 seen as, in the words of the chairman, aspirational. We
5 did not have information systems which would monitor the
6 quality of patient care in specialty X in hospital Y.
7 Those information systems did not exist, I believe,
8 anywhere within the UK. And therefore we had no basis
9 for comparing what was happening in one institution with
10 another, nor did we have the information available which
11 would enable us to say, "If the quality of care is
12 level A, it should be increased to level B". Those
13 suggest a degree of sophistication which we were, at
14 that time at least, incapable of delivering on.
15 So to have included an aspiration to improve patient
16 care in the sense that the overall impact on individual
17 patients would not have been something we could have
18 delivered on. Now, I accept, had we included
19 a reference to incidents, yes, that could have been
20 recorded because even though we didn't have the most
21 systematic mechanism, as we've discussed, for achieving
22 that -- but quality of care in a generic sense I don't
23 think could have been monitored in terms of the overall
24 level of the quality of care across different
25 professional groups as well as different areas of health

1 and social care.
2 Q. I think what he has in mind is, as you've just touched
3 on yourself, monitoring the incidence of serious adverse
4 incidents, for example, or as I think they might have
5 been called there, serious adverse events. That at
6 least gives you a measure --
7 A. It would.
8 Q. And that might have been possible, to at least require
9 people to move towards --
10 A. Of course.
11 Q. That could have happened then?
12 A. It could have happened. It could have happened directly
13 in the reference of information to the department or the
14 executive. It could also have happened through
15 Directors of Public Health themselves. Because in their
16 role as part of the commissioning team of Health and
17 Social Services boards, one would have expected
18 Directors of Public Health to try and keep their finger
19 on the pulse of what was happening, not least in regard
20 to untoward incidents.
21 Q. And you monitored them. In a way, you monitored how
22 they were monitoring the trusts. That was another
23 aspect of your monitoring --
24 A. Yes.
25 Q. -- to the extent that they could have delivered that

1 through a requirement in their commissioning agreements.
2 A. Yes.
3 Q. That was something you could have monitored?
4 A. We certainly could.
5 Q. Can I ask you something else about the quality of care?
6 The CMO has said in her witness statement -- we don't
7 need to pull it up, but the reference is 075/2,
8 page 3 -- that the quality of care was not part of her
9 role as Chief Medical Officer; would you accept that?
10 A. Um ... I would accept that in respect of what
11 I understood she was talking about in regard to the
12 specification of clinical guidelines and standards,
13 which more properly, I believe, would be for the
14 professional bodies. So I would qualify any expectation
15 on what it would be practical for the Chief Medical
16 Officer to undertake in that regard.
17 Q. But did you not require, for example when things did go
18 wrong and they came to your attention -- and that could
19 be of a quality nature -- did you not require her to
20 advise as to whether that was something that you should
21 take cognisance of or that was sort of an aberration and
22 we don't need to worry, that's not anything we think
23 will be repeated?
24 A. I would certainly have taken her advice on such matters.
25 THE CHAIRMAN: I'm not sure how clear the picture is from

1 the mid-1990s, but it seems to me that it's at least
2 arguable that the CMO might be giving more than advice;
3 the CMO might be expected to take something of a lead in
4 finding out why something had happened and obtaining
5 reassurance that it wouldn't happen again.
6 A. Yes, and I would expect that to be undertaken through
7 medical channels and, if necessary, then to be
8 incorporated in Management Executive guidance, not least
9 to commissioners, for the purchase of care.
10 THE CHAIRMAN: That wouldn't be an area of strength for you
11 or your colleagues in the Management Executive.
12 A. No.
13 THE CHAIRMAN: That's something that you need the --
14 A. Expertise --
15 THE CHAIRMAN: -- medical --
16 A. Exactly.
17 THE CHAIRMAN: So she might identify: look, this needs to be
18 probed and we'll get Dr X and Dr Y to do it.
19 A. That's right.
20 THE CHAIRMAN: And so on. The problem is, from what
21 you have said, that just never happened that you can
22 remember.
23 A. I can't recall. I can't recall.
24 THE CHAIRMAN: You thought there was a system in place
25 whereby it would happen. On the incidents with which

1 the inquiry is familiar, it didn't happen.
2 A. That's right.
3 THE CHAIRMAN: Okay.
4 MS ANYADIKE-DANES: Mr Chairman, now that you've expressed
5 a view as to how she might have assisted, perhaps it is
6 fair to her to put what she put in her witness
7 statement. I think maybe we ought to call up then
8 witness statement 075/2, page 3.
9 So it is just under "5", Mr Hunter. You see there
10 she says:
11 "It's not part of the role of the Chief Medical
12 Officer."
13 That is where she's being directly asked about the
14 quality of care provided to patients, and then she goes
15 on to say how before the statutory duty for quality,
16 what she regarded as -- she's put it in terms of the
17 chain of responsibility. I'm not sure that's exactly
18 the question that is being asked, but in any event this
19 is how she puts it. She has the doctors being
20 responsible for the quality of care they provide and
21 I think you have more or less said that yourself:
22 "The trusts have a duty of care. Any concerns about
23 the standard of care of a doctor can be addressed by,
24 for example, the GMC, if it's a doctor, the trust, as
25 the employer, or the commissioning body. Concerns about

1 the performance of a trust can be dealt with by the
2 trust board. The chair of the trust appointed by the
3 minister is directly accountable to the minister."
4 But if one looks as, say, where the chairman was
5 taking you to, that area around (iii), looking at the
6 response that there might be from the commissioning body
7 and, for that matter, the response there might be from
8 the trust in (iv), if you as a department who are
9 monitoring those things wanted to know whether it was
10 appropriate for any circular, guidance, standard, to
11 issue as a result of that, you'd be discussing that sort
12 of thing with the CMO?
13 A. I would, yes.
14 Q. Yes.
15 THE CHAIRMAN: But the two people that the CMO has cut out
16 of that reporting mechanism are herself and you, aren't
17 they?
18 A. Yes.
19 THE CHAIRMAN: She's got the trust, she's got the board and
20 she's got the minister?
21 A. Mm-hm.
22 THE CHAIRMAN: So she has cut out any professional leads
23 such as yourself or the CNO.
24 A. Yes.
25 THE CHAIRMAN: She has cut out the Management Executive and

1 she may have the Permanent Secretary by implication at
2 (v), but she's cut out the two particular points where
3 you thought there was a role where you would expect
4 events to go to her and from her to you and to the
5 minister?
6 A. Yes, I would look at this from the perspective of being
7 the accounting officer for health and social care. And
8 within that ambit, I believe that I would have had an
9 interest in that matter. And I believe the minister
10 would have expected the department -- whether myself,
11 Chief Medical Officer or the Permanent Secretary -- to
12 alert him or her to the issue because of the expectation
13 that he or she might be called upon to give public
14 comment.
15 THE CHAIRMAN: I don't want to overstate this, Mr Hunter,
16 because you, for instance, were not told about Adam's
17 death and you weren't told about Claire's death. Adam
18 in 1995, Claire in 1996.
19 A. Yes.
20 THE CHAIRMAN: In Lucy's case, the Western Board was told
21 about it in 2000, but the department appears not to have
22 been told, and then the system did work when Raychel
23 died in 2001 to the extent that there was a direct
24 report from Altnagelvin to the department. There was
25 a direct report to the CMO and there was a direct report

1 to the Western Board.
2 A. Mm-hm.
3 THE CHAIRMAN: So it worked better in that incidence.
4 A. Yes.
5 THE CHAIRMAN: Whatever other issues arose from that, but it
6 worked better in 2001, it worked partially in 2000
7 in the sense that the Western Board was told about Lucy,
8 but it appears not to have worked at all in 1995 or
9 1996.
10 A. Yes.
11 MS ANYADIKE-DANES: Then if we now move to deal more
12 specifically with accountability. Although I'm not
13 quite sure whether you accepted -- you certainly
14 commented on what Professor Scally had said about the
15 quality of care. Do you accept that there is no ready
16 or there's little ready evidence to indicate that there
17 was a firm expectation that the trusts and the boards
18 would be subject to systematic monitoring of the quality
19 of care provided to patients? Would you accept that?
20 A. No, because, as I've said earlier, we monitored the
21 performance of hospitals in regard to such matters as
22 hospital waiting times, waiting lists and those issues,
23 including issues associated with the charter for
24 patients and clients.
25 Q. Yes, but if one looked at the quality of care as being,

1 for example, whether you had avoided an adverse incident
2 or not, so if one took adverse incidents as a barometer
3 for when things were going wrong with the quality of
4 care and applied that to what Professor Scally has said
5 here, would you accept that, during your time of office,
6 there wasn't any evidence that the trusts and the boards
7 were being subjected to systematic monitoring of that?
8 A. We did not systematically monitor untoward incidents.
9 Q. Yes.
10 THE CHAIRMAN: And I think you make the point that nor was
11 there any systematic monitoring of untoward incidents in
12 Britain until some years later.
13 A. That's right, yes.
14 MS ANYADIKE-DANES: I just want to be clear about this.
15 This is something that the professor has expressed
16 a view on, so I just want to make sure that we have your
17 evidence clear. There wasn't, in your view, any
18 systematic monitoring of that in the UK, but there seems
19 to have been an instruction that goes out in 1995 that
20 they should begin to put those systems in place, and
21 I think you have said no such instruction went out
22 during the time of your office.
23 A. I can't recall such an instruction going out.
24 Q. Thank you. And then if we go to, as I was going to go
25 to, the accountability. We looked at the part of that

1 circular that you signed on 1 October 1993, and I think
2 you had agreed that one way in which you would render
3 the trusts and boards accountable was by looking at
4 their management plans.
5 A. Yes.
6 Q. And in fact, the executive published its own management
7 plan, indicating what it expected.
8 A. Yes.
9 Q. We can look at the one for 1995/1996. It's at
10 306-083-001, but if we can go instead of 001 to 003 and
11 pull up alongside it 004.
12 If we start with that, one sees the mission
13 statement there:
14 "Leading the implementation of government policy and
15 by ensuring the provision of high quality services which
16 are efficient and cost-effective."
17 And if we see under the main objectives:
18 "To provide leadership."
19 And the second:
20 "To set and ensure the achievement of precise
21 objectives and targets for health in accordance with the
22 national and regional policies and priorities."
23 Then the third:
24 "To monitor the performance of the Health and
25 Personal Social Services in assessing need and improving

1 the health and social well-being of the population."
2 Then this plan, which is the 1995/1996 one, you go
3 on over the page in that final paragraph to say:
4 "The plan is something focusing on the role of the
5 boards as purchasers and also the GP fundholders [who
6 were also purchasers]. It is also, of course, relevant
7 to the trusts."
8 So they are to have knowledge of it also. And then
9 if we go and put up page 005 and, alongside 005, perhaps
10 put 010, so you can see these two things together. One
11 looks to see at 1.2.2:
12 "The plan provides direction to boards, trusts and
13 others involved in the commissioning and delivery of
14 health and social care."
15 And also:
16 "Health and social services trusts, directly managed
17 units and GP fundholders will be expected to reflect
18 relevant targets in their business plans."
19 And then one looks at 010, it says:
20 "The department [at 3.3.5] has decided to establish
21 a clinical standards group to evaluate and disseminate
22 information about clinical effectiveness. This will
23 help purchasers to contract for clinically effective
24 treatments and care."
25 Can you help us with who was providing the advice

1 for that clinical standards group and how did that fit
2 into the work that you were doing in monitoring
3 standards?
4 A. I regret that I can't recall anything to do with the
5 clinical standards group. But I would believe that the
6 Chief Medical Officer's department, Chief Nursing
7 Officer's department, would both, together with other
8 professionals, have been commissioned to provide
9 whatever support was required to that group and its
10 activities. So even though the Chief Medical Officer
11 might not have been a member of it, for example, I would
12 have expected her department to support it.
13 Q. So then you set out what you want to have delivered in
14 this period of time that's covered by your plan and the
15 trusts and the boards are to provide their own plans to
16 you and the boards' plan has to be approved by you;
17 that's correct, isn't it?
18 A. That's right, yes.
19 Q. And the trusts also have to provide annually updated
20 five-year strategic direction and business plans?
21 A. Yes.
22 Q. And you have to see that?
23 A. Yes.
24 Q. And all of this is for you to satisfy yourself that they
25 have the wherewithal to deliver what you want in your

1 plan.
2 A. Exactly.
3 Q. I think it goes on to say that the business planning
4 process was to be the main vehicle to secure
5 accountability to the chief executive. How did you
6 actually do that?
7 A. Obviously, I had a staff within the executive that would
8 have liaised both with boards and with trusts and would
9 have consulted with them in regard to the content of
10 those business plans. I would have paid particular
11 attention to the resourcing issues associated with those
12 plans, not least the need for capital investment to
13 achieve the objectives and targets that had been set,
14 but also to look closely at the financial assumptions on
15 which the business plan was based because it was
16 important from my perspective as the accounting officer
17 to ensure that boards and trusts live within their
18 means, and in particular that hospital services, which
19 were inevitably subject to significant pressures of
20 a financial kind through service delivery, would have
21 managed their resources within the budgets set for them,
22 largely through the commissioning process. So I would
23 have explored all those issues before those documents
24 would have been signed off.
25 Q. So you're looking to see if there's financial rigour?

1 A. Yes.
2 Q. But in terms of then monitoring during the period
3 covered by those plans, how are you actually monitoring
4 that what they set out they were going to do and what
5 you required them to do by your plan, certainly in terms
6 of thing that relate to quality of service, are actually
7 being achieved? What are the means that you have at
8 your disposal?
9 A. We would have had information on hospital throughputs,
10 so to that extent we were measuring performance. We did
11 not have information on quality of patient care and, as
12 I said earlier, nor do I believe any other part of the
13 United Kingdom had information systems which would have
14 given them the information on quality of care and any
15 changes arising from improvements in that standard.
16 Q. If we go to that because one of the things that you set
17 out in your accountability framework in that letter of
18 1 October 1993 was that there would be times when the
19 Management Executive would intervene.
20 A. Yes.
21 Q. And in fact, they're referred to as ground rules for
22 intervention. So they're supposed to be exceptional --
23 A. Yes.
24 Q. But nonetheless, a circumstance where the Management
25 Executive might intervene is where there are items of

1 concern relating to patient or client care. We don't
2 need to pull it up, but the reference for it is
3 323-001a-007.
4 A. I'm aware of that.
5 Q. What might that involve?
6 A. It could have involved an untoward incident such as
7 you've already referred to. But I cannot recall an
8 instance, while I was the chief executive of the
9 Management Executive, where that item -- that kind of
10 item emerged.
11 Q. So it could involve a quality issue just as you've
12 mentioned, an untoward incident?
13 A. It could have done.
14 Q. If you were going to be able to intervene on things like
15 that, you have to have information come to you in
16 a reliable form so that you can act on that.
17 A. That's right.
18 Q. And I think the point you've been making to the chairman
19 is that you didn't necessarily have that at that time.
20 You did in relation to two statutory areas, which is
21 what might happen in mental hospitals and so forth, and
22 anything that might happen in relation to equipment, for
23 example --
24 A. Mm-hm.
25 Q. -- because there's specific provision for that. But

1 outside that, you didn't have a reliable mechanism for
2 allowing you to intervene on that basis.
3 A. That's correct.
4 Q. The chairman has given you some examples of things that
5 the department didn't know about in relation to the
6 children that the inquiry is looking at. If I give you
7 some others, maybe we can test the sort of thing that
8 you might have been interested to intervene in.
9 There was a concern amongst some clinicians in the
10 Children's Hospital that clinicians in the district
11 hospitals didn't always appreciate the dangers of using
12 particular types of IV fluid which were used very, very
13 commonly with children. And there was a concern about
14 that. It didn't emerge as any guideline that went out,
15 but there was a concern amongst some of them. If the
16 department had known about that, that there was
17 therefore a potential risk, is that something the
18 department would have been interested in and asked the
19 CMO to follow up?
20 A. Yes, I believe so.
21 Q. There was also a concern coming out of Adam's inquest
22 about perhaps the need to change certain practices
23 in relation to intravenous fluid for children,
24 particularly associated with surgery, and I know that
25 you've been provided with it. There was a statement

1 that was given to the coroner and ultimately parts of
2 that appeared in the local press. The
3 Children's Hospital believed that there was some general
4 applicability to that and they would organise a seminar.
5 Ultimately, that didn't happen, but that just indicates
6 they felt it was something that wasn't just confined to
7 that small group of paediatric anaesthetists.
8 If that had come to the knowledge of the department,
9 might the department have been interested in whether
10 a seminar like that was in fact being held and whether
11 whatever concerns it was to address were being followed
12 up? Might the department have been concerned about
13 that?
14 A. I think the department might have been concerned about
15 that, but I think the department would have looked to
16 the Chief Medical Officer for advice on the most
17 appropriate course of action to take. So we would not
18 have acted unilaterally.
19 THE CHAIRMAN: In fact this is an example of, from what you
20 said earlier, two instances where the department would
21 have expected to have known. Let me put this
22 specifically because using the term "department" is too
23 broad. There were two ways in which Adam's death should
24 have come to your attention: one is through you being
25 told that there was an apparently avoidable death of

1 a young boy who was having a transplant.
2 A. Mm-hm.
3 THE CHAIRMAN: That would be the first in time, that would
4 be the first instance. The second would be, at the time
5 of the inquest -- because the inquest turned into
6 a fairly significant event. It was the first appearance
7 in this context of Dr Sumner in Northern Ireland and it
8 was at least taken seriously enough within the
9 Children's Hospital that they prepared a statement which
10 they gave to the coroner about how practices had
11 changed. And I rather gather from what you have said
12 already, Mr Hunter, that you would have expected each of
13 those issues to come to the attention of the CMO and,
14 through her, to come to your attention, at least to be
15 informed about it. What action you might need to take
16 would depend on how reassured you were that action was
17 already been taken.
18 A. Yes.
19 THE CHAIRMAN: But you would have expected to know at both
20 levels, wouldn't you?
21 A. I would have expected -- not least because part of my
22 role and a very important part of my role would have
23 been to keep the minister briefed on any issue which
24 might affect public perception of his political
25 responsibilities for the Health Service.

1 THE CHAIRMAN: This turns out not to be the case, but there
2 might be a scenario in which you learn of a child dying
3 during a transplant operation, which raises an issue
4 about whether we had the sufficient throughput of
5 children receiving transplants of that kind for that
6 service to be continued in Northern Ireland.
7 A. Very much so.
8 THE CHAIRMAN: That wasn't a specific issue in Adam's case,
9 but is that the sort of query that you would raise if
10 that came to your attention?
11 A. That's right.
12 THE CHAIRMAN: You'd want reassurance that in fact
13 transplants should continue?
14 A. Yes.
15 MS ANYADIKE-DANES: I think you talked about the media
16 becoming involved. And that's a trigger for you wanting
17 to know something and, for that matter, I presume the
18 Permanent Secretary wanted to know something because the
19 minister may become involved and the minister may be
20 asked to give a statement. So for no other reason,
21 leaving aside the quality of care issues, there was
22 a reason there. I just want to pull up this very, very
23 quickly if we have it. 069a-102-423.
24 That might not come up and I can very easily read to
25 you what's on it. It's one of the many press reports

1 that appeared after Adam's inquest. The reason for
2 telling you is, apart from the fact that it encapsulates
3 in its report the statement that the trust made at the
4 time as to their change in practice, it also includes
5 the consultant nephrologist for Adam saying that he had
6 recently become aware of nine other deaths in the UK
7 which shared similarities and would like to have those
8 investigated. It concludes with the coroner saying:
9 "This type of death is relatively rare, but I agree
10 there should be further investigation into the other
11 cases."
12 I have just taken it at face value, irrespective of
13 whether you knew there were in fact nine other cases and
14 so forth. That's the sort of thing which might prompt
15 a query to the minister and also might indicate that
16 there is a problem that should be being addressed.
17 A. Yes.
18 Q. In your statement to the inquiry at 349/1, page 3, you
19 said that you could not personally hold each and every
20 trust to account, that would just be too burdensome to
21 expect you to do that, but what you did instead was you
22 held the boards to account and interrogated their
23 methods of holding the trusts to account. And in that
24 way, other than if something came directly to you about
25 a trust, that was your normal way of monitoring what was

1 happening and ensuring that they were properly
2 accountable to you. Would that be a fair way of
3 describing it?
4 A. Yes.
5 Q. At the time --
6 THE CHAIRMAN: I'm sorry, I just want to avoid any
7 ambiguity. When you say on page 3 of your statement,
8 Mr Hunter, at the end of your answer to question 9:
9 "I held the boards, as purchasers, to account ..."
10 So the board that's being referred to there is, for
11 instance, the Eastern Health Board, it's not the board
12 of the Royal Trust?
13 A. No, you're right, chairman, it was the board of the
14 Eastern Health Board. I'm sorry for that ambiguity.
15 THE CHAIRMAN: Don't worry, you're fine.
16 MS ANYADIKE-DANES: If you were going to use that as your
17 basic mechanism -- not your sole, but your basic
18 mechanism -- did you have any input as between the
19 purchaser board and the trust?
20 A. As I recall events, the interest in the Management
21 Executive in the contracting arrangements would have
22 been particularly in regard to regional services where
23 the department had a responsibility for ensuring the
24 coordination of the purchasing plans of the four boards
25 in respect of those regional services delivered, in the

1 main, in the big Belfast hospitals.
2 Q. For example like neurology, like paediatric intensive
3 care, that sort of thing?
4 A. Cardiac surgery. Not least because the developments in
5 those services would have required capital investment or
6 additional investment in terms of resources for skilled
7 staff.
8 Q. But did you also look at them to satisfy yourself that
9 what was set out there was a means by which the boards
10 could reasonably be expected to know that the trusts
11 were indeed performing in the way that you wished them
12 to perform? Did you look at those mechanisms?
13 A. It's difficult to recall this. I think at the time
14 we would have looked primarily at the statistical
15 information available in terms of the performance of
16 hospitals in regard to activity rates.
17 Q. Yes.
18 A. That would have been the collective mechanism that we
19 would have, I think, used.
20 Q. The reason I'm asking you that is because, if you're
21 going to use the boards as a way of satisfying you that
22 the trusts are being held to account, then does it not
23 give you an interest in making sure that the boards
24 themselves have included an appropriate mechanism for
25 that in their purchasing agreements?

1 A. Of course, yes.
2 Q. I now want to put to you a statement that the
3 chief executive of the Royal Trust at the time,
4 Mr McKee -- and I'm sure you've been given an extract
5 from his statement -- has made as to what he thought was
6 the responsibility, both of himself as chief executive
7 and also of the board. He explained that there came
8 a time when personal responsibility did devolve, there
9 was a change in the statutory position and personal
10 responsibility did devolve --
11 A. Yes.
12 Q. -- on to he and the board. But until that happened, his
13 view was that he wasn't personally responsible, nor for
14 that matter was the board. The department's position,
15 when the department was giving its statement on these
16 matters to the chairman in answer to a question of the
17 chairman, said they didn't actually really think there
18 was very much difference between the responsibility of
19 the trust boards and, for that matter, the
20 chief executive before and after the statutory change in
21 2003. All the legislation did was essentially
22 encapsulate something that was already a responsibility.
23 A. Yes.
24 Q. When you were asked whether you agreed with Mr McKee's
25 position, I think you rather took the view that he was

1 referring to the fact that -- in fact, we can pull it
2 up, it's probably the fairer way to do it. 349/1,
3 pages 3 and 4. If we can pull them up next to each
4 other. Witness statement 349/1, pages 3 and 4.
5 If we look down at 10, it's being put to you what
6 Mr McKee has said. He says:
7 "In 1993 --
8 THE CHAIRMAN: We don't need to read it out because it slows
9 down the transcript. You have what Mr McKee said and
10 then you have what Mr Mills said.
11 MS ANYADIKE-DANES: And then you're being asked, firstly,
12 whether you agree with Mr McKee and you've given your
13 answer there. I think you're distinguishing between the
14 trusts and Mr McKee as an individual being responsible.
15 I think you say:
16 "I believe the trusts had an overall responsibility
17 for clinical care and the duty would have been
18 discharged by ensuring there were effective
19 arrangements."
20 And then:
21 "I do not see how a non-professional [that's
22 Mr McKee] on behalf of the trust could be held
23 personally accountable for clinical care as distinct
24 from the professional monitoring arrangements."
25 Did you nonetheless think that Mr McKee bore any

1 responsibility as the chairman or the chief executive of
2 the trust? Did you feel he had any responsibility?
3 A. Yes, I believe he had a responsibility for ensuring that
4 there were systems within the hospital to ensure that
5 clinicians operate in a system of clinical audit,
6 et cetera. So I believe, as the trust chief executive,
7 he was not responsible for the decisions, obviously, of
8 those committees or for their actions because of the
9 professional nature of their operation, but he had
10 a duty as the chief executive of the trust to make sure
11 there were effective systems in place.
12 THE CHAIRMAN: And if things were going wrong, that
13 information should have fed its way to the trust board?
14 A. That's right.
15 MS ANYADIKE-DANES: And the board had a responsibility also?
16 A. I believe so.
17 Q. What he ended up by saying -- we don't need to go
18 through it in detail, but I will just give you the last
19 bit of it because that encapsulates it. He gave
20 evidence to the chairman on 17 January 2013 and he was
21 pressed rather hard as to what exactly he meant by not
22 having responsibility before the change in 2003, and
23 ultimately he said on page 17:
24 "And your evidence is that neither the board nor
25 yourself had any responsibility for the healthcare and

1 the quality of healthcare given to patients in the
2 hospital [that is in this pre-2003 period]?"
3 And he says:
4 "I have to answer that question, Mr Chairman, yes,
5 that was the case."
6 And then the chairman asks him, because he has gone
7 on to answer that he felt the responsibility for these
8 things really fell with the professionals, the
9 clinicians and the nurses, and they had their own
10 professional bodies. So the chairman asked him:
11 "So was this entirely a matter for the individual
12 doctors and nurses?"
13 And ultimately he agrees that at that time it was
14 entirely a matter for the individual doctors and nurses.
15 Do I take it from how you've answered the chairman that
16 you don't agree with that?
17 A. I would believe that the clinicians were responsible for
18 the operation of the systems, but that there was
19 a responsibility on the part of the trust, exercised by
20 the chief executive, to make sure that there were
21 effective systems in place.
22 THE CHAIRMAN: So in essence, he's rather understated the
23 responsibility which the trust board had for what was
24 going on?
25 A. That's right.

1 MS ANYADIKE-DANES: And to the extent that he didn't think
2 the trust board had a responsibility at all until the
3 legislative change in 2003, you would have disagreed
4 with that, obviously, from what you've said?
5 A. I would have disagreed with it. I think the problem may
6 be that he was interpreting the question and the issue
7 in terms of his right to engage in issues, which at that
8 time was seen as the preserve of clinicians in respect
9 of their clinical autonomy. And I can understand him
10 being reluctant, if that was his interpretation, to
11 appear to be second-guessing what the clinicians may
12 have been exploring and discussing and concluding.
13 Q. The reason for asking you this is in fact he was given
14 quite a lot of opportunity to develop exactly what he
15 meant by that and ultimately he absolved, in the
16 pre-2003 period, both himself and the board of
17 responsibility for these matters of quality of care.
18 But why I'm asking you that is: are you surprised that
19 that was his view, that he didn't hold the board or
20 himself as having a responsibility for quality of care?
21 A. I'm surprised as you describe it. I wouldn't say
22 I would be surprised if, in the course of his
23 examination, he genuinely felt that he was being asked
24 about his capacity to intervene in matters which he
25 believed were the preserve of clinicians.

1 Q. Yes, I understand why you think that, but the chairman's
2 heard his evidence. Why I'm asking you this question is
3 not so much to sort of get into the whys and wherefores
4 of Mr McKee, but if you were in charge of monitoring
5 what was happening and how standards were being
6 implemented in the trusts, if you were in charge of
7 that, ultimately is that something that you would have
8 expected to know, that one of the chief executives of
9 a trust as important as the Royal Trust didn't think
10 that either he or his board bore that kind of
11 responsibility?
12 A. It's a similar relationship, I suspect, to within the
13 department. I would have expected the chief executive
14 of any trust to engage in close discussion with the
15 medical director of the trust in regard to issues such
16 as you've described and, to that extent, to have an
17 active interest in what was happening.
18 Q. Yes, and if you're scrutinising the relationship with
19 the boards holding the trusts to account, if that were
20 Mr McKee's views, you would have expected to know that
21 because that would be untenable, would it not?
22 A. Yes. Yes, if that was the interpretation placed upon
23 it, yes. And I would have expected that to come through
24 the board as the purchaser of the service.
25 Q. Yes. And if that was the view and you didn't know it,

1 might it indicate perhaps the system that you had for
2 keeping your finger on the pulse may not have been quite
3 as robust as it might have been if that could slip
4 through in your relationship with the boards?
5 A. It would certainly cause me concern about weaknesses
6 in the system.
7 MS ANYADIKE-DANES: Thank you.
8 Mr Chairman, I was going on to audit. I wonder if
9 we could break now for a few minutes?
10 THE CHAIRMAN: We'll take a break for a few minutes,
11 Mr Hunter. Thank you.
12 (11.15 am)
13 (A short break)
14 (11.30 am)
15 THE CHAIRMAN: Mr McMillen, Mr Hunter's been very direct and
16 very helpful in his evidence, but it does seem to me, on
17 the basis of what he's said so far, that his
18 understanding from the time of the system that was in
19 place isn't really matched by the reality. If we only
20 ever take Adam's case on this, then there were at least
21 two ways in which that should have come into the
22 department and it appears not to. And we know Claire's
23 case didn't come in either.
24 I acknowledge that in 2000 at least something had
25 improved to the extent that the Western Board was told

1 about Lucy's case. In 2001, the department was told
2 about Raychel's case. So there's progress on that
3 level.
4 But if we stick with the relevant time for
5 Mr Hunter, I'm tempted to ask Ms Anyadike-Danes to move
6 on through a number of areas that she was going to
7 question him about on the basis that, as I have heard
8 Mr Hunter's evidence to date, if there was a system, it
9 wasn't a system that worked and perhaps, more to the
10 point, the Royal didn't play into that system because --
11 MR McMILLEN: Yes, Mr Chairman. Hopefully we made it clear
12 in my opening, and also in some documents filed for the
13 inquiry, that we accept there was no formal system in
14 place for reporting. What we did say was that in two
15 domains -- I think this is generally reflected in this
16 witness's evidence -- we would expect information to
17 come to the department, number 1, if there was what
18 could be a clinical or a medical issue of regional
19 importance or, number 2, if there was a matter which
20 could generally affect the public's confidence in the
21 Health Service or would otherwise be a matter of
22 interest to the minister. I think largely that is what
23 this witness is saying, so we do accept that position.
24 THE CHAIRMAN: Well, I don't want to move Ms Anyadike-Danes
25 on and then find there's an area of dispute afterwards.

1 Would the unexpected, avoidable death of a boy like Adam
2 during transplant surgery be an issue that should be
3 brought to the attention of the minister on the
4 department's approach?
5 MR McMILLEN: Generally, the view of most witnesses for the
6 department is "yes" --
7 THE CHAIRMAN: Okay.
8 MR McMILLEN: -- particularly with the statement afterwards.
9 THE CHAIRMAN: Yes. So the fact that that didn't happen
10 either means that the system didn't work or in fact it
11 wasn't a system that could necessarily be relied on.
12 Well, it either means that there wasn't a system or it
13 was a system which didn't work. That isn't much of
14 a choice.
15 MR McMILLEN: It was a system based on expectations that
16 people would act in a certain way, professional people
17 would make a judgment and, as Professor Scally said in
18 his evidence, it was always a judgment call whether to
19 take things further up the line. Certainly insofar as
20 the information didn't come to the department's
21 attention, manifestly it didn't work.
22 THE CHAIRMAN: I'm also struck, I have to say, by the
23 reference to the CMO's statement because it's not clear
24 to me that Dr Campbell expected this system to work in
25 the way it has been otherwise described because she

1 excluded from her expected reporting mechanism both
2 herself and the Management Executive. She includes the
3 trust board, she includes the area board, like the
4 Eastern Board, and then she says the department because
5 the minister knows, but she doesn't include herself as
6 a person to go to, whereas what Mr Hunter is saying is,
7 "I would expect this to come in through the professional
8 line", and that, at least today, it makes sense to me
9 because if there is an issue, if Adam has died,
10 Mr Hunter's strengths don't lie in analysing the medical
11 consequences of that. But the CMO will either be able
12 to do it herself, or through access to her fellow
13 professionals she'd be able to work out whether this is
14 something that has an effect on the regional transplant
15 services or if this is a terrible one-off accident.
16 MR McMILLEN: I think Dr Campbell will have to give her own
17 evidence on Thursday. I think we'll hear from Mr Gowdy
18 that his expectation was even over and above the
19 professional routes, through the Directors of Public
20 Health, et cetera. He would expect, if there was
21 a major issue, the chairman of the trust board or
22 chairman of a board to ring him because they did that on
23 a number of occasions for a variety of different
24 reasons.
25 THE CHAIRMAN: Yes.

1 MR McMILLEN: But that was the route he thought would be
2 used.
3 THE CHAIRMAN: I'm also struck by the fact that, before your
4 own personal involvement, we had the rather stark
5 evidence of Mr McKee last September, I think, last year,
6 in which he was putting rather more distance between the
7 doctors in the Royal and the board of the Royal than any
8 subsequent witness appears to have done.
9 MR McMILLEN: Well, again, as we hopefully made clear in our
10 opening, we simply don't accept any person or anybody
11 involved in the Health Service can simply walk away and
12 say "I have no responsibility". The question is what is
13 the responsibility, what does it mean in any particular
14 domain? It's a matter for yourself, Mr Chairman, but --
15 THE CHAIRMAN: It is. I have to say it's a bit disturbing
16 that the chief executive of one of the most significant
17 trusts in Northern Ireland held that view. It gives me
18 the impression of some degree of confusion about how the
19 system was operating as it changed during the 1990s. If
20 we go back before the 1990s, in effect the
21 professionals -- the doctors and nurses -- they were
22 quasi-independent, it seems, in terms of the way they
23 liaised with management. Dr Carson has described this
24 process as the doctors and nurses being drawn into
25 management. So what was going on in the 1990s might, to

1 some extent, reflect the locking-in of the new system.
2 MR McMILLEN: I did read Mr McKee's evidence. I can't
3 remember the precise details of it and on which areas
4 he was pressed. On one analysis he could be saying
5 "Well, clinicians are responsible for the clinical
6 matters", which is clearly correct.
7 THE CHAIRMAN: Yes.
8 MR McMILLEN: It's hard to see how a trust board or a trust
9 as the employers and direct line managers of clinicians
10 cannot have responsibility either in tort, for example,
11 or vicariously or if they, for example, employed an
12 incompetent clinician or continued to employ one, they'd
13 have direct responsibility. Even on that very basic
14 analysis, one finds it hard to see if there's any
15 support for Mr McKee.
16 THE CHAIRMAN: Otherwise you would have disclaimer notices
17 up around the Royal saying the Royal Trust is not
18 responsible for the quality of care.
19 MR McMILLEN: It would be ludicrous.
20 THE CHAIRMAN: That would be an interesting sign. That's
21 helpful.
22 The purpose of this exchange is to help us focus on
23 the areas that Mr Hunter still needs to give evidence on
24 and I think that what he has been quite frank about
25 earlier this morning is very helpful and will help

1 reduce the areas of questioning which still remain.
2 Thank you very much.
3 MS ANYADIKE-DANES: Mr Chairman, thank you very much indeed.
4 Just in the interests of clarity, the particular
5 part, which I don't want called up, of the transcript of
6 Mr McKee's evidence is 17 January 2013, and it runs from
7 page 13 to page 17. I know that you have it,
8 Mr Chairman, because you've looked at it previously, but
9 I really would commend that as to exactly how bald
10 a statement Mr McKee was making about responsibility.
11 Then if I move on with this, Mr Hunter, I think what
12 the chairman has really summed up is that however
13 anybody might have picked up the phone and called, the
14 true position is there was no systematic way of you, the
15 Management Executive, being alerted to serious adverse
16 incidents.
17 A. That's right.
18 Q. Thank you. I want to move on to two areas in which
19 serious adverse incidents were dealt with. One is
20 in relation to the circular dealing with adverse
21 incidents from reactions of defective products, which
22 related to medical and, for that matter, non-medical
23 equipment. That was one. And there was a particular
24 circular put out about that. That is to be found in
25 witness statement 062/1 at page 13.

1 We may be having a little trouble with it. No?
2 Okay, don't worry. It issues from the Management
3 Executive and it's dated 27 July 1994, so it's one of
4 the ones that you would have issued. It goes out to the
5 general managers, the chief executives of boards, the
6 chief executives of trusts and a number of others. What
7 it is to do is to update what's called the hazard
8 reporting procedure to take account of the European
9 directive that had just come in at that stage. This was
10 a duty that already existed, but it was now being made
11 EU compliant, if I can put it that way. They were being
12 told that:
13 "The general managers and the chief executives were
14 responsible for ensuring prompt reporting of adverse
15 incidents and reactions and defective products relating
16 to medical and non-medical equipment, supplies, food,
17 buildings and plant."
18 And that the adverse drug reactions have to be
19 reported to the Medicines Control Agency on the
20 yellow-card system and we know that the yellow-card
21 system was used in relation to one child, which is
22 Raychel, which is after your tenure. So that was the
23 system.
24 But this would require these people, these
25 officials, to report an adverse incident that satisfied

1 those criteria. So that was a formal way of the
2 Management Executive knowing that an adverse incident
3 had occurred.
4 A. Yes.
5 Q. The other one was untoward events involving patients in
6 psychiatric or special care hospitals. One sees that in
7 witness statement 075/1, page 32.
8 So this is pre-dates your time because it's
9 30 October 1973, but nonetheless would be a means,
10 a formal means, of reporting. There's a series of --
11 well, firstly the untoward events are defined as in (a),
12 (b) and (c), which include, but are not obviously
13 confined to, sudden unexpected or unnatural deaths.
14 You're giving details from (a) through to (f) as to what
15 actually has to be done by way of reporting.
16 So this was a formal means and you knew about that
17 during your term of office?
18 A. Yes.
19 Q. What I want to ask you is, given that some thought had
20 been given as to the circumstances in which there should
21 be formal reporting of adverse incidents, during your
22 time was there any discussion at least of whether that
23 system should be extended to untoward events happening
24 in hospitals in relation to medical care?
25 A. I can recall no discussion of that topic.

1 Q. Why not? Why wouldn't there have been that
2 consideration?
3 A. I suppose the simplest reason is that on issues
4 associated with untoward incidents such as these that
5 you've quoted we would probably have taken the lead from
6 the Department of Health in London and followed whatever
7 decisions had been reached there in regard to
8 communication with the Health Service. So we would have
9 relied on their lead on such matters.
10 Q. But that's exactly what they were doing about that
11 letter in 1995.
12 A. You said that, yes.
13 Q. So you have a system, a formal system, in relation to
14 two sorts of things.
15 A. Yes.
16 Q. In 1995, in England, they are moving to require systems
17 to be set up to do that generally.
18 A. Mm-hm.
19 Q. And we're aware of it here in Northern Ireland, but
20 during your term you don't recall anybody discussing
21 extending it in that way?
22 A. Exactly.
23 Q. And you can't help us with why that wasn't happening?
24 A. I don't know.
25 Q. Thank you.

1 THE CHAIRMAN: It obviously makes sense now, looking back on
2 it, but --
3 A. Mm-hm.
4 MS ANYADIKE-DANES: And then Professor Scally sums up the
5 situation. In the light of the reporting systems that
6 were available to the Management Executive and the
7 department generally, he says at 341-002-019:
8 "It is unsurprising that the deaths did not come to
9 the attention of the department in a systematic fashion
10 due to the fact that the information came in a series of
11 [what he describes as] unstructured communications,
12 often by means of telephone calls, outside any
13 recognised protocols and heavily reliant on
14 interpersonal relationships."
15 Would you say that's a fair characterisation?
16 A. As far as I can recall the situation, yes.
17 Q. There was -- I'll just pull it up now -- a risk
18 management manual that was issued in the NHS in 1994.
19 Can we please pull up two pages alongside each other,
20 314-013-001 and 002? Sorry, this is how it came to us
21 and the colour makes it a little bit harder to read, but
22 if you can bear with me.
23 This was issued in 1994. You can see what it's
24 dealing with:
25 "Implementing risk management: tracking, trending,

1 monitoring and projection."
2 Some of that is what you were trying to do in the
3 Management Executive.
4 A. Well, I haven't had time to read this document. Sorry.
5 Q. I beg your pardon. Let me take you through it. If one
6 looks at "tracking", it's what you'd imagine it to be:
7 recording of data, assimilation of information. If one
8 sees the second paragraph:
9 "The foundation of a good tracking system is
10 a comprehensive incident reporting system."
11 That's not something that we had at that stage, but
12 this is making the case for having these sorts of
13 arrangements.
14 A. Mm-hm, mm-hm.
15 Q. Then if one sees under monitoring:
16 "Monitoring of any given [which is an exercise that
17 the Management Executive engaged in] criteria recorded
18 on incident forms gives a useful early warning system of
19 a downturn in standards and an increase in incidents,
20 which may result in a legal claim."
21 It goes on over the page to say:
22 "As monitoring continues and information is fed back
23 to the departments, they are able to see the effect of
24 the risk controlled measures introduced."
25 And you, interested as you were with value for

1 money, decreasing the cost to the taxpayer of the
2 delivery of the Health Service, increasing the quality,
3 this is the sort of thing that you were interested in?
4 A. Yes, we had a general interest in those issues.
5 Q. And you can see under "projection" that the benefits of
6 that is to project trends and costs and so forth.
7 That's one of the reasons you'd be doing it.
8 If one goes then to page 004. As I say, this was
9 a manual in the rest of the UK in 1994. So 314-013-004.
10 It's coming out of all of this, it's the action points.
11 There's one action point there:
12 "Steps should be taken to implement a tracking,
13 trending and monitoring system for untoward incidents.
14 Reports produced regularly."
15 That means you've got your reporting and you want to
16 monitor and track them and so forth. And then, in the
17 page that I haven't quite been able to get up yet, the
18 action point coming from that is that not only should
19 there be an incident reporting system, but there should
20 be a standardised incident reporting system. So not
21 the judgment that was being described as to whether one
22 chief executive thinks "This is something I need to
23 phone through to the department", but a standardised
24 system and:
25 "A clear message should be given to staff that the

1 reporting of untoward incidents won't result in punitive
2 action against that staff member."
3 In other words, to create a culture whereby that is
4 an acceptable, even a good thing, to be doing.
5 So insofar as you were trying to keep abreast or at
6 least aware of developments in the UK, were you aware of
7 this?
8 A. I have no recollection of it.
9 Q. If you had, is this something that you would have wanted
10 to be able to move towards to assist you in the work
11 that you had to do?
12 A. Yes, I think it would have been.
13 Q. Then just finally on the state of play, Professor Scally
14 has referred to a report produced by Healthcare Risk
15 Resources International. They were asked to do a sort
16 of baseline survey of where things stood and they were
17 asked to do that in 1998, and they finally reported in
18 1999. That report, Mr Chairman, is attached as
19 appendix 5 to a report by the NIAO in 2002 on
20 compensation payments for clinical negligence.
21 THE CHAIRMAN: NIAO being the audit office?
22 MS ANYADIKE-DANES: The Northern Ireland Audit Office, yes.
23 They were looking really to see how matters had
24 developed since that period of time. That report falls
25 way outside your time, Mr Hunter, so we'll look at that

1 with others in due course. But this survey doesn't
2 because it's dated -- well, they were commissioned in
3 1998 and they were looking back over a period of time
4 that would have covered some of your tenure.
5 The criticisms that they make, which are referred to
6 by Professor Scally, we see at 338-006-106. And perhaps
7 if we can pull up alongside of that page 107. This is
8 a synopsis of the report.
9 THE CHAIRMAN: Sorry, who commissioned this report?
10 MS ANYADIKE-DANES: This was commissioned by the department.
11 THE CHAIRMAN: Right.
12 MS ANYADIKE-DANES: You see the first issue is to do with
13 risk management and they conclude:
14 "Greater efforts need to be made in order to ensure
15 that the strategy is endorsed fully by the board of the
16 trust concerned and that all managers [and so forth] are
17 fully aware of it."
18 The strategy, of course, is implementing a proper
19 risk management strategy. Is a risk management strategy
20 something that could have been included in the
21 purchasing agreement between the board and the trust?
22 A. Yes, it could have been. As I reflect back on my time
23 in the Management Executive, the concept of risk
24 management hadn't emerged to the extent that it
25 subsequently emerged as a key governance instrument.

1 Q. I see.
2 A. So whatever interest we had in risk management at the
3 time -- and I can't recall -- it would have been, in
4 governance terms, an embryonic understanding of the
5 concept, which has been developed substantively since
6 then.
7 Q. I understand. Then if we look across at the incident
8 reporting which you've been taken through, and look
9 at the last couple of sentences there, it refers to:
10 "The major deficiency relates to the very limited
11 and probably significant under-reporting of clinical
12 incidents and near misses."
13 And they say:
14 "A major effort needs to be made in almost all
15 trusts to improve in this area."
16 So that's the sort of thing you were talking about:
17 there wasn't a systematic way of doing it; without that
18 and without you therefore being able to check what's
19 going on, it's very likely that there was
20 under-reporting or at least lack of accurate reporting?
21 A. Well, all of the evidence not just from
22 Northern Ireland, but also the UK, is that there was
23 significant under-reporting within the Health Service
24 generally.
25 Q. If we look at patient records, which is a primary source

1 of data, it talks there about:
2 "A low level of compliance with this amongst the
3 majority of trusts and a real need for most trusts to
4 develop an explicit policy document incorporating all
5 the elements for the system and routine audit of
6 compliance with that policy."
7 Were you aware of any concerns about the quality of
8 patient records when you were chief executive?
9 A. I recall visiting for information purposes, at my own
10 request, the information department in the Royal
11 Victoria Hospital, where it was clear, even on the most
12 superficial of visits, that there were substantial
13 issues over maintaining effective patient records
14 because of the manual nature of the system then in
15 place. So both hospital management and clinicians were
16 coping with a system which had outgrown its
17 effectiveness.
18 Q. Yes. That's an issue that has been touched on in almost
19 all the cases.
20 THE CHAIRMAN: What did that lead on to, Mr Hunter?
21 A. It led on to issues about how we computerised patient
22 records and issues around that still continue to occupy
23 the interest of ministers and government departments.
24 THE CHAIRMAN: It does, but I don't want to gloss over that
25 because that's a proactive example of you perhaps being

1 alerted to something to see whether there was an issue,
2 going to the Royal and seeing with your own eyes that
3 it's an issue.
4 A. Yes.
5 THE CHAIRMAN: And then being, I presume, encouraging or
6 cajoling others if they needed that to look for a better
7 way forward.
8 A. Well, my interest wasn't casual in that I was conscious
9 of problems across the Health Service, which were not
10 peculiar to the Royal in respect of hospital information
11 systems. The executive at the time was seeking to
12 develop improved hospital information and record
13 systems. So if you like this experience reinforced the
14 importance of that initiative. But it was a huge
15 challenge given the scale of the records dating back
16 obviously many decades and many instances.
17 THE CHAIRMAN: And given the comparatively primitive
18 development of computer systems at the time?
19 A. Exactly, exactly.
20 THE CHAIRMAN: Thank you.
21 MS ANYADIKE-DANES: Then if one looks at clinical audit,
22 which is something else that we've been discussing or
23 you've been helping us with, the consultants were able
24 to identify very few examples of a multidisciplinary
25 clinical audit being done as a tool for risk reduction

1 and risk control. So actually using the audit to assist
2 with improvements in care and reducing risk.
3 A. Exactly.
4 Q. And I think you would have to agree that that probably
5 was the case during the time when you were
6 chief executive.
7 A. I don't have to agree; I readily agree.
8 Q. Sorry, I didn't mean it in quite that way. It's after
9 your time, but I wonder if, because of the importance of
10 medical notes and records, any thought was being given
11 during your time to a development that subsequently
12 happened in the NHS, which is to render chief executives
13 and senior managers personally accountable for record
14 management? There was a publication in 1999 titled
15 "Record-managing records in the NHS and Health
16 Authorities", and that did that. So whether they were
17 being controlled or not, they were actually made liable
18 for them. Were you aware of any kind of discussion to
19 drive forward the improvement in medical record keeping?
20 A. No, no. I have no recollection of that at all.
21 Q. Thank you. I don't want to go through this much more,
22 Mr Chairman, because I think, in a way, this witness has
23 accepted there were deficiencies and this is all this
24 document is pulling out, some of those deficiencies.
25 THE CHAIRMAN: Some are more serious than others and I'm

1 sure that virtually any organisation which is subject to
2 scrutiny by an organisation such as this will find that
3 there are weaknesses here and there, and that is --
4 MS ANYADIKE-DANES: In fairness there are some strengths.
5 I won't go into it, but you can see that issue 7 is an
6 area of strength. So it's not that it was all bad, if
7 you like, but the problem is it wasn't terribly
8 systematic or formal.
9 If I return to something we started off with, which
10 is leadership. Professor Scally, in his report,
11 believed that there was a leadership role for the
12 department in ushering in a level of cultural change in
13 a way necessary for some of these changes to be accepted
14 and embedded. We've already seen in some of the
15 documents that the chief executive and the Management
16 Executive had a leadership role. Would you accept what
17 he says, that there was a leadership role in trying to
18 effect this kind of change?
19 A. The scale of the change was such that it demanded
20 a leadership role on the part of the department, acting
21 under the minister's authority. We required completely
22 new systems of governance across the NHS, across the
23 HPSS. We required new systems within the mechanisms for
24 planning and developing and delivering health services.
25 So the changes were of a very radical nature and the

1 responsibility for driving those changes rested with the
2 department from the minister down.
3 Q. Yes. Because although everybody would have their part
4 to play in giving effect to them, I think what
5 Professor Scally was saying is that the trusts and
6 boards couldn't do that alone; you would need the
7 leadership being shown, whether you call it by the
8 Management Executive or by the department as a whole, to
9 create the right climate for those changes to be
10 accepted and embedded; would you accept that?
11 A. I would accept that with one qualification. That is
12 that the minister, having determined the change
13 programme, expected all parts of the management
14 structure to pull together to deliver it.
15 Q. Yes.
16 A. So it wasn't a case of the department exclusively
17 providing leadership. There was an expectation, which
18 I believe was fulfilled, that boards would display
19 leadership in respect of the purchasing of healthcare in
20 their new role and the trusts would display leadership
21 in respect of the management and delivery of services.
22 Q. Yes, but that leadership is something that -- it was not
23 a one-off role, that was something that you continually
24 had to display?
25 A. Yes.

1 Q. So to the extent that there were those who perhaps
2 weren't responding as enthusiastically as you might have
3 wanted them, there was a continuing leadership role for
4 the Management Executive --
5 A. There was.
6 Q. -- to ensure that that focus remained?
7 A. Exactly.
8 Q. And then I just finally want to take you to an issue to
9 do with guidelines if I may. CREST, as we understand
10 it, which was a body that was established really, as
11 we've been told, at the instigation of the clinicians to
12 enable there to be a sort of consistency in guidelines,
13 that body was established in -- I think it was 1988, and
14 so it was well-established by the time you came into
15 your post.
16 A. Yes.
17 Q. And given when you were involved in the department, do
18 you remember that being established, CREST?
19 A. I don't remember it being established, but I certainly
20 recall its existence.
21 Q. Yes. In fact, Dr Carson gave evidence about CREST. The
22 chairman will hear from Dr Carson later on when he gives
23 evidence in his position at the RQIA. But in any event,
24 can I ask you where CREST sat in the departmental
25 structure? Was it part of the department or not?

1 A. It was part of the department, but its membership
2 included experts from outside the department, as
3 I recall it. So whether they thought themselves part of
4 the department, I'm not sure, but I certainly believe
5 that the department saw it as part of the department.
6 Q. And it was funded by the department?
7 A. It was funded by the department.
8 Q. And did the Management Executive have much interaction
9 with CREST? Because the Management Executive sometimes
10 issued its own guidelines.
11 A. Yes. My recollection is that this was part of the
12 medical kind of hierarchy or the professional hierarchy
13 within the department or on that side of department.
14 I confess not to having a clear recollection of exactly
15 how it was positioned or how it was serviced.
16 Q. Perhaps if I just pull this up, this is just a very
17 short extract from Dr Carson's transcript of 11 June of
18 this year. It's at page 176. That's the transcript,
19 11 June 2013, page 176. What Dr Carson was saying
20 is that -- and this was his concern about how guidelines
21 were being managed. So he refers to CREST as having
22 a large volume of regionally developed guidelines and
23 nobody was being critical because of that. But he was
24 concerned that the focus of clinical audit was a bit
25 diverse and not very well focused because there were

1 a number of different guidelines coming in from a number
2 of different sources, and he talks about audits at area
3 board level and regional audits and multi-professional
4 audits and so forth. Was there any concern when
5 you were in office about there being a central source
6 which could develop guidelines, track their
7 implementation and follow up with them and improve them
8 and so forth, but that should be located in one
9 particular body? Was there any discussion like that?
10 A. I don't recall any discussion of that nature.
11 Q. Now Dr Carson is talking about audits, there was one
12 thing that I had wanted to ask about just so that we see
13 the structure of audit because that's a tool for you.
14 A. Mm-hm.
15 Q. Obviously, you envisaged that the trusts would carry out
16 audit, but there were also things called regional audit
17 committees.
18 A. Mm-hm.
19 Q. Were they a resource for you to find out what was
20 happening?
21 A. They were. I would have seen them as a resource in
22 terms of service development because I would have hoped
23 that out of good practice identified at indeed every
24 level of audit that the implications for service
25 delivery would have then fed through into the

1 commissioning of health and social care and that, as
2 necessary, the department/executive would have
3 influenced those commissioning activities so that they
4 took account of the best practice.
5 Q. The reason I was particularly asking you about the
6 regional audit committees is because I wasn't entirely
7 clear, as we were doing our investigations, where they
8 sat in the arrangements, if you like, for monitoring and
9 keeping track of where things were going, and also
10 because they were the subject of a little criticism at
11 CEMACH, and that's why I was asking you your experience
12 of them. Were they a useful tool for the Management
13 Executive or did you hope that they would be?
14 A. I certainly hoped that they would be. I can't recall at
15 this distance the extent to which we took into account
16 their advice, but I certainly would hope that any
17 particular developments which they believed would
18 improve the quality of care would have been both
19 communicated to us and then implemented through the
20 guidance and the commissioning documents, which would
21 have led to improvements in service delivery.
22 Q. I can quickly take you to something to illustrate what
23 I'm talking about and we'll go back to one particular
24 guidance that you did issue. The reference for this is
25 320-067-007. This is a meeting on 5 February 1996, so

1 that's still within your time, of the Directors of
2 Public Health and the DHSS. As you know, there was
3 a representative of either the CMO or a representative
4 from her office attending those meetings. Can you see
5 down at the bottom "regional audit committee"?
6 A. Yes.
7 Q. The first comment from Dr McConnell is that the regional
8 audit committee had not published reports. And then
9 Dr Watson was concerned that the committee did not
10 appear to be possessed of any direction and perhaps
11 needed to be restructured.
12 Then Dr Clements picks up saying that the committee,
13 the regional audit committee, was intended to be the
14 driving force behind audit in Northern Ireland, but
15 probably lacked the infrastructure to accomplish this
16 effectively.
17 So there was a concern about the role that these
18 audit committees could play given their structure,
19 perhaps their funding, and the reason I put this to you
20 is because you had thought that this might be a source
21 of reliable information for you to discharge your
22 functions.
23 A. Yes.
24 Q. Were you aware of this concern?
25 A. I cannot recall that concern.

1 Q. If there had been a concern like that, and given that
2 the CMO's office is represented, is that the sort of
3 thing again that you would expect to be brought to your
4 attention?
5 A. I would expect it to be brought to my attention because
6 I would have believed that it was important that the
7 executive effectively used the information coming
8 through this hierarchical audit system.
9 Q. Exactly, thank you. Then let me just go back to one of
10 the guidelines that you issued in your time. That's the
11 guideline to do with consent. We can see that at
12 305-002-003. If we can also pull up the second page to
13 that, 004.
14 When you were being asked in your witness statement
15 whether the Management Executive played any role in the
16 issuing of guidelines, you acknowledged that you did.
17 When you were asked how did you ensure that they were
18 being complied with, you said it rather depended what
19 kind of guideline you were issuing, but if it was
20 appropriate you would include that there had to be
21 a notification or response so that you knew what people
22 were doing in relation to it.
23 A. Yes.
24 Q. This is a little bit fuzzy and I'm sorry for that, but
25 this really is to signal a change in the arrangements

1 in relation to the formal taking of consent. There are
2 forms which have to be, I'm sure you know, completed
3 in the hospital and it's important, for all sorts of
4 healthcare reasons, that a proper constant is given to
5 procedures.
6 A. Yes.
7 Q. So you're writing this letter to advise as to that
8 change and you cancel the previous arrangement which
9 existed under your letter of 31 December 1990 and you
10 attach to this -- this is really all borrowing on
11 what was used in the UK -- the booklet that's called
12 "A guide to consent for examination or treatment".
13 What I want to ask you about is -- you put in your
14 action paragraphs:
15 "The Health and Social Services boards and trusts
16 are asked to ensure that procedures are put in place to
17 assure that consent is obtained along the lines set out
18 in the handbook and to introduce revised documentation."
19 So they have to ensure that that is happening?
20 A. Mm-hm.
21 Q. That's what you want.
22 A. Mm-hm.
23 Q. Then you say over the page at 5 --
24 THE CHAIRMAN: Just before you go over the page, they're to.
25 "Introduce revised documentation with adequate

1 monitoring arrangements."
2 MS ANYADIKE-DANES: Thank you. I beg your pardon. I had
3 meant to read that out. Thank you, Mr Chairman.
4 So not only do they have to change it, but they have
5 to have monitoring arrangements which would let them
6 know where they are in the implementation of it.
7 A. Mm-hm.
8 Q. Over the page, item 5, they're asked to confirm by
9 31 December 1995 that this has been done, and then
10 they're told where they give that confirmation to. But
11 it's essentially to come to you in due course.
12 A. Mm-hm.
13 Q. That's quite clear. What we've been unable to do is to
14 find out whether the Royal ever communicated either by
15 31 December 1995 or at all that they had done what you
16 asked them to do: revise their documentation, implement
17 the new practice, and have adequate monitoring
18 arrangements.
19 A. I wish I could shed light on that, but I can't, I'm
20 sorry.
21 Q. I didn't think you could from this remove. What
22 I wanted to ask you is: what would be the system that
23 you would have in the Management Executive for knowing
24 whether that had been complied with?
25 A. It was unusual in my recollection to ask for

1 confirmation from the recipients that everything had
2 been complied with.
3 Q. Yes.
4 A. But in this particular instance, with an express
5 request, obviously we expected those that received this
6 document to confirm with Mr Lunn that indeed compliance
7 will be achieved.
8 Q. So what would be the system that you would have for
9 knowing whether they had done that or not?
10 A. Well, Mr Lunn would have collated the information that
11 had come in and would have referred it to me.
12 Q. We've seen absolutely no evidence that the Royal ever do
13 that. Nobody at the Royal remembers doing that.
14 A number of clinicians at the Royal were not aware that
15 this change had happened and, as a matter of fact, the
16 Royal didn't change its systems for some time. In fact,
17 I think they changed their systems early in 2000.
18 A. Mm-hm.
19 Q. And by that time, of course, Adam had been treated, so
20 had Claire. In fact, all the children bar Raychel had
21 been treated. So whether or not a trust had complied
22 with this was dependent upon Mr Lunn making a list of
23 all those he'd sent it out to and essentially ticking
24 off whether he'd received something back?
25 A. Yes.

1 THE CHAIRMAN: If it was unusual to ask recipients for
2 confirmation of compliance, would that indicate there
3 was a particular importance attached to the new, more
4 detailed patient consent forms?
5 A. I think that, chairman, must have been the case.
6 THE CHAIRMAN: It really follows from that that your stress
7 on compliance would be the greater because if these are
8 significant enough for you to ask for confirmation of
9 compliance, then one might think that would be an issue
10 to follow up on to confirm that there has in fact been
11 compliance.
12 A. I would agree with you.
13 THE CHAIRMAN: Okay.
14 MS ANYADIKE-DANES: Did you, before you left, institute any
15 system for satisfying yourself that any circular that
16 you'd sent out requiring something to be done, whether
17 or not you put on the bottom "Please let me know that
18 you are doing this", leaving aside that, just any
19 circular going out requiring changes to be effected,
20 whether you put in place any system whereby you would
21 know that that had actually happened?
22 A. I think the system was, in this instance,
23 straightforward. The bodies concerned were to advise
24 Mr Lunn if they had complied and Mr Lunn was to advise
25 me in due course of that compliance. But I can't recall

1 the process that followed. I don't think in this
2 particular instance I needed a more complex system to
3 receive that assurance.
4 Q. Yes, sorry, I have put it to you in a slightly different
5 way. This one makes it quite straightforward: the
6 person you contact is Mr Lunn, and this is what you need
7 to tell him, and that either breaks down or it doesn't
8 break down.
9 A. Yes.
10 Q. Given that the Management Executive did issue circulars
11 and did issue letters which related to things that
12 people had to do, action points, what I was asking you
13 was slightly different. Did you have a system whereby
14 you could monitor or satisfy yourself that those action
15 points in your circulars and letters had actually been
16 complied with?
17 A. No, but I say that there could not have been a uniform
18 system because the nature and range of the guidance
19 issued by the executive would have precluded a uniform
20 system being adopted or instituted, as I recall it. So
21 each time, I believe, we would have developed the
22 appropriate mechanism for reviewing that and also have
23 followed up in terms of the accountability framework,
24 because many of the circulars and guidances, unlike the
25 one in "Examination and treatment", weren't a tick box,

1 there was a process involved, associated with
2 implementation. So they would have been more complex
3 than in this particular instance.
4 Q. Then just finally -- and then I have finished, this
5 particular one, though. Firstly, this was an important
6 issue, I think you'll agree, changes to the consent
7 arrangements?
8 A. Yes.
9 Q. And secondly, not only did you have to demonstrate or at
10 least record that you had changed them, you had to have
11 a monitoring system, so that was an ongoing piece of
12 business that had to be done to ensure that what you
13 wanted was actually happening.
14 A. Yes.
15 Q. What I'm just asking you is: do you think, in
16 retrospect, there ought to have been a system that could
17 at least not only just have known they were going to do
18 that, but be in a position to express a view as to
19 whether their monitoring system was adequate on which
20 you might have brought in the CMO to advise you?
21 A. I think with any monitoring arrangement it should be
22 subject to regular review to make sure it's operating
23 effectively, particularly on issues of significance.
24 Q. And had that happened, you may have been aware of the
25 fact that the Royal didn't change its practice until

1 2000.
2 A. Exactly.
3 MS ANYADIKE-DANES: Thank you very much indeed.
4 THE CHAIRMAN: Any questions from the families? No? Before
5 I come to Mr McMillen, any questions from the other
6 bodies? No? Mr Hunter, thank you very much for your
7 time. Unless there's anything you want to add that
8 we haven't covered, you are now free to leave.
9 A. Nothing, chairman, thank you.
10 (The witness withdrew)
11 THE CHAIRMAN: We'll take a break, ladies and gentlemen,
12 until 12.30 and we'll resume with Professor Hill.
13 (12.18 pm)
14 (A short break)
15 (12.34 pm)
16 THE CHAIRMAN: Mr Reid?
17 MR REID: Thank you, Mr Chairman. If I can call Professor
18 Dame Judith Hill, please.
19 PROFESSOR DAME JUDITH HILL (called)
20 Questions from MR REID
21 MR REID: Professor, you have made two witness statements to
22 the inquiry. If I can just remind you of those:
23 WS082/1, dated 6 July 2005, and your latest statement,
24 WS082/2, dated 27 September 2013.
25 A. Yes.

1 Q. Do you wish to adopt those witness statements as your
2 evidence before this inquiry?
3 A. Yes, I do, thank you.
4 Q. Thank you, professor. As a preliminary matter, have you
5 made any other statements for anyone, other than your
6 inquiry statements, about the circumstances that the
7 inquiry is investigating?
8 A. No.
9 Q. Thank you. I believe you say you have a cold.
10 A. I'm sorry, I'll try and speak up.
11 Q. Thank you, if you could. If I can bring up your witness
12 statement at WS082/2, page 3, please. You give us
13 a nice synopsis of your career history -- and page 4 as
14 well, please. There we can see that you were fully
15 qualified as a registered general nurse in 1972.
16 A. Yes.
17 Q. You were a registered nurse tutor from 1978.
18 A. Yes.
19 Q. And then you took on various nursing and teaching
20 roles --
21 A. Yes.
22 Q. -- before you became regional nursing director of Wessex
23 Regional Health Authority in 1991 and subsequently the
24 South and West Regional Health Authority in 1994;
25 is that correct?

1 A. Yes, indeed.
2 Q. Would you mind just informing the inquiry -- how big
3 were those regional health authorities in terms of
4 population?
5 A. Wessex covered four counties and would have been in the
6 region -- around the 3-million-plus mark. That's a long
7 time ago. I can't give you the absolute detail there.
8 In terms of when we then joined with -- yes, I've got
9 the figures wrong. When we joined with South & West, it
10 was 9 million was the whole area. We went from
11 Portsmouth at one end to the Isles of Scilly in the
12 other end and up to Gloucester.
13 Q. So Wessex region got amalgamated within the South & West
14 region?
15 A. Yes.
16 Q. So you went from 3 million to about 9 million?
17 A. Yes.
18 Q. How did being a regional nursing director compare with
19 being Chief Nursing Officer for Northern Ireland? Were
20 they similar roles?
21 A. They were similar roles, but it was again an evolving
22 role. The Health Service was continually changing and,
23 in the period that I was regional nursing officer, the
24 purchaser/provider split came in, so the
25 responsibilities around a regional authority were

1 changing. The approach to the -- you're taking me back
2 a long way here and it is quite a long history. Just
3 remind me of your first question.
4 Q. It was just simply: how did being Chief Nursing Officer
5 compare with being the officer for the South & West
6 region?
7 A. In terms of the authority, that was working to
8 a regional board. Clearly, as Chief Nursing Officer
9 here, coming in as part of the Civil Service where
10 you're reporting to ministers and working with the
11 senior civil servants, that was the difference. You
12 weren't operating with the civil servants in the same
13 way. The move to bring the bigger regions together was
14 a step towards creating regional offices of the NHS in
15 England, where you would, in the end, become accountable
16 as part of the Civil Service, but that's at the point
17 that I left. So it's the difference between working
18 in the Civil Service and the difference of working in
19 the health system.
20 Q. I see. Were several of the tasks you were performing
21 similar in your two roles?
22 A. There would have been a leadership role for the
23 profession. They would have been taking forward key
24 policy areas, working with the Chief Nursing Officer in
25 London and relating to other regional nursing officers.

1 I was a Secretary of State appointment to the regulatory
2 body as part of that role as well. So those kind of
3 things.
4 Q. Okay. In 1995, you become Chief Nursing Officer for
5 Northern Ireland.
6 A. Yes.
7 Q. Is that the first time you were employed in
8 Northern Ireland?
9 A. It was.
10 Q. And you held that position until February 2005?
11 A. Yes.
12 Q. Since then, you've been the chief executive of the
13 Northern Ireland Hospice?
14 A. That's right.
15 Q. And you're also currently visiting professor at the
16 School of Nursing at the University of Ulster?
17 A. That's right.
18 Q. Thank you. We were just saying there that your
19 education and work had been outside Northern Ireland
20 until 1995. Whenever you came across from England and
21 Wales, what did you see as any of the key differences
22 between how the system in Northern Ireland works and the
23 system in England and Wales works?
24 A. In terms of on the ground then, things were -- nursing
25 practice and those kind of things were good. My

1 relationship with some of the nurses at the UKCC meant
2 that I knew there was good nursing leadership present
3 here in Northern Ireland. The purchaser/provider split
4 wasn't as advanced in Northern Ireland when I came over.
5 Some of the development of management roles and women in
6 management was not as advanced as in England. So
7 certainly within the senior Civil Service at the time,
8 we were rare individuals as women. That's not true now.
9 Those kind of things were the sort of things that struck
10 me.
11 Q. And did you see those as some of your priorities in
12 taking up the role that needed to be addressed?
13 A. I think the thing that I felt we needed to be doing was
14 recognising the degree of change that had gone on and
15 was continuing to go on. Some of that change, certainly
16 within the profession, was fairly major developments.
17 We had moved our colleges into the universities in
18 England. That was under discussion when I came to
19 Northern Ireland and was one of my first tasks, to say,
20 "We need to get on with that", because I felt strongly
21 that nursing needed to be on a par with the other
22 professions in terms of educational preparation because
23 the challenges ahead with increasing technology,
24 increasing specialisation in the clinical fields meant
25 we needed nurses who were equipped to work within senior

1 teams and to take on more independent roles. So that
2 whole development of the profession was a key thing that
3 I felt needed to be focused on.
4 Q. Can I ask you then, if we jump forward 10 years to you
5 retiring as CNO, what do you think changed in terms of
6 the nursing profession by 2005?
7 A. I think by 2005 we were -- terms like "evidence-based
8 practice", research careers for nurses were in place.
9 Independent roles for nurses, nurse consultants, were in
10 place. We had more specialised nurses, clinical nurse
11 specialists, on the ground. We had worked through
12 looking at developing primary care focus for nursing so
13 the roles that were happening outside of hospitals as
14 well as inside of hospitals were developing. There had
15 been major shifts around some of the clinical services
16 such as the cancer services, mental health services, so
17 there quite a change had gone on over those 10 years.
18 Q. And in terms of the position in which nurses were in
19 1995, by 2005, were they in a stronger position in
20 hospitals or do you think they were in a similar
21 position? If I can explain what I mean: in 1995 perhaps
22 the culture was maybe the doctor knows best or something
23 of that nature. Do you think that had changed by 2005?
24 A. I think there was -- nurses were more confident to be
25 speaking up within the multi-professional team. There's

1 a certain deprecating here, I think, within
2 Northern Ireland that people just step back a little
3 bit, but I think we had more confident nurses and that
4 was part of what we were trying to do. We had put in
5 place a clinical leadership programme that had
6 recognised leadership was not just something that
7 happened at the top of the organisation, but it happened
8 at all levels within the organisation, and we had
9 encouraged nurses to become engaged around things like
10 audit processes, not only unique professional audit, but
11 multi-professional audit. They were involved
12 in relation to education, the actual teachers of nursing
13 were more developed. They were still acquiring degrees
14 and masters programmes when I came in. Now it would be
15 an all graduate -- so those kind of things were going
16 on.
17 Q. We'll explore some of those as we go through. As CNO
18 you were head of the nursing and midwifery group;
19 is that correct?
20 A. Yes.
21 Q. And so you were the chief professional officer of that
22 group; is that fair to say?
23 A. Yes.
24 Q. And then we had your counterpart, the Chief Medical
25 Officer, who's head of the medical and allied services?

1 A. Yes.
2 Q. And we had the Chief Pharmaceutical Officer, who was
3 head of the pharmaceutical branch, and the Chief Dental
4 Officer and so on?
5 A. Yes.
6 Q. How many employees did you have in the nursing and
7 midwifery group?
8 A. There were four substantive posts reporting to the CNO
9 and a small admin support team to those posts. And then
10 there were nurses employed in other parts of the
11 organisation who had a professional link to the group,
12 so that was occupational health and it would have been
13 estates. Those were the main ones. Prisons nursing.
14 Q. The nursing and midwifery group, how did it compare in
15 size to, say, the Chief Medical Officer's branch?
16 A. Somewhat smaller.
17 Q. You give us a synopsis of your role on page 5 of that
18 statement. 082/2, page 5, please. If we can just
19 concentrate on the bottom half, you give us seven bullet
20 points there. If we can keep that up, please, as
21 I refer to other matters. If we can just look at the
22 first one there:
23 "Providing an expert professional contribution and
24 advice to the minister, Permanent Secretary and senior
25 Civil Service colleagues on all matters relating to

1 nursing and midwifery."
2 It was an advisory role; is that correct?
3 A. Yes.
4 Q. How closely did you work with the Chief Medical Officer
5 and the Chief Pharmaceutical Officer in that role?
6 A. I would have worked strongly with the team within the
7 medical side. I was a member of the executive group and
8 the policy group, which would have had colleagues from
9 the medical branch on. I would have worked with the
10 Chief Medical Officer around major strategies such as
11 the investing for health, the cancer services work that
12 she was involved in. And then, as a member of the
13 departmental board, I would have worked with her in
14 those ways.
15 In terms of the chief professional [sic] officer,
16 when we were introducing nurse prescribing, he was
17 certainly a key player to work with us on taking that
18 forward. So those -- and we would have worked again
19 with him around some of the issues that he was dealing
20 with, from administration of medicines and medicines
21 management issues.
22 Q. It would be fair to say that an issue that affected one
23 of the branches would often overlap and affect one or
24 both of the other two branches.
25 A. Indeed, yes.

1 Q. And if I can bring up, alongside page 5, page 7 of that
2 witness statement, please. You referred to when you
3 first arrived in a department you were not a member of
4 the departmental board, but of the Health and Social
5 Services Executive and Policy groups.
6 A. Yes.
7 Q. If you can just explain briefly what those were.
8 A. The slides that you had earlier indicated -- so the
9 policy group was led by one of the grade 3s in the
10 department, deputy secretaries, and the focus on that
11 was around ... particularly public health issues and
12 strategic documents side of things. So we worked on
13 those with them. In terms of the executive, that was
14 the one that was facing the services and we would have
15 covered a whole range of things, particularly around
16 service reconfiguration, and we had several goes at that
17 through my time there, trying to look at whether or not
18 we could strengthen the system generally in terms of
19 doing that. So it would be a whole range of things that
20 we would have looked at, but one was very much facing
21 the service; the other was more policy, in the broader
22 sense, for health and social care.
23 Q. So while being a member of the departmental board from
24 1996/97 on, you remained a member of the executive and
25 policy groups; is that correct?

1 A. No, they went at that point.
2 Q. I see. Who, as Chief Nursing Officer, were you directly
3 accountable to?
4 A. To the Permanent Secretary.
5 Q. We also see, on page 7, that within your own team you
6 had nurse advisers.
7 A. Yes, yes.
8 Q. And you had four posts and you were referring to those
9 earlier. Were those in place whenever you became Chief
10 Nursing Officer or did you instigate that structure?
11 A. There were a number in place. When I arrived there was
12 a degree of wanting to reduce the size, the total size
13 of the department. It was one of those pressures in the
14 system. So the actual number that I inherited --
15 I think there had been more posts in the group ahead of
16 my coming in, but those were the four.
17 Q. And we can see those four posts. The first seems to be
18 general profession matters, would that be correct,
19 post 1, in terms of education and strategy and
20 commissioning and leadership initiatives and so on?
21 Then second seems to be hospital services, acute
22 services, qualities and specialist services; would that
23 be right?
24 A. Yes. Post 1 was really directly the professional
25 issues, so it was around nursing education, regulation

1 and around equipping the profession to take on roles
2 within the commissioning structures, working with the
3 human resource directorate around workforce planning and
4 leadership development initiatives, and then research
5 and development as well. So it was around the issues to
6 do with the profession directly, whereas post 2 was more
7 related to the profession in the services and working on
8 the service issues.
9 Q. We see there, as you say, post 2 is about the service
10 and we see it covers specifically acute services and
11 quality.
12 A. Yes.
13 Q. What role then did that post have in monitoring quality
14 and whose quality was it monitoring?
15 A. That post really was working really through the sort of
16 strategic approach that we wanted to take. So prior to
17 my coming, there would have been work around the Charter
18 Mark initiative that had been introduced. We then
19 developed, with the Central Nursing Midwifery and
20 Advisory Committee, a strategy document, which would
21 have set out a range of areas where we were looking for
22 quality initiatives to come forward. So that post would
23 have been working with the directors of nursing, working
24 with teams within the services, enabling them to acquire
25 appropriate skills around developing quality

1 initiatives. So those sorts of things.
2 Q. In developing the quality initiatives, would you be, and
3 with that post, helping to set standards for nursing
4 care?
5 A. Not in terms of day-to-day practice, hands-on practice,
6 because what we were trying to do was to encourage the
7 nurses in the service to be doing that. The initial
8 approach to standard setting was that standards needed
9 to be locally developed, locally owned, and that was
10 a phrase that we would have used quite a bit. But as
11 our understanding around these issues developed, we
12 recognised that therefore what was happening in one
13 place, how were we judging that to be best practice
14 against what was happening in another place, and that's
15 why some of the big ticket items, as I would say, that
16 we were trying to put in place were about trying to get
17 people to use evidence properly, getting people to audit
18 properly, not only in their own terms but in terms with
19 other professions, equipping them through their
20 education system to become much more reflective on their
21 practice so that they were -- we were introducing things
22 like clinical supervision at the time as well. So
23 it would be those kind of things that we would have been
24 working on.
25 Q. And how would you, as Chief Nursing Officer, and your

1 nursing adviser know what was actually happening with
2 nurses at the ground level?
3 A. Through a number of ways, really. We would have known
4 it through the work of the Central Nursing and Midwifery
5 Advisory Committee raising issues. We would have known
6 it through the Nurse Leaders' Network that we set up,
7 which was across not only the trusts, but also education
8 and the boards as well. We would have known it by being
9 out and about in the service by invitation or by
10 visiting. So those kind of mechanisms. And we knew it
11 too by having sent out our strategic document, "Valuing
12 diversity", in 1998. We then did a review of that
13 implementation going forward. And we would have done it
14 through conferencing as well and being involved in
15 a range of things like quality awards. I would have
16 helped judge awards and things like that. So one had
17 a mixture of ways that you were picking things up
18 informally and other ways where it would be more formal.
19 Q. If I can bring you, almost maybe as a case study,
20 if we look at -- there will be nursing issues in several
21 of the cases that the inquiry has been investigating,
22 but if I can refer to Raychel's case. If I could bring
23 up the transcript in Raychel's case on 1 March 2013,
24 page 58, please.
25 This is the transcript of Sister Millar in Raychel's

1 case. What we can see there is her reflecting on how
2 she saw the how the nurses were being treated in terms
3 of Raychel's care and treatment and then after her
4 death. She says at line 7:
5 "I said that I thought it was totally unfair that
6 the nurses had such responsibility for the surgical
7 children. I felt it was unfair. I felt that we had to
8 be the lead all the time in looking after the surgical
9 children. We are nurses, we're not doctors, and whilst
10 we do our very best, I don't think we should be
11 prompting doctors. We would now maybe, but 12 years
12 ago ... or I don't think we should be telling a doctor
13 to do electrolytes. It's different now -- we're more
14 knowledgable, we've had quite a bit of education -- but
15 in those days really we were leading the care, I feel,
16 in looking after children."
17 Were you aware of issues such as the ones that
18 Sister Millar is raising here? Did those kind of issues
19 get as far up as you?
20 A. An individual situation wouldn't get as far up, but the
21 nature of -- the sort of ethos that she seems to be
22 talking about ... I have to say I would take slight
23 issue around some of the things that she would be saying
24 because I was always taught that we should be taking
25 responsibilities -- the nurses are there in the wards

1 all the time, so observation of what's going on with
2 children is a key skill for nursing and that is one of
3 the things that would be emphasised. So whatever the
4 nature of the children that were being cared for, the
5 ability to observe appropriately and report changes,
6 that would be normal nursing practice that I would be
7 expecting to happen. But in terms of having the issues
8 about increasing confidence, which was the sort of thing
9 that I was saying to you earlier, those were the kind of
10 things that are reflected in our document "Valuing
11 diversity", that we recognised -- that we had on the
12 wards nurses who had been prepared in many different
13 ways -- and I know you've had access to
14 Professor Hanratty's document, which has tracked for you
15 the way nursing has moved from being apprenticeship to
16 being supernumerary to being within higher education and
17 learning alongside other professions. So if you think
18 about it, in any ward team at any one time, you would
19 have had a mix of nurses from different kinds of
20 preparatory backgrounds and it takes a while to kind of
21 embed in those additional skills of the reflective
22 practitioner, getting used to going to evidence rather
23 than being -- doing what you've been told to do and
24 working under a hierarchy arrangement. So those would
25 be the kind of things that we were trying to address

1 through the whole statements that are made within
2 "Valuing diversity".
3 We recognised that, in practice, we needed to be
4 looking at what was best practice: were there practices
5 that needed to be let go, were there things that needed
6 to be core and maintained? So those were the kind of
7 things.
8 And with the change of student nurses basically
9 staffing the wards with one or two qualified nurses
10 supervising them, the nursing teams were becoming 60/40,
11 70/30 qualified nurses and 30 per cent unqualified, but
12 support staff on the wards. So the kind of things that
13 nurses were having to come to terms with was the change
14 in the teams that they were working in, the change of
15 preparation that students were having and their
16 responsibilities to those new cohorts of students coming
17 through. So those kind of issues, but in terms of
18 observation of patients and reporting issues to the
19 medical team, that's a core nursing skill.
20 Q. But in terms of issues such as Sister Millar has
21 raised -- and there are others in Raychel's case about
22 a lack of availability of nursing staff or staff being
23 exhausted and so on, you've said that you would have
24 been made aware of different issues through, say, CEMACH
25 or through your meetings with the Nurse Leaders'

1 Network --
2 A. Mm-hm.
3 Q. -- or your meetings with directors of nursing and so on.
4 A. Yes.
5 Q. What structure was in place so that certain events would
6 be raised by those organisations with your office?
7 A. Directly, my office ... What I would say is that the
8 nurses within the trusts would have a level of
9 responsibility around those issues, that the boards that
10 were commissioning would have a level of responsibility
11 around those issues. It would be the extraordinary
12 issues as opposed to the day-to-day managing that would
13 come through those systems. But I think we would say
14 that we would tend to have ears and eyes around the
15 place, but it's not -- those kind of issues of
16 day-to-day staffing of wards, unless it was beginning to
17 build, it wouldn't come as an issue to us. We did a lot
18 around workforce planning, so there was a process that
19 we would have engaged in around workforce planning, but
20 essentially we were steering a system with the human
21 resources team in the department, the policy team, to
22 look at staffing levels and to recognise where tensions
23 and difficulties might be coming in because we were
24 commissioning the numbers of students that were being
25 trained.

1 So the department's responsibility around staffing
2 the wards was very much more at a strategic level around
3 a workforce planning arrangement, and we would take
4 intelligence from the system that was around, issues
5 around, to do with numbers that needed to be
6 commissioned for training purposes, et cetera.
7 Q. But if we move away from the specific issue, would you
8 accept that it seemed to be down to the discretion of
9 those directors of nursing or the discretion of those in
10 CEMACH or the Nurse Leaders' Network that issues would
11 be brought to the Chief Nursing Officer's office?
12 A. Yes, I would agree with that.
13 Q. And would you agree that, to some extent, there was no
14 structure or framework as to what issues needed to be
15 raised with your office? It was simply down to that
16 discretion?
17 A. I would say so. I'm just reflecting around the sorts of
18 things that were coming in because I think what we would
19 be seeing is -- we wouldn't be seeing a lot of separate
20 lines coming in, that was not what was expected, that
21 there would be ... We worked towards getting in place
22 the likes of the reporting mechanisms that came in
23 later, but earlier in my time there it wasn't. But the
24 focus was about trying to get a single line of reporting
25 in to the department rather than a lot of separate lines

1 coming in, and then it would be a question of sharing
2 that information, and again I've been privy to the
3 discussion earlier today around some of those issues and
4 I would be endorsing the sorts of things that the
5 inquiry has been hearing around the systems that were in
6 place at that early time and the fact that there was
7 a recognition further down the line that those needed to
8 be strengthened and taken forward.
9 THE CHAIRMAN: Just on that, when you came over, part of the
10 exercise we're conducting is a comparison of how fast or
11 slow things moved in Northern Ireland compared to
12 Britain. You came over in 1995?
13 A. Yes.
14 THE CHAIRMAN: And at least on paper, there was
15 a recognition in England and Wales that there needed to
16 be some system in place for reporting what are now
17 called serious adverse incidents. Had that reached you
18 in the south?
19 A. It hadn't kicked in to any great extent.
20 THE CHAIRMAN: Right.
21 A. The mechanisms that I would have -- essentially, the
22 area I was working with, there would have been 50
23 trusts, for example, that you were dealing with. At the
24 time that I left, essentially there was one nurse at the
25 regional office, so it was very dispersed kind of

1 arrangement.
2 THE CHAIRMAN: Let me take this in stages. The issue of
3 reporting those incidents, was it on the agenda, even if
4 it hadn't developed very far?
5 A. Yes. What I would have been familiar with would have
6 been down the midwifery side of things rather than the
7 nursing side of things. So under midwifery there was
8 a local supervising authority for midwifery and in
9 England the region would have been that local
10 supervising authority. So if there was anything to do
11 with the midwives' practice, that would automatically
12 come through to me as the regional nursing officer.
13 When I came to Northern Ireland, the local supervising
14 authorities in Northern Ireland were actually the
15 boards, and so the boards took the responsibility there.
16 I think that's why I'm saying the relationship between
17 trusts and boards was seen as the mechanism for picking
18 up some of those day-to-day issues.
19 MR REID: Just finally on this topic, we discussed how there
20 were several different lines and you've said you were
21 trying to develop a single line.
22 A. Yes.
23 Q. Would you accept, to some extent, because of that ad hoc
24 nature the lines were somewhat one-way in that the
25 department wasn't able to know what was going on in

1 hospitals unless they were told by directors of nursing
2 and the Nurse Leaders' Network and so on?
3 A. That's correct.
4 Q. And to be fair, professor, during your tenure as Chief
5 Nursing Officer, you established the Nurse Leaders'
6 Network --
7 A. Yes.
8 Q. -- which was the meetings of the different nurse
9 directors and so on; isn't that right?
10 A. Yes.
11 Q. And I think you've said you would have met three or four
12 times a year to discuss matters.
13 A. Yes.
14 Q. At those meetings would you ever discuss individual
15 cases?
16 A. No.
17 Q. It was general policies?
18 A. It was principally around policy and strategy and the
19 big-ticket items that we were taking forward at the
20 time.
21 Q. Because to compare your situation to the Chief Medical
22 Officer, the Chief Medical Officer would have met the
23 Directors of Public Health and, at different times, then
24 as well the medical directors of the trusts on a regular
25 basis. And I think she has said that sometimes she

1 would be informally notified of individual cases at
2 those meetings. But that didn't happen within the
3 nursing structure?
4 A. Not as I recall.
5 Q. Thank you.
6 THE CHAIRMAN: During your ten years from 1995 to 2005, do
7 you remember any single events coming to your attention
8 such as the unexpected death of a child -- I think you
9 weren't aware of the children that the inquiry is
10 concerned with.
11 A. No, I was not.
12 THE CHAIRMAN: What does that say about the system, do you
13 think? If you're relying on nurses going to their
14 directors of nursing and, if appropriate, information
15 comes into your office and you weren't aware of any of
16 these deaths from that route, does that suggest to you
17 that whatever system there was or was supposed to be, it
18 wasn't working, or do you not think it should have come
19 to you in any event?
20 A. Um ... I think what I would say is that I would --
21 I would have expected things to come to me where there
22 needed to be that regional response, that there was
23 an issue that needed to be escalated to us so that there
24 could be -- again, as the inquiry has heard, in terms of
25 further sharing of information across the region,

1 supporting the minister in that way, and anything that
2 needed to be taken forward that had implications for the
3 sorts of things that we were doing, which was
4 commissioning nurse education, which was supporting the
5 workforce planning arrangements for nursing ... So in
6 terms of reporting of clinical incidents directly to me,
7 again I think the sense was that that would have
8 happened on the rare occasions. The fact that these
9 children's deaths didn't come into the department,
10 I would agree with the comments that the inquiry have
11 heard earlier, that the system was not as robust.
12 THE CHAIRMAN: Thank you. Because you do need the incident
13 to come in to the department, to your office, to the
14 CMO's office, to Management Executive, for somebody to
15 look at it or a number of people to look at it and then
16 say, "Well, actually, that can be dealt with at local
17 level" --
18 A. Yes.
19 THE CHAIRMAN: -- or "It can be raised a regional issue".
20 A. Yes.
21 THE CHAIRMAN: But unless and until the incidents come in,
22 you're in the dark?
23 A. Indeed.
24 THE CHAIRMAN: And you can't take anything forward because
25 you don't know anything about those --

1 A. About those particular incidents, yes.
2 THE CHAIRMAN: So you don't necessarily respond to each
3 incident, but if you know about the incident you can
4 decide whether to respond to the incident?
5 A. Yes, and ask relevant questions.
6 THE CHAIRMAN: Thank you.
7 MR REID: If I can just ask you one or two more questions
8 about your role before I move on.
9 We've discussed quality in detail. Would you accept
10 that to some extent that you were responsible for
11 quality of care given by nurses within Northern Ireland
12 as the Chief Nursing Officer?
13 A. As Chief Nursing Officer, I would say I was responsible
14 for trying to set the context for the quality of nursing
15 care, and those were the kind of things that we were
16 endeavouring to do. We were putting out a strategy
17 document, we were working to ensure nurses were being
18 prepared appropriately through their training, we were
19 implementing things like the prep guidelines that have
20 come through from UKCC, which was about continuing
21 professional development, and trying to get the
22 profession to recognise they needed to take ownership of
23 their own professional development. We were working to
24 commission appropriate programmes, whether for
25 specialist nurses -- and we were working to develop the

1 kind of roles that nurses needed to be undertaking that
2 would have assured quality of care.
3 So I would see my role as very much being around
4 setting the context, working through appropriate
5 legislative change, appropriate organisational change,
6 that actually enabled nurses on the ground to be
7 delivering quality care, and that's really what I would
8 see my role was.
9 Q. If I can bring up witness statement 075/2 at page 3.
10 This is Dr Campbell's witness statement to the inquiry,
11 who was Chief Medical Officer, and Ms Anyadike-Danes
12 referred to this earlier during Mr Hunter's evidence and
13 she was asked in her witness statement:
14 "Please explain your responsibilities as CMO in
15 regard to the quality of care provided to patients by
16 hospitals, including any responsibilities to ensure that
17 trusts exercise their statutory duty to provide quality
18 care."
19 And she replied:
20 "This was not part of the role of Chief Medical
21 Officer."
22 Would you agree with that?
23 A. I wouldn't see it in those terms. I would see, I think
24 as I have said to you, that my role was around setting
25 the context, and I think it was important that in order

1 for nurses to be able to deliver quality care, certain
2 things had to be in place, and a number of those were
3 fairly major structural changes that required not only
4 the department to agree policy on, but actually required
5 legislative change. Things like nurse prescribing and
6 things like that required us to actually take things
7 through the legislative framework. So if you're
8 actually going to improve quality of care, yes you could
9 say I wasn't responsible for the day-to-day quality, but
10 I was responsible for trying to set the context and to
11 make sure that things were in place so that nurses had
12 the things available to them so that they could take
13 quality care forward.
14 Q. In short, if you didn't do your job, then the quality of
15 care couldn't --
16 A. It would be very difficult. It would be very difficult
17 for the nurses to do it, yes.
18 Q. Thank you.
19 The chairman has raised the issue of clinical
20 governance and the only thing I'd like to ask you is:
21 what did you think that your role entailed in terms of
22 improving the clinical governance in Northern Ireland?
23 A. I saw it as helping to put the building blocks for
24 clinical governance in place. When I arrived,
25 a two-year project on nursing audit had just finished

1 and a multi-professional audit project went forward
2 in the next couple of years. That was one building
3 block. The issues around continuing professional
4 development was a further building block that needed to
5 be put in place and supported. The issues around nurses
6 getting involved in research, not simply as assistants
7 to the doctors to carry out research, but actually
8 researching nursing and being part of multi-professional
9 teams, the work that we did to help set up the R&D
10 office, as it now is. Those were the kind of things
11 that I was involved in. And the other issues around
12 education and training that I've mentioned.
13 Also, with the changes to professional regulation,
14 we were losing our Northern Ireland National Board,
15 which had been part of the quality assurance mechanism
16 for nurse education. And we were under devolution at
17 that time and plans for devolution. As part of our
18 strategy, we had talked about a policy and practice
19 network and I felt there was an opportunity with the
20 national board going, but still needing to have local
21 quality assurance for education available, for us to put
22 policy in practice for nursing together with education
23 into a new local body for nurses, and that's the
24 Northern Ireland Practice and Education Council. That
25 took some time to establish, it needed to go through

1 legislation, but nevertheless it was a vehicle whereby
2 we secured resources that would enable us to continue to
3 develop nursing in what I would see as an appropriate
4 way under clinical and social care governance.
5 We designed it so that it would work with the likes
6 of RQIA that was coming down the line, there would be
7 a body that could take on issues around nursing practice
8 and around the development of nurses that could be
9 directed by the department or could be directed by the
10 nurses in the service to undertake certain pieces of
11 work that would support them in their roles.
12 Q. If your responsibility was putting the building blocks
13 there for the development of clinical governance, who
14 had prime responsibility then of ensuring that clinical
15 governance was moved on?
16 A. Well, I would see myself as part of the collective
17 responsibility that we had around, (a), getting a policy
18 framework in place that supported it and then getting
19 mechanisms in place for the different elements to be
20 happening in the service. But that was a collective
21 activity and a growing one that emerged as we were going
22 forward. These were really quite new concepts back
23 in the early -- late 80s, early 90s, and they take
24 a while to embed. I think it took us time to recognise
25 that you actually then needed those systems and

1 processes around it, it wasn't just a professional
2 activity, but there needed to be an ownership around the
3 rest of the system to support best practice, and those
4 were the kind of things that we then began to work on as
5 a collective within the department.
6 Q. Can I ask you about guidelines? To what extent was the
7 dissemination of guidelines for nurses part of your
8 remit?
9 A. Not the breadth of guidelines around everything that
10 nurses did and do, the actual setting of standards for
11 practice and those kind of things are within the
12 regulation system. Where there were areas of particular
13 need, we would focus in. So we would do things like
14 guidelines around the introduction of nurse prescribing,
15 for example, that needed activity to go forward. So
16 it would be around those areas that we would get
17 involved.
18 Q. And in doing so, would you work with CREST?
19 A. From time to time. The nurse in the health estates in
20 particular would have worked with CREST because she
21 would have worked a lot around the medical devices
22 issues. And as technology increased for nurses over
23 those years then she would have been involved in the
24 sorts of work that went on there. We would have been
25 linking in on the wound management work, for example,

1 that CREST did and would have been well aware of that,
2 and some of the other initiatives, the control of
3 infection type work we would have been linked into.
4 Q. If I can move on to the cases themselves which are
5 before the inquiry --
6 A. Indeed.
7 Q. -- and the children. If we turn to page 10 of your
8 witness statement, 082/2, page 10, please. The
9 chairman's already asked you about serious adverse
10 incidents and we see that at (j) and you said:
11 "Were they ever reported to you, whether formally or
12 informally?"
13 I think you have said you can't recall any specific
14 incident. Does that mean that there weren't any or
15 simply that you can't recall any?
16 A. I can't recall any directly around nursing matters.
17 I can't.
18 Q. At (j) you say that, first of all, health estates and
19 the Adverse Incident Centre would inform you of any
20 nursing practice issues arising out of equipment and
21 medical devices --
22 A. Yes.
23 Q. -- and that's what you've just been discussing. But
24 then also:
25 "There was an alert system in place across the

1 health and social care system where a nurse or midwife
2 could be reported to the regulatory body under fitness
3 to practice."
4 So that's NMC complaints effectively; is that right?
5 A. Yes.
6 Q. And then in (k) you say you'd be in receipt of the
7 Ombudsman report in relation to unresolved complaints
8 and again the fitness to practise report.
9 A. Yes.
10 Q. So we have there Ombudsman complaints, the NMC fitness
11 to practice, informal discussions at CNMAC or the Nurse
12 Leaders' Network --
13 A. Yes.
14 Q. -- and the Adverse Incident Centre. Would you have
15 expected to have been informed of any of the deaths that
16 the inquiry's been involved with under any of those
17 mechanisms?
18 A. I would have expected, where the nursing practice meant
19 that there was an alert issue, to have been informed.
20 I would have recognised that if there were other
21 issues ... I've reflected a lot on this as to
22 what was -- what would I have expected in terms of this.
23 I think we have acknowledged, and the department has
24 acknowledged, that this information should have come to
25 us. Whatever the mechanism, it should have come to us,

1 and there should have been a response from us. So you
2 know, I think rather than sort of looking at it in --
3 which mechanism would I have expected, I think we
4 acknowledge that we should have heard about this.
5 I acknowledge that, that we should have heard of it
6 and --
7 Q. Ms Anyadike-Danes asked Mr Hunter earlier about the fact
8 that there were two systems, one of which you refer to
9 there, which is the adverse incidents arising out of
10 medical devices or equipment, and then there's the
11 psychiatric adverse incidents or mental health issues.
12 A. Yes.
13 Q. Do you accept that a formal serious adverse incident
14 system was in place in those capacities and could have
15 been expanded to cover, say, for example, the deaths of
16 children in hospitals?
17 A. Yes. Again, on reflection, and just having heard that
18 evidence this morning, I was just trying to think that
19 through a little bit. I think in relation to mental
20 health and learning disability there would have been
21 certain acts that would have required that kind of
22 reporting mechanism under the likes of the Mental Health
23 Act, et cetera. I haven't got the detail, I don't have
24 a mental health nursing background, but I think that's
25 why those were in place. It was part of the operating

1 of those acts around the care of people with mental
2 health and learning disability, they were seen as
3 particularly vulnerable. I may be wrong, but that's
4 what occurred to me. The fact that there wasn't
5 a system in place at that time around the rest of the
6 service, you know, I think the fact that we've moved
7 forward to put that system in place is a recognition
8 that that was an omission.
9 THE CHAIRMAN: The equipment procedure had to come about
10 because European law said it was required.
11 A. Yes.
12 THE CHAIRMAN: The children in care and people with mental
13 health problems are specific groups who have
14 disadvantages, which have to be protected.
15 A. Yes.
16 THE CHAIRMAN: Children then, I'm told repeatedly, rarely
17 die in hospital. I'm setting aside children who have
18 cancer and leukaemia in its various forms, but deaths
19 other than those for children are comparatively rare,
20 aren't they?
21 A. Yes.
22 THE CHAIRMAN: So it wouldn't have taken a great deal to
23 work out a system at least for children?
24 A. I accept that. There was an inspection by the Social
25 Services Inspectorate into the care of children in

1 hospitals that went to look at -- I mean, one of our
2 team would have been part of that -- to look at the care
3 of children and there have been various reports around
4 the care of children in hospital to try and ensure
5 that (a) they get protected space and those kind of --
6 they're often environmental, those reports. But
7 I accept, it is a very rare occurrence and that's why it
8 should have triggered that we should have been informed.
9 MR REID: Raychel Ferguson dies and the matter is referred
10 to the department by the informal mechanisms --
11 A. Yes.
12 Q. -- and the CMO convenes the working party and the
13 working party works and creates the guidelines. You've
14 stated in your witness statement, if it could be brought
15 up, at WS082/2, page 15, please, that:
16 "[You] would have expected to have the opportunity
17 to view and comment on the guidelines if they were to be
18 issued for nurses as part of the clinical team."
19 Is that a statement by you saying that you would
20 have liked to have been involved in the production of
21 the guidelines?
22 A. I would have expected my group to be involved, yes.
23 Q. Can you offer any explanation why you weren't involved?
24 A. The only thing that I -- I mean, and it's my comments,
25 my view, around this. The nurse who was involved,

1 Mrs McElkerney, was seen as a senior professional expert
2 in children's nursing. She had worked with the CMO's
3 team around the nursing of acutely ill children in
4 hospitals review and she had chaired the nursing group
5 that had been the response to that. So she certainly
6 would -- if they had come to me and asked me who should
7 be on the group, she would have been the person I would
8 have been suggesting.
9 At the time that the group was being set up and
10 getting into operation, the nurse adviser with the
11 responsibility around this area was just about to go on
12 maternity leave and, in fact, did go on maternity leave
13 as the working party got under way. So by the time the
14 guidelines were produced, she was back. Normally, where
15 we get these sort of experts in from the service to be
16 part of working groups, they would have a link with
17 a person on my group, and she would have been the
18 natural link, and in fact would have worked with
19 Mrs McElkerney on a number of issues around children's
20 if she was seeking help and advice on that.
21 Q. But is the involvement of Mrs McElkerney in the working
22 group not a tacit admission of the fact that this area
23 involved nursing issues?
24 A. Well, absolutely, but I didn't know about the group,
25 I didn't know about the guidelines and I didn't know

1 about Mrs McElkerney's involvement.
2 THE CHAIRMAN: I don't want to take away from the guidelines
3 because the guidelines are good --
4 A. Yes, absolutely.
5 THE CHAIRMAN: -- and Mrs McElkerney's presence on the group
6 is significant --
7 A. Yes.
8 THE CHAIRMAN: -- but are you not curious about how on earth
9 you didn't know about all this going on?
10 A. Yes, I really cannot recall what was happening around
11 that time that the thing was being set up and things
12 were happening and why we weren't involved, I really
13 cannot -- I can't recall anything that would give me
14 a clue as to what happened.
15 THE CHAIRMAN: Does it make sense to you that you didn't
16 know anything about this ongoing work? Because I'm told
17 that it would be fairly rare for the department to set
18 up a working party on guidelines -- and all the more
19 credit to it to the CMO that she did set up this group
20 and that they reported effectively, they reported
21 quickly and they got the guidelines out.
22 A. Yes.
23 THE CHAIRMAN: But since they do have a definite nursing
24 aspect to them, it seems to me to be hard to understand
25 why you didn't even become aware of this in passing.

1 A. It's hard for me to understand as well.
2 THE CHAIRMAN: Okay.
3 A. I really can't help you on that.
4 THE CHAIRMAN: Thank you.
5 MR REID: The best explanation you can offer at the moment
6 is perhaps that the person who would have told you was
7 on maternity leave at the time.
8 A. Yes.
9 Q. The guidelines are published alongside a letter from the
10 Chief Medical Officer. If I can bring up 007-001-001,
11 please. It was a letter dated 25 March 2002 from the
12 CMO. As you can see, after "medical directors of acute
13 trusts", the second addressee on the letter are the
14 directors of nursing in acute trusts.
15 A. Yes.
16 Q. So again, these are disseminated amongst the directors
17 of nursing across Northern Ireland; isn't that right?
18 A. Yes.
19 Q. Were you aware at this point of the guidelines having
20 been created and published?
21 A. No, I was not aware. Not that I can recall that I was
22 aware.
23 Q. You think the first time you became aware was around the
24 time of Raychel Ferguson's inquest?
25 A. No, it was to do with the media, with Lucy.

1 Q. Which was 2004, February 2004; is that correct?
2 A. Yes. But you see, these would have been issued at the
3 time when my colleague was on maternity leave. It's not
4 an excuse, it's just that I was not aware. I can't
5 recall that I was aware that this went out.
6 Q. And it was also then published in the CMO's update
7 of April of that year, but you weren't aware of that
8 either?
9 A. No.
10 Q. Were you aware of any of the circumstances surrounding
11 Raychel's inquest in February 2003?
12 A. No, not that I can recall.
13 Q. And you didn't see the UTV programme "Vital Signs",
14 which was broadcast on 27 February 2003?
15 A. No.
16 Q. You were meeting up with the departmental board on
17 a monthly basis, which would involve the CMO and the CPO
18 and the Permanent Secretary and so on; isn't that right?
19 A. Yes.
20 Q. At no point can you recall Dr Campbell or anyone
21 mentioning the fact that they'd published these
22 guidelines, which were being disseminated across
23 Northern Ireland?
24 A. I'm sorry, I really can't recall it.
25 Q. If you had been made aware at that stage, even maybe

1 at the stage after publication, what do you think you
2 would have done to assist matters?
3 A. Well, I think what I did later when I did become aware
4 of it, which was to -- because the issues that appeared
5 to be the issue was around education and what was being
6 taught and had they been picked up within the education
7 system, and I would have done what I did, which was to
8 make enquiries about that.
9 Q. Yes, I think if we turn to page 12 of your witness
10 statement, 082/2, please. You are responding to the
11 witness statement of Martin Bradley, who succeeded you
12 actually as Chief Nursing Officer.
13 A. Indeed.
14 Q. But he told the inquiry he was chief nurse at the
15 Western Board at the time of both Lucy and Raychel's
16 deaths. He said:
17 "In 2000, I would have raised the following issues
18 with local directors of nursing: the importance of
19 maintaining accurate clinical records, in particular
20 fluid balance; importance of ensuring accuracy in
21 administration of IV fluids, the need for maintaining
22 good observations of a sick child; and being aware of
23 early signs of deterioration."
24 And:
25 "[He] would have raised these issues with fellow

1 area board chief nurses at the regular meetings."
2 A. Yes.
3 Q. Whenever you did find out, did you raise the issue to
4 see how the guidelines were being implemented with any
5 of the area board chief nurses or the directors of
6 nursing?
7 A. I didn't. It was -- I looked at the education issues.
8 THE CHAIRMAN: Perhaps you could develop that for me. When
9 you say you looked at the education issues, what does
10 that mean?
11 A. Well -- and this, I'm afraid, is where my memory does
12 fail me. In my 2005 statement, I indicate that I did
13 ask for somebody to enquire about that and received
14 information back. I really cannot recall the
15 conversation that we had asking for that, so although
16 I put it down in my 2005 -- I obviously recalled it in
17 2005. I'm afraid at this distance I don't recall it.
18 I have had opportunity to speak to the individual, but
19 it's her recollection, it's not my recollection.
20 THE CHAIRMAN: I see.
21 MR REID: We've established that you didn't know about the
22 production of the guidelines. Apart from the nursing
23 adviser in your office, who was off on maternity leave,
24 who would you have expected to notify you of the fact
25 that this issue was here and these guidelines were being

1 produced?
2 A. Who else within my team or who else --
3 Q. Who else in general would you have expected to have
4 informed you of the fact that these guidelines were
5 being developed?
6 A. I would have assumed it should be part of the
7 department's communication system.
8 Q. So would you have expected someone within the Chief
9 Medical Officer's office to have informed you, as Chief
10 Nursing Officer, or someone within your office of the
11 fact that there were guidelines being developed which
12 involved nursing issues?
13 A. I would have expected that. Again, I don't recall that
14 it happened and I don't necessarily recall that it
15 didn't happen. I suppose what I'm saying is we weren't
16 part of the working group. Whether we were given
17 further information once they were produced, I cannot
18 recall.
19 Q. If I could bring up the background paper of
20 Professor Hanratty, which you referred to earlier. It's
21 308-004-080. I'll read the excerpt for you.
22 A. I have a copy of that.
23 Q. You've come prepared. She states --
24 A. What page are we looking at?
25 THE CHAIRMAN: Do you have the internal page number for the

1 witness?
2 MR REID: I don't, unfortunately, Mr Chairman. If you'll
3 allow me one moment.
4 THE CHAIRMAN: Repeat the number again, just one more time.
5 MR REID: 308-004-080. I will just address the issue on it.
6 She states in relation to how the guidelines on
7 hyponatraemia were implemented within nursing practice,
8 she says:
9 "On the whole there was little attention paid to the
10 Department of Health guidance on the management of
11 hyponatraemia that was circulated in 2002, and this led
12 to the RQIA assessment in 2008 finding that changes in
13 practice were patchy."
14 Do you consider, firstly, if you had been involved
15 in an earlier stage that perhaps you could have assisted
16 in the implementation of the guidelines within nursing
17 practice to prevent this patchy nature?
18 A. Well, I would like to think I would have been able to do
19 something, yes.
20 Q. And do you accept perhaps that when you did find out in
21 2004 that maybe something more could have been done to
22 ensure that the guidelines were properly implemented in
23 nursing practice?
24 A. At the time the focus was not around the nursing matters
25 at that point and there was work being done to address

1 the different elements that were coming to the fore at
2 that point: the review that had been done by the trust,
3 some of the issues around medical staff. And over that
4 year, the discussions moved towards this inquiry being
5 set up. So having raised the issue with the education
6 system around the guidelines, I didn't take any further
7 steps.
8 Q. If I could bring up a letter from the coroner. The
9 reference is 006-002-157. This is a letter from the
10 coroner to the Chief Medical Officer after Raychel's
11 inquest. If I can bring up page 156 as well, please,
12 just for the context.
13 We can see it's a letter dated 11 February from
14 Her Majesty's Coroner to Dr Campbell, Chief Medical
15 Officer. He's discussing the recent inquest of
16 Raychel Ferguson. At the end of that, he raises some of
17 the issues that Dr Sumner raised at the inquest and some
18 of the issues that arose in the case. In just almost
19 the penultimate paragraph, he asks Dr Campbell to
20 consider whether what emerged at the inquest has
21 implications for the training of both doctors and
22 nurses.
23 First of all, were you aware of the coroner's
24 concerns about the implications for training of nurses?
25 A. Not that I recall.

1 Q. And would you have expected a letter such as this from
2 Her Majesty's Coroner, which mentions nurse training, to
3 have been brought to your attention?
4 A. Well, certainly, I think.
5 THE CHAIRMAN: It should have come to you, shouldn't it?
6 A. I think that would have been helpful, yes.
7 THE CHAIRMAN: Even for you to say, "Well, look, what came
8 out doesn't actually have any implications for
9 training"?
10 A. Yes.
11 THE CHAIRMAN: But if the coroner is sufficiently worried --
12 A. Yes.
13 THE CHAIRMAN: -- to raise that with the CMO, you would
14 expect that to be the subject of some internal
15 discussion?
16 A. Indeed.
17 MR REID: You came into the job in September 1995 --
18 A. Yes.
19 Q. -- and the following year was Adam Strain's inquest. At
20 that inquest there was a statement made by the
21 Belfast Trust, by the Royal, which was also published
22 in the media. Were you made aware of that statement at
23 any time?
24 A. Not as I recall.
25 Q. I can bring up the statement, actually. It's

1 011-014-107a. That's the draft statement there, the
2 C5 statement. You never saw that?
3 A. No. Not -- no. Not that I recall.
4 THE CHAIRMAN: The only people who saw it were paediatric
5 anaesthetists.
6 MR REID: You'll note just in the second paragraph it says:
7 "All anaesthetic staff will be made aware of these
8 particular phenomena and advised to act appropriately."
9 A. I'm not sure who signed this, sorry.
10 Q. It was signed by Dr Robert Taylor, consultant
11 anaesthetist at the Children's Hospital. Would you have
12 wanted to be made aware of a statement such as this in
13 your role as Chief Nursing Officer if it was published
14 in, for example, the Belfast Telegraph?
15 A. I think that would have been helpful.
16 Q. And what would you have done as a result of receiving
17 a statement such as this?
18 A. Well, again, I think we would have looked at the
19 education programmes because that was my responsibility
20 side of things, but you know, we would have had
21 a discussion, I'm sure, around this.
22 Q. If I can refer you to WS082/2. It's your witness
23 statement at page 13. You're asked, at number 9, to:
24 "Describe in detail the steps you took to discover
25 why the department was not made aware of the deaths of

1 the children at an earlier stage?"
2 And you have stated:
3 "I personally did not take any steps to discover why
4 the deaths were not reported to the department earlier.
5 Because the deaths were not directly raised with me by
6 health and social care staff nor by my colleagues in the
7 department and therefore appeared to be handled
8 appropriately and also at the time the approach to
9 alerting adverse incidents in the arrangements of trusts
10 and boards was through the Northern Ireland Adverse
11 Incidents Centre."
12 A. Yes.
13 Q. Would you accept that, to some extent, you took a quite
14 limited role there, that you could have done more to
15 investigate why your office wasn't notified of the
16 deaths?
17 A. I would have seen that as not something that
18 I personally would be taking forward, but it would be in
19 consult really with colleagues within the department and
20 that those with the responsibilities for trusts would
21 have helped me think that through in terms of what was
22 appropriate.
23 THE CHAIRMAN: But when you saw the publicity, professor,
24 and when you heard about the television documentary and
25 you heard about the establishment of the inquiry, did

1 you not think, "The system hasn't worked very well here.
2 I need to check that there aren't other instances where
3 I should at least be advised of events so that I can
4 decide whether I can help with them or help improve
5 things for the future"? That seems to me to be the
6 problem. I think you're rightly concerned that you
7 weren't alerted to these events. How much you might
8 have done at the time in response to each one is
9 hypothetical.
10 A. Yes.
11 THE CHAIRMAN: But you just didn't know about them in the
12 first place?
13 A. No.
14 THE CHAIRMAN: Would that not be an issue of concern to you,
15 where at least you would say, "Look, I'm not very happy
16 with whatever system we have at the moment. It doesn't
17 seem to be working, we need to make it better"?
18 A. I would agree with you that there was probably more that
19 I could have done to have found out what had happened
20 and why, on the ground, people had not thought that it
21 was appropriate to come through to me. I actually had
22 a conversation with one of the nursing directors just
23 recently around what their expectation of my role would
24 be. The discussion really was around strategy and
25 policy at the department level and that operational

1 matters were boards and trusts. I'm disappointed that
2 the trust nurses and the board nurses that were involved
3 in the deaths of these children did not raise this with
4 me because they had every opportunity to. I was
5 regularly meeting them and I don't know -- I can't
6 answer to you now at the moment why I didn't pursue that
7 in any greater depth once things did become more clear.
8 What I did do, which I go on to describe, was to
9 take steps to safeguard the children who were currently
10 being cared for at the Erne because we heard that there
11 were staffing issues on the ward --
12 THE CHAIRMAN: Yes.
13 A. -- and that issue concerned me and I felt that these
14 were situations that had happened in the past. We were
15 beginning to take steps to try to increase the reporting
16 mechanisms, and therefore things were in play around
17 addressing some of that issue. But here were children
18 now who needed to be safeguarded and therefore
19 I instigated getting my colleague to go down and just
20 visit the ward, see what was happening, see whether
21 there were further issues, and on the back of that then
22 I contacted the nurse director and spoke to him about
23 the concerns that we had.
24 THE CHAIRMAN: And that's important. That's an example of
25 an involvement that you would have, which doesn't have

1 to be hyponatraemia-related, but which is
2 nursing-related.
3 A. Absolutely.
4 THE CHAIRMAN: But because you weren't aware of Lucy's death
5 until, what, 2003 or 2004 --
6 A. That's right.
7 THE CHAIRMAN: -- your support, your intervention, comes
8 three to four years after the event.
9 A. It does. It's disappointing. It is disappointing.
10 THE CHAIRMAN: And then in Raychel's care, you weren't aware
11 of that at the time?
12 A. No.
13 THE CHAIRMAN: And there are certainly nursing issues in
14 Raychel's case.
15 A. Yes.
16 THE CHAIRMAN: Going back to 1995/1996, one of the issues of
17 concern to me was that the investigations which were
18 carried out in the Royal did not include the nurses at
19 all.
20 A. No.
21 THE CHAIRMAN: And that again would concern you, wouldn't
22 it?
23 A. Yes, it would.
24 THE CHAIRMAN: And I think at least on one case, if not
25 both, the nursing director in the Royal was unaware of

1 the death.
2 A. Yes.
3 THE CHAIRMAN: And again, that can't possibly be right, can
4 it?
5 A. No.
6 THE CHAIRMAN: Of course that might explain why it doesn't
7 get to you if even the nursing director in the trust
8 isn't aware of it.
9 A. Absolutely.
10 THE CHAIRMAN: I know you've been out of this line of
11 nursing since 2005 when you have been with the hospice
12 and doing many other jobs, but by the time you left in
13 2005 were nurses more willing to speak up, more willing
14 to raise concerns than they might have been ten years
15 earlier?
16 A. I think they were increasingly confident. Whether
17 they're fully confident would -- I would say that it was
18 patchy. There was still quite a hierarchical system
19 both within nursing itself and between the professions
20 and between management. So overcoming that has been
21 quite a major work, and part of the work that I was
22 trying to do in, as I say, putting those building blocks
23 in place was to give nurses more confidence and also to
24 remind them that it's their responsibility.
25 THE CHAIRMAN: Because that is something that's

1 specifically --
2 A. Absolutely.
3 THE CHAIRMAN: -- reserved under your code, isn't it?
4 A. That's what I was going to go on to say. These matters,
5 if you look at the development of the nursing code over
6 these years, things like quality, things like audit,
7 things like using best evidence are all put in place.
8 The issue of working within a team is in place and
9 reporting adverse incidents and concerns is in place.
10 And what our task was was to get every nurse to have
11 that confidence and to be working as we would anticipate
12 to that code, but you've 15,000 nurses to deal with and
13 to get operating, so it's quite a task to do. That's
14 not to say we shouldn't be doing it, and I think that's
15 what we were trying to do, but it clearly wasn't moving
16 in the way that we would have wanted it to.
17 THE CHAIRMAN: Okay. Thank you.
18 MR REID: I have no further questions, Mr Chairman.
19 THE CHAIRMAN: Anything from the families? Any other
20 questions from the floor? No?
21 Professor, thank you very much for your time today.
22 We've finished our questions for you, so unless there's
23 anything else you want to add, you're now free to leave.
24 Thank you very much.
25 A. Thank you very much, Mr Chairman, and thank you.

1 I suppose I would not want to go away from this without
2 acknowledging the hurt and distress that the families
3 have experienced through all of this. There are very
4 important lessons that need to be learnt arising from
5 this inquiry and I regret very much the experience that
6 those families have and are still having.
7 THE CHAIRMAN: Thank you very much indeed.
8 (The witness withdrew)
9 Ladies and gentlemen, thank you for accommodating
10 and working with me today so we finished early, as
11 I have to do. We'll be back on the normal timetable
12 tomorrow morning at 10 o'clock with Mr Elliott and
13 Mr Morrow. Thank you.
14 (1.55 pm)
15 (The hearing adjourned until 10.00 am the following day)
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