Wednesday, 16 January 2013

(10.00 am)

(Delay in proceedings)

(10.18 am)

DR IAN CARSON (continued)

Questions from MR STEWART (continued)

THE CHAIRMAN: Good morning. I'm sorry we kept you waiting a little bit.

Dr Carson, could you come back, please?

MR STEWART: Good morning. We left off yesterday evening with a discussion about investigation of cases, especially those in which negligence had been suggested. And we took that discussion from paragraph 5.45 of the complaints procedure of 1996, which appears at 314-016-017.

I think you agreed with me yesterday afternoon that that appears to be correct and that there should have been a full and thorough investigation of the events. We see there in paragraph 5.45 that, in fact, such an investigation would be pursuant to the principles of good claims management and risk management.

I think you suggested that the trouble with applying the principles of good risk management was that there wasn't any guidance on investigation at the time; is that roughly where we left it?

A. Yes, I think that is where we left it. I suppose one of the difficulties I'm having is trying to interpret a guidance on the management of complaints in relation to the cases that we're looking at as an inquiry, in that I was hinting that this had not emerged through the complaints management line and subsequently, at the time the incidents occurred in relation to Adam Strain, I think that's what we were dealing with in this particular case.

Q. Yes.

A. Nor had the emergence of a clinical negligence claim arisen. I think the important thing, if an investigation is going to be of any benefit, one of the important things is to get an early determination of the facts that surround it if you wish to take remedial action as a consequence of that. The problem with complaints, as we know, is that if there's a hint of clinical negligence, the complaints process is stalled or was stalled at that time. Certainly I don't know whether in the more recent guidance in relation to complaints there's any change in that. And again, I have views on clinical negligence as well. I think that had, in many ways, impeded investigation at an early stage of untoward events.

THE CHAIRMAN: In very broad terms, doctor, is this because

if there's a claim as intimated, people become defensive and they don't actually contribute to an investigation in a full sense?

A. Possibly.

THE CHAIRMAN: Or, to a degree, they're covering themselves?

A. In the most serious cases. If for example a criminal charge is brought to a doctor, they don't have to say anything, in my understanding, and I think the GMC drew attention to that in their guidance to doctors.

THE CHAIRMAN: Yes.

MR STEWART: This discussion arose from the fact that a clinical negligence claim was intimated or commenced by letter in April 1996. And according to the complaints procedure and guidance, which was in operation at the time, an investigation should have been pursued. You've explained why perhaps it wasn't. Who would have undertaken such an investigation at that time?

A. The responsibility for handling investigations ultimately would be the responsibility, I believe, of the Trust medical director to ensure that that took place. We've heard, earlier in the course of the inquiry, evidence from Dr Murnaghan. Prior to the Trust coming into being in 1993, Dr Murnaghan administered the clinical negligence process on behalf of the Trust and

continued to do that after 1993. Because ultimately if ... If one of the outcomes of an investigation were to lead to disciplinary action against a doctor, the medical director would have been on that ultimate decision-making panel in relation to an outcome in relation to the doctor, so the medical director would never have been first in line, if you like, in determining the facts of an early investigation. And I would have looked principally to Dr Murnaghan to ensure that a fair and thorough investigation took place.

Q. I'm going to suggest to you that, in 1996, clear risk-management advice would have been available to you as to exactly how you would have mounted an investigation.

A. May I ask on what you're basing that?

Q. Well, I'm basing it on a number of suggestions I was going to make to you. The first is a document I know that you're aware of at the time. It's "Risk Management in the NHS" --

A. Mm-hm.

Q. -- which has chapters on all the things that you would have had to deal with in this regard: chapters helping you to identify risk relating to standards of care; chapters and information and guidance on reporting of

adverse clinical incidents; and, of course, investigation. That appears at pages 104 and 105 of the book. You did use this book back in the mid-90s?

A. I am aware of the book. It's an excellent book. It's described -- I think it describes itself as being a handbook and it was produced by the NHS executive in England. It was unusually one of those -- what I'd call an English document that was adopted in its entirety by the management executive within the DHSS. It was a document that the NHS executive actually involved in its compilation a number of experts in the area of risk management who worked in the private sector within the Health Service.

So in many ways, it was a handbook, it was a textbook as to how this should be done, how risk management should be structured and developed within trusts. In 1993 and right through to the mid-90s, I would suggest that trusts in Northern Ireland used a variety of means to improve and strengthen their risk-management systems internally. Some of them would have turned to companies like Merritt, one of the authors of whom contributed to that handbook, to develop trust risk-management systems. There was very little guidance other than this manual, this handbook, in terms -- very little instruction to trusts, I would

suggest, at that time, as to how you should do this.

Q. All right. First of all, this handbook was used by you and it was used to inform your approach to risk management.

A. Correct.

Q. The book identifies -- well, first of all, I would suggest to you that an investigation is not hard. You secure the documents, you secure the witnesses, you secure the equipment and, if necessary, you get an expert, and that informs you as to what happens. That's a pretty straightforward proposition, isn't it?

A. I accept the proposition; I'm not suggesting for one minute that it's straightforward.

THE CHAIRMAN: It depends on the case.

A. Very much so.

THE CHAIRMAN: But unless you start the investigation, you don't know how complicated it'll become.

A. I accept that. I would also suggest, Mr Chairman, that in the run-up to the establishment of trusts that trust medical directors had very little training or even experience in the handling of serious issues such as this. I made reference in documents that I made available to the inquiry, I referenced an article published in the BMJ by Professor Sir Liam Donaldson where he expressed a very genuine concern that this

transfer of responsibility to trust level was going to expose medical directors and others to considerable -- a very steep learning curve, let's put it that way.

These incidents thankfully don't occur all that frequently. The experience that a senior representative within a trust such as a medical director needs to be able to accumulate -- to know how to handle these sensitively and correctly. It takes some time to gather. He was working at a regional level in the northern Yorkshire region, an area twice the size of Northern Ireland, concerns -- serious concerns about the performance of doctors would have been reported to him as a regional director of public health. And he was drawing on that experience that he had expressed a concern that, at trust level, this level of experience might not be there. And that was certainly the case prior to the establishment of trusts.

MR STEWART: Yesterday, you described how one of your responsibilities was to take part in the disciplinary procedure of some clinicians who had shown competence issues. How would you prosecute a disciplinary proceedings of such a clinician unless you'd had an investigation into what had happened?

A. I fully -- I accept that. You would not have embarked on a disciplinary procedure of a doctor unless

a preliminary investigation to determine the facts had taken place. But I would have to suggest that determination of those facts would certainly not have been to the level of depth of investigation, for example, as it has been demonstrated through, for example, this inquiry or anything near to that.

Q. Of course not, and no one would suggest -- but I'm not sure that you appreciate how little was done in Adam Strain's case, for example, to conduct any investigation.

A. I accept that. But if I, as Trust medical director, didn't know that Adam Strain had even died until almost a year after the event, I put it to you that it would be difficult for me, on behalf of the Trust, as an executive director of the Trust, to conduct that investigation.

Q. But if you, as medical director, are responsible for risk management systems at the time, you are responsible for ensuring that unexpected, unexplained deaths, deaths where issues may arise, should be investigated, and certainly when a letter of claim is received from a solicitor, a full and thorough investigation should have been conducted, and you had at that time, apart from your access to the network of other people who are medical managers across the lead teaching hospitals of

England, you had this risk management manual, telling you how to do it.

A. I accept that. I would put it to you, however, that the development of risk management in health and social care trusts at that time between 1993 and until quite late in the 1990s evolved around health and safety issues; it did not focus on clinical risk management. We didn't even have a clinical risk managers appointed in the Trust until the late 90s. So the concentration -- and in fact, all the circulars that came from the department to trusts in relation to risk management came from the finance directorate within the Department of Health. In other words, I would put it to you that their emphasis, their focus, their concentration on risk management was on financial risk rather than clinical risk.

Q. There may have been a major concentration on those issues, but it was not to the exclusion of clinical risk management and we'll revert to that in a moment because I think this point needs to be fully developed before we're deflected.

One of the issues in Adam Strain's case was that there was no investigation to the extent that it was unclear as to which operating theatre he had, to all intents and purposes, died in, and nobody even knew who was present in the room when he died. That's an

extraordinary state of affairs, I'm going to suggest to you, and one which would never have happened if the simple, straightforward, one-page guidance of investigation set out in the risk management manual had been followed. Apart from the obvious of getting the witnesses and getting them to make statements, it specifically advises:

"In addition to individual witness statements, it is useful to record the names of all staff on duty at the time of the incident, perhaps in the form of a staff rota."

The work of this inquiry would have been enormously assisted if the simplest of investigations had been pursued; do you accept that?

A. I would accept that, yes.

Q. In relation to --

THE CHAIRMAN: I think it goes back a bit further than that, doctor. One of the reasons for this inquiry is that there seems to have been a series of hyponatraemia deaths. There is an argument that had Adam's death and then Claire's death been properly investigated and people really got to the heart of it, then that might have prevented the subsequent deaths of Lucy Crawford and Raychel Ferguson to name but two.

A. I would accept that there is -- and I think I've said in

some of my statements that every adverse event has got learning within that. I accept that we're maybe not very good at learning from incidents and adverse events and certainly for more serious events, such as the deaths of children, it's more pertinent to actually learn from them maybe than other less serious events.

I would suggest also that -- you made reference yesterday to my involvement in medical education. And one of the areas that clinical tutors, regional advisers and those involved in medical education would have been -- would have been to assess and evaluate the performance of junior doctors as they progressed through their careers. Certainly during my tenure as Trust medical director, senior doctors, consultants supervising juniors, if they were -- and in fulfilment of good medical practice -- if they had had a concern about a junior doctor, they quite readily brought that directly to my attention. And early investigations to determine the facts -- usually by Dr Murnaghan on behalf of the Trust in the first instance -- were followed through and, in a number of situations, remedial action was necessary. And that was carried out.

I accept that in Adam Strain's -- and also in Claire's -- case, more could have been done and more should have been done.

THE CHAIRMAN: You see, I don't expect that there would ever have been an investigation along the lines of this inquiry in 1995. That's impossible and perhaps entirely unnecessary because, if there's a lesson to be learned, it's to be learned at the time and it's learned more speedily and cheaply than this inquiry takes. But it's a knock-on effect of that not happening and then not happening again in Claire's case that leads to the embarrassment of the documentary that leads more seriously, perhaps, on to the information not being learned and, perhaps at least, contributes to other adverse incidents or deaths, to put it bluntly.

A. I accept that entirely.

THE CHAIRMAN: What I think Mr Stewart is looking at with you is when you say -- I'll stop for a moment, but what I would like to do is, before your evidence finishes today -- I will let Mr Stewart continue now -- I would like to hear from you. When you say, "We're not good at learning from adverse incidents", I'd like you to tell me if things are much better now than they were in 1995/1996, but that's -- this inquiry is not just looking back about what happened in the past; I have to make recommendations to the department, which will be for them to take up or not, and those need to reflect what is happening now.

A. Mr Chairman, I firmly believe that things have improved in that.

THE CHAIRMAN: We'll come back to that. We'll let Mr Stewart develop the historic stuff and then come back later on.

MR STEWART: I'm sorry to bring you back to the historical, but WS306/1, page 17, is to return to your own professional responsibilities. This was October 1995. We had got to (d) and moving on to (f):

"Advice to the Trust on professional medical issues."

That really is advising the board, and those issues would be both strategic, broad issues, and also, on occasion, the particular; yes?

A. Right, yes. Very broad.

Q. And, at (g), you were charged with:

"Ensuring that professional standards are maintained in the provision of medical services within the general guidance ... and ... contracts with purchasers."

That reference to "purchasers": were the purchasing boards giving criteria for quality at that time in relation to the services you were providing?

A. I'm sorry, I haven't seen the reference to purchasers there on that page 17.

Q. Paragraph (g):

"Ensuring that professional standards are maintained in the provision of medical services ... within the terms of contracts with purchasers."

The question was: were standards, criteria, for quality of healthcare contained within the purchasers' contracts with the board?

A. I think this is a good question. I hinted yesterday that the focus in the early 1990s was -- and this came out of the Thatcher government reforms -- very much on the development of this internal market between purchasers and providers. And I hinted yesterday that the focus was largely on how many and for how much, the focus was very much about the quantity of service that a provider could provide to meet the needs of the purchaser and addressing the health needs of the community that they served and also the associated costs that would go with this.

Quality standards should have been -- and I think, to a certain extent, were -- built into contracts. I do not think that those contracts went into the depth in terms of clinical standards that I think we would see today. We have got frameworks for cardiovascular disease that are quite explicit and commissioners of services would purchase against those standards. For many of the services that were being delivered in the

early days by trusts, explicit standards either didn't exist or they were vague.

Q. Was it done perhaps by way of accreditation that a board had to for example achieve accreditation from the King's Fund or meet certain broad standards?

A. Well, I don't think any of the commissioning boards undertook King's Fund Organisational Audit, to the best of my knowledge. In Northern Ireland we do, and in the UK in general, the concept of accreditation is not widely used. It's interesting that laboratory services go through a form of accreditation. Accreditation is much more common in Europe and in the Republic of Ireland than it is within what I'll call the broad NHS in the UK. The standards that would be quite often developed around clinical services are what I would call professional standards, quite often generated by clinical professionals working within their medical Royal College, saying, "This would be an ideal standard or quality of service for paediatric nephrology, paediatric cardiology, or ENT surgery," or whatever.

So a lot of those standards were developed professionally and professional advice to the departments and to -- in particular, in drawing up standards would have been drawn on by government departments in the four countries.

Q. Thank you. Paragraph (h), you were responsible for:

"Contributing to and ensuring that an appropriate system of clinical audit is in place for assessing and reviewing the quality of services provided."

Was that a major part of your responsibility or did you delegate that to others?

A. At board level, it would have been my responsibility as the Trust medical director. Dr Murnaghan administered and ran the clinical audit department within the Trust. We were doing clinical audit and, prior to that, medical audit was conducted throughout the organisation by clinicians, by doctors and, ultimately, by multi-professional groups. So audit was being undertaken within the Trust prior to and following its commencement. My responsibility as an executive director at board level was to ensure that a clinical audit system was in place.

Q. Was it also your responsibility --

MR QUINN: Mr Chairman, our screen isn't working on our desk here.

THE CHAIRMAN: We'll get it sorted out.

MR STEWART: The audit system was your responsibility. Was it also your responsibility to ensure the system was working properly?

A. Yes. Ultimately, yes.

Q. In this case, the paediatric directorate had a monthly paediatric directorate audit, at which all deaths within the Royal Belfast Hospital for Sick Children were presented in the mortality section of the audit meeting, and there's no evidence, convincing evidence, that either in Adam's case or in Claire's was their death included in the mortality meeting within the audit structure; does that surprise you?
A. Can I preface my response to that by saying that morbidity and mortality conferences or meetings have taken place in the Royal complex for many years, long before the time we're talking about. Morbidity and mortality meetings were common in the surgical disciplines mostly and in obstetric disciplines. Anaesthesia and intensive care would have had morbidity and mortality meetings. And they were in place before the NHS guidance or local departmental guidance in Northern Ireland, requiring doctors to participate in a system of regular and systematic clinical audit.
I think many of those morbidity and mortality meetings, they were enshrined largely within an educational context. These were the sorts of things that medical Royal Colleges looked for when they came to do an accreditation visit or a training visit to a hospital to ensure that the environment in which young

doctors were being trained was appropriate and that they were learning through systems like morbidity and mortality meetings, like clinicopathological meetings, et cetera.
These were seen as being educational and there was no way in a monthly meeting that every death in every department within that hospital could be discussed at a morbidity and mortality meeting. So the person, the consultant who had responsibility -- usually a clinical tutor or a consultant in charge of training -- and I for many years, when I was the college tutor for anaesthesia took responsibility for about eight or ten years. I ran a morbidity and mortality meeting in the anaesthetic division. And there was no way I could present at every mortality meeting every death that took place.
Q. Every death in the Children's Hospital did go to the paediatric directorate monthly audit meeting and was discussed within the mortality section of that meeting. And the question was: are you surprised that in neither case is there any evidence that this happened?
A. Um ... I'm not quite sure what the question here is. Whether it's in relation to the fact that meetings weren't recorded or minuted and I have noticed through transcripts that that has been an area that the inquiry have looked at. Or are you suggesting that these

particular deaths were not discussed at the morbidity mortality meetings?
Q. It looks like they weren't discussed.
MR UBEROI: I'm not sure that's right.
THE CHAIRMAN: There's some ambivalent evidence about Claire's death.
MR UBEROI: I agree with that, but certainly with regard to Claire Roberts' death, I think the distinction the witness has drawn is probably a fair one. There might be a way that the question can be broken down in that there is an issue that I understand the inquiry is interested in about the policy of the discussion not being recorded and notes not being found, but that's different to the suggestion that Claire Roberts' death certainly wasn't discussed at a mortality meeting because various witnesses have said they would expect it was.
THE CHAIRMAN: Yes, except, Mr Uberoi, the problem about that is that the people who should have been directly involved in it -- for instance Dr Webb and Dr Sands -- don't recall that it was. There's a difference in recollections about whether Claire's death was ever the subject of a meeting or was ever part of a meeting.
MR UBEROI: There is, sir, from Dr Webb's point of view. I think, from memory, Dr Steen again couldn't remember

positively or negatively, but would have expected it to have been presented, but simply couldn't remember.
MR STEWART: [Inaudible: no microphone] would have expected it. The only person who said that they had any recollection or belief of recollection was Dr McKaigue; neither Steen or Webb nor anyone else said they could remember anything about it. No notes exist to suggest it took place and, after lengthy cross-examination with individuals who were asked what they might have expected to have happened at it and what they might have expected to have come from it were not able to advance the proposition that it occurred at all.
MR UBEROI: I think Mr Stewart has probably hit the nail on the head there. For example, if Dr McKaigue recalls it happening, that's some evidence, and then in precisely the way this witness is trying to get to the bottom of this question, really, there's the complicating issue of the fact that these things were not recorded, but that is different from suggesting that it has been established that there was no discussion.
THE CHAIRMAN: There's a couple of issues. One is the fact that the meetings aren't recorded any way; that makes it more difficult, but that's a separate issue, I think, doctor. There's another issue about how there doesn't seem to have been one involving Adam and the evidence

about one involving Claire is uncertain, to put it neutrally. But the other issue is, you have said -- and I understand how in the Royal -- you have said there were many deaths and you couldn't possibly discuss all the deaths at these meetings. But the understanding I've been given about the Children's Hospital is quite different: that there were very, very few deaths in the Children's Hospital, so that when a child died, that was a much more significant event than it would be in what I'll call the adult hospital for want of a better word; do you agree with that?

A. It wouldn't surprise me that that was the approach within the Children's Hospital. I have to say that the responsibility for managing a local system and process was very much up to the directorate. That was a devolved responsibility to the clinical directorate to ensure that whatever they had agreed locally would take place.

Could I also preface this, Mr Chairman, by saying -- and it goes to the whole area of what I will call the initial investigation of death. There would have been a convention present in medical practice -- and certainly it was present in the Royal from my days even as a junior doctor -- that if a death occurred, any death occurred in a ward, and the consultant in charge

of that patient -- it would have been an accepted and, I would say, a standard professional convention that the consultant in charge, either the next morning or very soon after the death of a patient, he would have met with his junior medical staff, he might have even met with his nursing colleagues, the ward sister, and they would have discussed the circumstances surrounding the death of a patient. Many of these deaths take place out of the hours with junior doctors covering the hospital, so the consultant who was ultimately responsible for the care of that patient, under good medical practice, and -- I'm using lower case the whole way through there -- would have carried out a very initial and early assessment of what happened.

If he had a concern, particularly in relation to the skills, the competency and the practice of a junior doctor, it would have been the responsibility of that consultant to bring that to the attention of somebody else. If there was conflict, let me use that word, or dispute around the circumstances in relation to a death, certainly from the time that clinical directorates were put in place, it would have been the responsibility of that consultant to bring that to the attention initially, I would suggest, to his clinical director, and if the clinical director, on his evaluation, felt

that there were matters here that should be brought to the attention of the medical director. That is what should have happened in every death, I would put to you.

MR STEWART: That's the purpose of the management structure, so this information can go up and down.

THE CHAIRMAN: Mr Fortune, what is your point?

MR FORTUNE: Despite the convention, that's a world away from what happened in the case of Adam Strain.

THE CHAIRMAN: I'm just going to come on to that because I have to say, doctor, that I don't think there's any evidence that that convention was followed in either death.

A. I'm not disputing that, Mr Chairman. That is what one would have expected to happen.

THE CHAIRMAN: But if that's the convention -- and I don't want to get too hung up on what the formal processes are or developing processes and so on. We have here a situation in which two children die within 15 months of each other -- a year -- in the Royal. And the formal processes don't work, the system doesn't work, and the long-standing convention isn't followed.

I have to say this: your introduction of this convention just seems to make things worse in the sense that -- and I'm grateful to you for your openness in describing the convention because I think you must know,

since you've indicated you've been following the transcripts, that this simply wasn't followed in either case.

A. And I suspect, Mr Chairman, that that would also have been the case in other deaths that took place within the hospital.

THE CHAIRMAN: But then it's not a convention. There's no point in saying there's a convention, doctor, if in two testing circumstances where children have died -- probably avoidably died -- the convention isn't followed.

A. The convention ... The use of the word "convention", it's not something that's written down in black and white. That's the problem. And if you're looking to custom and practice, good medical practice, I said in lower case, this is what [inaudible] and that is what I would have expected of any --

THE CHAIRMAN: But isn't it even more worrying when they don't kick in in the cases of two deaths?

A. I accept that, but there were other deaths, I suspect, in the hospital where the convention was likewise not followed. It's an example, I think, of where the system is weak and you're depending on -- to depend on ... I think what has happened as the whole concept of governance has strengthened over the years, we rely much

less on convention now than we do on proper process.
MR QUINN: I think the point that the Roberts family would want to make is that Claire's death is totally unexpected. One can see where the convention is followed where you have a death that is expected where somebody has been ill for a long time or where it's an old person who's been suffering for a long time. But when Adam Strain and Claire Roberts --
THE CHAIRMAN: That seems to me, Mr Quinn, to be a situation in which the convention -- if you have an expected death, if a child has leukaemia, say, and that child passes away, the convention to have an assessment afterwards of how the child was treated, that's perhaps more debatable about whether that is necessary because that's a child who is, sadly, dying of a disease --
A. Sorry, Mr Chairman. I would have expected the convention to kick in more frequently when a death is unexpected rather than expected.
MR QUINN: Yes, exactly. And that's the point I make --
THE CHAIRMAN: So that's the point. Mr Fortune?
MR FORTUNE: Adam's death was unexpected and we know what happened: George Murnaghan was informed. We then have the discussions within the ranks of the consultants as to what took place and, frankly, no inquiry by the hospital because it's all left effectively to the

coroner to sort it out.
THE CHAIRMAN: I suspect, Mr Fortune, it's because of this embarrassment that two of the consultants involved are rather pointing the finger at Dr Taylor, and Dr Taylor's a man who's rightly held, probably, in very high esteem and this actually makes it more difficult to do anything about.
MR FORTUNE: But we also know, sir, that there should have been strong legal advice given by the Trust solicitor as to how the matter should have been better managed.
THE CHAIRMAN: Yes. You've made the point before, but I'm not worried at this stage so much about what Mr Brangam advised or didn't advise at that time. I'm more concerned about what happened within the hospital. Because if the lessons are going to be learned, they're going to be learned within the hospital and, frankly, you don't need the Trust solicitor to tell the hospital doctors how to learn lessons. The doctors should be doing that themselves in conjunction with Dr Carson and Dr Murnaghan.
MR FORTUNE: I would invite you to consider this: that a Trust solicitor should be expected to give his client proper advice. For instance, that there must be a robust inquiry into these circumstances.
THE CHAIRMAN: But if he's giving that advice, he should be

giving that advice to people who already know that they should be obliged to investigate. So he's reinforcing something that they should know.
MR FORTUNE: I accept that.
A. I don't think I have ever received advice from a Trust solicitor advising me how to conduct an initial or an early inquiry into an incident that took place in a trust. I think that that responsibility lies with the trust medical director.
THE CHAIRMAN: And frankly, for it to reach the trust solicitor in the first place it's going to go through some senior people who should themselves recognise from the events that there's a need for a robust inquiry.
A. And we know that the triggers for a clinical negligence claim are going to be significantly after the event.
THE CHAIRMAN: Yes.
A. Sometimes years after an event. And the benefits that come from any early investigation are going to be determined early rather than late. And the chances of securing information, getting early recall when people can remember, it needs to be much earlier than --
THE CHAIRMAN: You've also got the problem about if one or two of our doctors or nurses, for that matter, have behaved in a way which has contributed to a patient's death, do we need to do anything about that doctor or

nurse immediately?
A. Correct.
THE CHAIRMAN: So an investigation in six months' time doesn't solve the immediate problem that may exist.
A. My ultimate responsibility, I suspect, as a trust medical director is to ensure that patients are safe.
THE CHAIRMAN: Yes.
MR QUINN: Mr Fortune raised this issue. In our case, we didn't even have the fallback position of the coroner. Perhaps the witness could be asked that -- maybe Mr Stewart will deal with that later on, about the system in place in relation to the coroner's investigation. And not only that, but the nurse in charge of the ward didn't even know. So there seems to be a complete wall of silence about Claire Roberts' case.
THE CHAIRMAN: The nursing director knew about neither death.
MR QUINN: Yes.
THE CHAIRMAN: Mr Brown, who was involved in assisting Mr Keane in Adam's operation, says he didn't know that Adam had died. We don't know who the nurses are. And Dr Sands, I think, picked it up by word of mouth.
MR QUINN: Exactly, I was going to make that point.
THE CHAIRMAN: Not in the context of those involved being

gathered together over the next day or two to discuss it.

MR QUINN: As did Dr Bartholome who was treating Claire. She was the doctor in charge of Claire that evening, and she didn't pick it up for three days, according to the evidence. Is that what one would expect of a system that is operating properly?

THE CHAIRMAN: I think the answer is easy to that. It's not good enough, is it?

A. No.

MR STEWART: The system wasn't working properly, you can see that and agree that. You were talking about the convention of what you'd expect in terms of this reporting. Neither death was brought to your attention, neither death was brought to the attention of the clinical directors, Claire's case wasn't even brought to the attention of the ward sister, Pollock. So the convention, as you described it, simply wasn't working. By convention, is that what you mean by what you'd have expected to have happened?

A. Yes.

Q. Were you in any sense in contact with what was happening on the wards to determine whether what you expected might happen was happening?

MR UBEROI: I'm sorry to rise again. May I rise to

hopefully assist and slightly correct a point factually? In Adam's case, the clinical director was aware. I think once Dr Gaston, as clinical director of ATICS, becomes aware of the matter, it rather bounces across to Dr Murnaghan, whereby, in terms of the convention as described, there is an argument for suggesting it should have gone to Dr Carson, but Dr Gaston was aware of the death of Adam Strain.

MR STEWART: That is perfectly correct. Dr Gaston was the lead in ATICS, but he wasn't within the Children's Hospital. The clinical director of the paediatric directorate, Dr Conor Mulholland, was not informed. He is the individual I was referring to as the clinical director as opposed to the individual, Dr Gaston, who was outside the Children's Hospital.

MR UBEROI: Thank you for that clarification.

A. It is possible that Adam's case -- and I'm not ... I can't remember precise details -- could have been -- should have been -- discussed at morbidity/mortality audit meetings in both the paediatric directorate and in the anaesthetic directorate. So in a sense, both clinical directors should have been informed or been aware.

THE CHAIRMAN: [Inaudible: no microphone] on the establishment of the Trust, the clinical director for

anaesthetics had almost no role in the Children's Hospitals. But the anaesthetists, like Dr Taylor, who were working there, were at least in theory responsible to him.

A. They were entirely responsible to him. I can confirm that. That was the structure in the anaesthetic service.

THE CHAIRMAN: But not to the paediatric director?

A. Sorry?

THE CHAIRMAN: Not to the paediatric director, Dr Mulholland.

A. They did not report to Dr Mulholland as the paediatric clinical director.

THE CHAIRMAN: So that's why Dr Gaston knew about Adam's death, but Dr Mulholland did not know.

A. And Dr Mulholland should have known.

MR STEWART: He should have known because at that stage the anaesthetists were not saying, "This is an anaesthetic problem", were they?

A. Well, I'm not in a position to comment on what.

Q. Dr Taylor was saying he could see no physiological cause for the death. It wasn't anything that he had done, and accordingly, at that stage, it wasn't a matter necessarily for reporting to Dr Gaston, it should have been reported to the clinical lead of the paediatric

directorate, shouldn't it?

THE CHAIRMAN: I think in any event Dr Carson accepts that whatever the position, Dr Mulholland should have known as the paediatric director.

MR STEWART: Can I just revert to that question I posed a moment ago: what you might have expected to have been happening doesn't seem to have been happening in these two cases? Were you taking any steps to find out whether what was happening on the wards was indeed what you'd have expected to have happened?

A. Obviously, I had very close contact with all of the clinical directors. I would have been out and about and walked the wards, the operating theatres. I was a practising clinician so I have a fair idea of what was happening in the hospital, the heartbeat of the hospital, I think, I was pretty close to. But I did not go round the hospital determining whether every convention was being followed, no. How could I?

Q. Quite.

THE CHAIRMAN: Sorry to interrupt again. How taken aback are you about what you now know about what happened after Adam's death and what happened after Claire's death in terms of the way that the system didn't work? Are you shocked by it or are you just disappointed or is this just, "Well, that's what happened"?

A. You sort of asked me this question yesterday, Mr Chairman, and I maybe didn't answer it very well. How do I react? First of all, I'm very disappointed because the hospital prided itself on its reputation -- and I think its justifiable reputation -- for delivering a high standard of care in every area of its responsibilities. So that would have been the first thing.

Secondly, in relation to these two particular deaths, I think it goes beyond just personal disappointment that convention wasn't followed. I would have had a concern that more wasn't done immediately to escalate, if you like, the level of concern around these two particular deaths. In a sense, what I said yesterday was that -- I mean, Adam was a complex child, a child with complex medical condition. It was a difficult and challenging operation and there were difficulties within that for by the failings that actually took place during the operation. And in a sense -- and there were obviously lots of things to learn from that.

I suspect that the learning actually should have gone beyond the immediate clinical teams, the theatre staff, the anaesthetic staff, the surgical staff, the nephrology staff. I think there were issues that should

have been learnt in relation to the whole development of paediatric transplantation service. So if we jump forwards to the seminar that Dr Murnaghan was keen to put in, I would have wanted to have broadened that to involve, for example, commissioners of service, because I think there were maybe lessons to be learnt. One of the problems in Northern Ireland in some of the smaller regional specialties is that -- and we see this even today, for example, in the whole area of paediatric cardiac surgery -- and this is still a very current debate as to whether certain services are sustainable within the context of Northern Ireland, the critical mass being so small.

So I think there were broader lessons to be learnt there. In relation to Claire's case, I said I was more surprised that that hadn't come to me because -- and again, I was not aware of Claire's death at the time, it wasn't brought to my attention and I had left the Trust by the time that the Roberts family drew the hospital's attention to their concerns. And learning from the transcripts and so on of the inquiry, there were incidents that took place during Claire's management that I think merited further investigation. Who was in charge of the patient? Who looked after -- who was responsible? The issue about drugs, administration of

drugs, overdose of drugs. I mean, those should have been triggers that should have precipitated a further investigation and a deeper investigation at the time.

The debate around whether a death certificate could or could not be signed, you know, there was sufficient, I think, grounds there for a discussion to be held, even with the coroner's office.

I can remember as a junior doctor -- and this was certainly before the reform of the coroner's system in Northern Ireland. Many's an occasion when I was a junior doctor working in an intensive care unit and a patient died. I quite often lifted the phone to the coroner's office to get advice and say: this is a patient who has had surgery a month ago, he has been in intensive care for a month with liver failure, renal failure, pulmonary failure, the death is not unexpected; do you wish me to refer this?

So what I'm trying to get at, the coroner's office is in a position to give advice to a doctor. So there were things in relation to Claire's case that not only disappoint me, but I was surprised that they weren't escalated.

THE CHAIRMAN: Thank you.

MR STEWART: Were you also surprised, just on that issue, that Mr and Mrs Roberts had to wait until 2004 to be

told that hyponatraemia was indicated in their daughter's death? Was that a matter of surprise to you?

A. I didn't know the circumstances in relation to Claire's management in detail at all. In some ways, I'm not surprised because, obviously, the dissemination and the learning in relation to hyponatraemia that came out of Adam's case hadn't percolated through this system as much as it should have.

THE CHAIRMAN: Because it was too confined? That was a failure after Adam's case, that, if there was anything learning at all, it was too confined?

A. I think that's correct, yes.

MR QUINN: Mr Chairman, while we're on this point, I don't want to miss this issue while it is pertinent: could the witness be asked if he's surprised that there was no referral to the coroner in 1996? He mentioned that he would have phoned the coroner, but maybe he could be asked if he was surprised that no one phoned the coroner, made investigations and the case wasn't referred at that stage.

A. I can respond to that in that if a doctor, on the basis of their clinical decision-making, on the basis of what diagnosis they've made, if they feel that they can sign a death certificate, then I am not surprised that the coroner wasn't informed. Now, whether the doctor was in

a position to make that decision is a different matter. But if a doctor feels that they can write a cause of death on a death certificate, then I'm not surprised that it doesn't get referred to a coroner.

THE CHAIRMAN: What concerns me about that particular point is this: Dr Steen is the named consultant who doesn't, for various reasons, see Claire from Monday evening when she's admitted until Wednesday morning when she's called in, and Claire is already in PICU and is, to all intents and purposes, dead. She has had no involvement in her care. She discusses Claire's case with Dr Webb, who has had involvement in her care, and has done his best, although, on the evidence of the experts to the inquiry, he has unfortunately been rather on the wrong track.

But Dr Webb expected that when he left the hospital on Tuesday morning that Claire's condition was under control and the last thing he expected was that she was going to die.

A. Yes.

THE CHAIRMAN: So you have a discussion between two consultants, one of whom expected Claire to recover, and one of whom hadn't been involved in Claire's case at all. Isn't there a surprising degree of confidence on Dr Steen's part to --

A. Sorry?

THE CHAIRMAN: Isn't it surprising that Dr Steen was sufficiently confident to sign a death certificate about the cause of Claire's death, given that she hadn't been involved in any way in Claire's treatment and given that Dr Webb must surely have been telling her that he was taken aback as he thought she was on the road to recovery?

A. I would agree with that.

MR STEWART: The point I was attempting to make was one relating to honesty. One doesn't require all the clinical governance directives to realise that honesty and trust is part of the relationship between a doctor and patient.

A. Correct.

Q. Hyponatraemia appeared in Claire's medical notes and records as a diagnosis -- perhaps a query diagnosis -- when she was in Allen Ward and when she was in intensive care. And it appeared clearly as a diagnosis on the discharge sheet from intensive care. It appeared in clinical coding. But yet Claire's parents weren't told of hyponatraemia for eight years; does that surprise you?

A. I don't ... It's hard to respond about whether it surprises me or not. This comes down to the quality of the communication that takes place between doctors and

relatives, family in particular, in relation to children, parents or guardians. The skills that a doctor needs to develop in relation to communication have been a concern for many years. The university tried to build it and have spent a considerable effort to improve communication skills, building it into undergraduate programmes. It's part of, if you like, almost the assessment of doctors as they progress through their training. And I know that in the whole area -- I mean, there are published articles in the literature, whenever a doctor -- in the area of consent for post-mortem, for example. We know -- and the chairman knows maybe better than most -- that at the time of the human organ inquiry, one of the features of consent for -- communication with families, at the time consent was required for a hospital post-mortem, that was not very good, to say the least.

At the very point of having to inform parents that a child has died, to move the debate on to, "We'd like to do a limited post-mortem, we think a limited post-mortem would give us the information we need", obviously the amount of information ... The doctor has got to balance or evaluate how much information to bombard grieving parents with at a very awkward and difficult -- it's an area of vulnerability. So in

a sense, in a sense, when we talk about coding, the depth of coding and wanting to drill down to every contributing factor that you would want to be captured, if you like, as the process of coding, it wouldn't surprise me that when you get down to level 2, 3 or 4 that that might not be communicated to a family.

Q. Might it surprise you if the family were told it was a viral illness, but that the doctor didn't put that on the medical certificate of cause of death, nor hyponatraemia, which was apparent from the notes; would that surprise you?

A. What I would agree is that there are inconsistencies there.

Q. All right. Can we go back then to the page that appears on the screen? At (i), you were responsible for:

"The coordination and promotion of high standards at all stages of medical education, including continuing medical education."

How did you do that?

A. Continuing medical education, CME, is a responsibility. Every senior doctor under their professional obligations, under good medical practice, are required to undertake continuing medical education. They built into their contract of employment -- that would have been a clause within their contract of employment.

It would also -- they would have been entitled to time off to undertake continuing medical education and there would even have been funds available to enable doctors to participate in continuing medical education.

Q. And then that goes on to paragraph (j):

"Encouragement of the development of evidence-based clinical practice and research."

Evidence-based clinical practice: is that learning from lessons of what's happened in practice?

A. The use of evidence-based medicine is very much -- I think the focus there was more on what are the current developments in medical practice saying this is the best way to treat a patient, rather than looking back at the evidence of how a patient was ... So this is evolving good practice, the standards, the evolving improvement in clinical practice so doctors should be encouraged to always move forwards. And as we all know, medical practice today has -- the practice of medicine has become much more complex, it's also much more effective in the outputs and the outcomes in many cases, and we're now delivering care to an increasingly high-risk population as they grow older and as multi-system disease becomes -- in sicker and sicker patients.

So doctors are encouraged to participate and to even help move forwards the boundary of medicine and to

produce evidence to show what is now acceptable and improving standards for care.

Q. Then on to paragraph --

A. What I'm getting at, sorry -- this is a more prospective -- forward-looking agenda rather than a retrospective-looking agenda.

Q. I understand. Paragraph (m), which is perhaps the most important of your responsibilities insofar as this debate is concerned. You are charged with:

"Providing leadership on medical standards by ensuring that effective procedures are developed for dealing with clinical complaints and clinical risk management and monitoring these procedures.

What processes did you put in place to roll out the clinical risk management procedures?

A. Well, I've indicated earlier, chairman, that the systems that were in place in the early 1990s were not highly developed, not very well developed. The early focus was on the whole area, as far as the trust was concerned -- sorry, it's an aside.

I remember the director of finance coming into my office one day and he said, "What do you know about risk management?". And the focus, as I suggested, was very much around how could financial risk to the organisation be minimised or managed. So the focus was very much on

those areas where the Trust was going to be liable and under that umbrella comes the liability under health and safety legislation --

Q. Yes.

A. -- and corporate manslaughter as a result of failures of health and safety procedures. So the early emphasis in those days was in relation to non-clinical risk.

Q. What days are we talking about? What dates?

A. Whenever the management ... When the management executive shared the book that you have shared -- and I can't remember the ...

Q. 1993. December 1993.

A. I can't remember when the management executive and the DHSS forwarded that with a covering letter to trusts. I can't remember the date of that.

THE CHAIRMAN: Sorry, Mr Stewart, that publication is December 1993 --

MR STEWART: December 1993.

THE CHAIRMAN: -- in England? So then it comes over to here --

MR STEWART: It comes here immediately --

THE CHAIRMAN: It comes through the department --

A. I'm not sure when that would have been cascaded down to trusts from the Department of Health.

MR STEWART: All I can do to help you with that is that

Mr Stephen Ramsden, who provided a report for the inquiry, contacted Hilary Merritt, who was one of the authors of this and she confirmed that it had been circulated to NHS organisations in Northern Ireland.

A. I'm not disagreeing with that at all. I do not know when the Department of Health, the management executive within the Department of Health, conveyed that good practice to the trusts. But it would have been around 1993/94.

Q. So what you're saying is before this, before you received this NHS risk management advice, there would have been very little?

A. What I'd suggest to you is even after that was received, for a number of years, as trusts developed their internal systems and processes, they were not highly defined. And it was not until the Trust appointed a health and safety manager -- a Mr Orchin who reported initially to Dr Murnaghan -- that we started to develop the concept of incident reporting.

Q. All right.

A. Then around 19 ...

THE CHAIRMAN: Sorry, I just want to make sure I understand this: when you say "health and safety manager" and "incident reporting", by "incident" do you mean somebody slipping in a hallway or do you mean something going

wrong clinically, or does it cover both?
A. Um ... The expectation, I suspect, was that ... If you use guidance that we're referring to, the handbook, the manuals, the anticipation is that this should have included clinical. But in practice ... Incident reporting probably was at its most refined along the nursing line. There was a ward incident book, which, you're quite right, Mr Chairman, would have addressed issues around slips, trips and falls, but it might also have included a misadministration ... A medical ... A drug administration problem, either too much drug or somebody didn't get their 4 o'clock dose of this, that, or the other. So a lot of the incidents that were being reported through the nursing ward-based incident book were of that level.

When the health and safety manager was put in place and the IR1 forms introduced, then the breadth and the depth of reporting was expected to increase. It was not until significantly later, probably around 1998 or thereabouts, just after George Murnaghan left, that we were able to appoint a clinical risk manager to carry out, across the trusts, training and information -- dissemination of information to clinical directorates. We also, as part of my programme of taking this agenda forwards -- was appointing somebody within each

directorate who would take responsibility for risk management, if you like a directorate risk manager, somebody who could collate and collect information at a directorate level, feed that through to Mr Orchin and to the clinical risk manager. And at that time, after Dr Murnaghan's retirement, then that responsibility for risk and occupational health transferred to Dr Stephens, who then handled it on behalf of the Trust and who prepared Trust health and safety and risk reports.
THE CHAIRMAN: Okay. To help me understand this, can you give me an example of how the clinical risk manager, when appointed in the late 1990s --
MR STEWART: Sorry, sir. I don't mean to -- perhaps there is a way of getting there in rather more ...

Do I understand you to be saying that until the late 1990s there was no real management structure for clinical risk management?
A. I suspect the structure was there, but it hadn't been developed or refined to the extent that it eventually has become.
Q. I see. Can I ask you to look, please, at WS061/2, page 232? This is the health and safety policy of the Trust in November 1993, and this pre-dates the publication of the "Risk management in the NHS" document. We can go over the page to 235. We'll see an

introduction to this policy document, the introduction is signed by W McKee, and he says immediately above the signature:

"This policy has my commitment and I expect all employees to give their commitment too."

Going on to page 241 of this document within the health and safety policy. Set out is the medical risk management group. You'll see from the composition of this group set out at the bottom of the page that you chair it. And the group has responsibility for clinical risk management within the Trust and its undertakings:

"The group will report through the risk management steering group to the hospital council on clinical risk management and related matters."

And you also chaired, I'm able to tell you from page 238, the risk management steering group. There we are.

Back to 241, please. There was obviously liaison between ordinary health and safety and clinical risk issues, but the medical risk management group -- in the middle of the page -- has specific responsibilities for:

"(i) clinical audit; (ii) research register; (iii) untoward incident reporting (clinical); (iv) medical negligence; (v) complaints."

And it goes on to say it will coordinate activities

in relation to drugs and other related sub-issues.

So it looks as though in chairing this group you had specific responsibility for untoward incident reporting; would that be correct?
A. That is correct, yes.
Q. Did that receive your commitment?
A. Absolutely.
Q. What did you do about introducing "untoward incident reporting (clinical)"?
A. Through the clinical directorate system, we encouraged clinical directors to ensure that that untoward incident reporting was complied with by the staff within the directorate.
Q. When did you do that?
A. Um ... You mean ... I mean, from the ... Um ... Once this document approved by hospital council -- hospital council, remember --
Q. Yes, if we go back to -- just to answer your question -- page --
A. Hospital council was chaired by the chief executive and all the clinical directors were in attendance, were members of the hospital council. When this document was approved and was adopted, accepted by the hospital council, each member of that council shares in the corporate responsibility for making sure that those

commitments were followed through at directorate level.
THE CHAIRMAN: So the answer to Mr Stewart's question is that since the clinical directors were all aware of this policy, it was your expectation that they would ensure that it was put into practice?
A. Correct.
THE CHAIRMAN: But what the policy sets out, is that something which you regard as new or a continuation -- perhaps described differently but a continuation of an existing policy?
A. Well, given that it's only been put in place in November 1993, it has to be -- I mean ...
THE CHAIRMAN: Sorry, I didn't express myself very well, Dr Carson. Untoward incident reporting is something which should have been going on in any event, whether it was described as untoward incident reporting or not. But does this not come back to what you said earlier about what the convention was? Is there a big separation in reality between the convention which you described, which long pre-dates trusts, and untoward incident reporting?
A. Yes, I think this is part of that transition, trying to move away from convention and to actually putting something into a Trust policy.
THE CHAIRMAN: But there's a fundamental similarity between

them, isn't there?
A. Yes, there is a similarity, but this is a further development of it.
THE CHAIRMAN: Yes.
A. Putting a framework around it. What was lacking, I was suggesting earlier on, just before we got on to the specific -- what was lacking was ... What we have here is a policy. What was maybe lacking were the processes and the necessary infrastructure to make sure that it actually happened.
MR STEWART: That's what I was asking. You were charged with that responsibility. You chaired that group with specific responsibilities, it had your commitment and I was asking what resulted from that commitment.
A. Well, the development of the IR1 reporting system, for example, the appointment of a health and safety manager, the development of ... At a senior level within the organisation, bringing together the knowledge and awareness, if you go to the page that covered the range of ... The next page, 235.
Q. Go to 241. What I was asking about was the development of policies or procedures for untoward incident reporting clinical, not health and safety issues on site --
A. Okay.

Q. -- but clinical untoward incident reporting.
A. If you look in the middle paragraph there, the risk management group has specific responsibilities for ... If you look at those five areas, if you like this was a way of capturing the responsibilities, that Dr Murnaghan had administered his responsibilities, management responsibilities. Those were the areas that he oversaw.
Q. Yes.
A. Clinical audit, the management of the research register, the reporting of clinical incidents and then the management or the administration of medical negligence. And the last one, (v), that should probably have said "complaints in regard to medical staff", not complaints in its entirety. Because I hinted earlier that that was the responsibility of the Trust.
Q. If we read this properly, we see from the second paragraph that the director of medical administration, that's to say Dr Murnaghan, will be the link between the two groups.
A. Correct.
Q. He was the linkman between the medical risk management group which you chaired and the risk management steering group which you also chaired. So you had overall responsibility, it seems, for both the general health

and safety on site, ordinary occupiers' and employers' liability issues, and you also had responsibility for untoward clinical incident reporting.
A. Mm-hm.
Q. It's quite clear that much was put in place, presumably under your leadership, in relation to -- you called it the IR1, and that was health and safety reporting. And we have this document, which is an important document, and this is the reporting procedure brought in in 1995. That is at WS061/2, page 175.
A. I think what we were trying to do, Mr Chairman, here, by putting this policy in place, was trying to demonstrate that we were following the guidance that came in the handbook on risk management. We were attempting to put in place structures. They needed development, further refinement. There's no doubt about that.
Q. What structures did you put in place to deal with untoward incident reporting clinical is the question.
A. We used exactly the same form. My recollection here is that we used exactly the same form for reporting clinical incidents as we did for non-clinical. I may be corrected on that, but that's my --
THE CHAIRMAN: That's the IR1 form?
A. Yes.
THE CHAIRMAN: Sorry, Mr Stewart, one moment. Mr Fortune,

do you have some point?
MR FORTUNE: Yes, I do, sir. Can we establish from Dr Carson whether the process was in fact in place by the time of Adam's death? Because if it was, why was it not invoked?
MR STEWART: Let's first of all look to see whether there was anything in place. Go to WS061/2, page 192. This is the 1995 "Report of injury or dangerous occurrence". And then if you can put up beside it page 193, which is page 2 of it.
This is the sort of form that you say an untoward clinical incident would be reported by, do you? "Contact with moving machinery."
A. This RIDDOR, the Reporting of Injuries and Diseases and Dangerous Occurrence Regulation, this is a requirement under law, and there are specific headings, fields, that need to be filled in when you're reporting a RIDDOR incident.
Q. Can you point to any part of this -- I'm awfully sorry that the copy quality is poor. There's nothing, I suggest to you --
THE CHAIRMAN: Let's take it a page at a time, Mr Stewart, because it comes up a bit better. Take the left-hand page. C is "Date, time and place of accident", "Dangerous occurrence or flammable gas incident". So at

C you could put in the date, time and place of an accident if you regard what went wrong in Adam's operation as an accident. Then injured person is "Adam" at D. Let's try to work through this as an example of how this form could be used.
Shall we go on to the next page?
MR FORTUNE: Sir, you start at A because this was a fatality.
THE CHAIRMAN: Yes, thank you. Let's go on to the next page.
MR STEWART: That's:
"Contact with moving machinery; struck by (including a flying or falling) object; moving vehicle (fixed or stationary); handling, lifting, carrying; slip, trip, fall; fall from a height; trapped --"
THE CHAIRMAN: I think the short form of this is you end up going to the fourth column, the last box is:
"Other kind of accident. Give details in section H."
So what you have to do -- I think the point is ... And then that's highlighted at F:
"Which, if any, of the categories of agent or factor below were involved?"
And again, you're going to have to go to box 17, which is "Any other agent", aren't you?

A. Mr Chairman, I mean, I'm not an expert in RIDDOR at all. This is very much -- this is the sort of health and safety under the particular regulations that related almost what I would call to industry accidents rather than clinical incidents. It was never used in the hospital. To the best of my knowledge --
THE CHAIRMAN: I think that's the point Mr Stewart is making.
MR STEWART: That is the point. What adverse untoward clinical incident reporting form did you put out there?
A. That's not the IR1 form.
Q. That's not the IR1 form?
A. No, to the best of my knowledge.
Q. I stand corrected.
MR FORTUNE: That is not an IR1 form, sir.
A. That's a RIDDOR reporting form under the regulations that control those. So the IR1 form, to the best of my knowledge, was used for non-clinical and for clinical.
MR STEWART: I do beg your pardon. It's at WS061/2, page 185.
MR FORTUNE: For the benefit of the stenographer, "RIDDOR" is R-I-D-D-O-R.
THE CHAIRMAN: Thank you.
MR STEWART: And it stands for?
A. It's on the top of the form -- I can't remember ...

THE CHAIRMAN: Don't be clever!
MR FORTUNE: "The reporting of injuries, diseases and dangerous occurrences regulations."
THE CHAIRMAN: Thank you.
MR STEWART: Full marks!
In relation to IR1, could we think of using this for an adverse clinical incident?
A. To the best of my recollection, this form was introduced initially to deal with non-clinical incidents, but we continued to use it for the reporting of clinical incidents.
THE CHAIRMAN: After the clinical risk manager was appointed in 1998, did the use of this form continue or was it adapted?
A. I think to the best of my knowledge it still continued, I can't remember, Mr Chairman. I do think it remained for some considerable time. But what did happen, what did change with the appointment of the clinical risk manager was there -- was both that individual and the health and safety manager conducted, I know, regular visits to trusts. They held training and educational and information meetings with staff in clinical directorates, helping them to -- encouraging them to report incidents and also to give feedback to the directorates as well in relation to reports and

incidents that were reported. And these were collated into health and safety and risk reports on behalf of the Trust, and that eventually got reported to the Trust board. I can't remember the exact dates of the first report.

MR STEWART: All right. Can we have page 186 beside that?

Again, I suggest to you that this reform would present difficulties if you were trying to fill it in for a clinical incident. At the bottom:

"Did the person suffer injury or ill health: abrasion, amputation, bruise, scalds? Apparent cause of ill health: assault, needlestick, sharps, patient lifting or handling, manual handling, slip, trip, falls, fall from height [et cetera, et cetera], struck by an object."

Was any thought given to introducing a proper form for untoward clinical incidents?

A. I honestly can't remember, Mr Chairman. It is well-known in the -- throughout the breadth of the NHS that the reporting of incidents, certainly in the early days of risk management -- the early days even of clinical risk management -- the reporting was not comprehensive. And certainly, even whenever the Department of Health took a specific interest in the whole area of incident reporting, the department was

inundated with what I would call trivial incidents and more serious incidents -- there's been a history in the Health Service of under-reporting of incidents. Doctors have probably been worse than nurses in terms of the frequency with which they report incidents, and again ... So this has been a learning -- a whole reform agenda within the Health Service. It has taken on a new impetus with the introduction of clinical governance, clinical and social care governance.

Q. Were you aware that there was an under-reporting of adverse clinical incidents in --

A. I suggest the literature is riddled with evidence that there was under-reporting. Sir Liam Donaldson produced an organisation -- a seminal document, "An organisation with a memory", which illustrates very clearly that there was under-reporting and even when there was reporting, again I said we weren't very good at learning from what was reported.

Q. Did you receive many reports of untoward clinical incidents on an IR1 form?

A. I don't have that information, I'm afraid. I can't recall. The information would have gone initially to the health and safety manager, the clinical risk manager and either Dr Murnaghan or later Dr Stephens. They would have received the totality of the IR1 forms and it

was their responsibility to analyse those to determine trends, patterns, and so on.

Q. In February 1997, you produced a risk management policy. We find that at WS061/2, page 228. There your name appears at the bottom left hand corner. Going over the page to 229, you describe the purpose of this policy. In fact, the purpose of risk management strategy being to, at 2, "improve the safety of patients". And at the bottom, you go on to describe the accountability and authority:

"The coordination of all risk management activities will be the responsibility of the chairperson of the risk management steering group."

And that's you.

Over the page again, at page 230, we come to the functions of risk management. Halfway down that paragraph you have written:

"It will assess the safe and professional care of patients through the establishment of an effective incident reporting and investigating system, a claims management system and a loss control programme."

We've already touched upon reporting and investigating. Claims management system: when this was published by you in February 1997, the medical negligence issues brought by Adam's mother were ongoing.

That wasn't a settlement of that until April 1997. The question is: was any part of the care of Adam Strain assessed as a result of the settlement of his claim where liability was admitted or liability was accepted by settlement?

A. I can't recall whether there was specific reference to Adam's case in terms of that. I don't know, I can't remember. Dr Murnaghan would have been in a much better position to respond to that.

Q. I think he told us that there was no further assessment of Adam's case after the matter was settled. What did you do to encourage Dr Murnaghan to use the medical negligence claims as a vehicle for learning?

A. We eventually -- I think in the first clinical governance report, after Dr Murnaghan retired we had ... I was in a position to restructure, if you like, the clinical governance framework within the Trust.

I appointed -- well, the Trust appointed two associate medical directors to work with me, and that was the first opportunity, if you like, that the medical director's office started to have, if you like, a proper structure within it. And people with specific responsibilities. And I know that when we brought our first clinical governance report to the Trust board, there was a summary in relation to clinical negligence

claims within the Trust.
Q. Is there any point in publishing a policy if you're not actually going to do anything about it? This isn't an aspirational document, this isn't a consultative document, this is the Royal's policy: we're going to assess patient care on the basis of the claims management system. The question is: why wasn't it done?
A. Well, I suggest to you, in the totality of things, that it was being done. This wasn't a policy document sitting in the ether.
THE CHAIRMAN: So in essence are you saying, Dr Carson, that through the 1990s the overview is that these documents show that there were not just policies being introduced, but gradually a change and development of practice?
A. I would put it to you that everything that I did as Trust medical director during those years, particularly from the mid-1990s onwards, was about advancing and developing systems and processes in the Trust. And I've given evidence to the inquiry specifically of initiatives that I took forward that were going to strengthen the whole area of patient safety. Counsel put to me on the opening day: when did this concept of "patient first" come? What we do see in the mid-1990s was a growing emphasis on the whole area of patient safety. This was happening at a national level through

"Organisation of a memory" [sic], the establishment of the National Patient Safety Agency and various other measures and institutions being established to advance the whole area of incident reporting and the Health Service learning from accidents and adverse events.
So this was very much a journey that we were on, and I would contend, quite strongly, that we made tremendous strides during that period of time to improve the systems that were in place.
THE CHAIRMAN: I think the problem we have here is that I'm not getting an overview from this inquiry; I'm looking at particular incidents, which frankly don't show the system in a good light.
A. I understand.
THE CHAIRMAN: So from that perspective, it may be that the view that I have is skewed by the fact that I'm focusing on deaths which should have been avoided and which were not properly followed up, were not properly investigated and from which lessons weren't learned until we finally get to Raychel's case, when, after her avoidable death, Altnagelvin went to the department and triggered what then emerged as the hyponatraemia guidelines. The reason why you're being asked these questions is to help us see from our perspective what was being done because what was being done didn't succeed in either Adam's case

or Claire's case, which are the two we're focusing on today.
A. I fully understand that and I recognise that whenever sad and unfortunate and tragic incidents like this come to light, systems are inevitably seen to have failed or let families down. And that's been the pattern throughout the history of the NHS. Whether it's individual failings, more likely than not, it's systems that fail.
THE CHAIRMAN: One of the reasons -- and we're going to take a break in a moment -- for focusing on this is that the families have said repeatedly -- but the general public concern must be that everybody knows that things go wrong and that will always happen no matter how good the processes are. The real question is: if things do go wrong, are lessons learned which make it less likely that things will go wrong again in the future or similar things will go wrong again in the future? The focus of this inquiry is such on hyponatraemia cases that there is a real concern about whether lessons were learned.
A. I understand exactly the position that the inquiry are in here. I would contend that during particularly the latter 1990s and into the early 2000s that systems did improve, and even after my tenure as Trust medical director when I moved from the hospital to the

department, systems were even strengthened at that level, giving further guidance to the service. But even within the Royal Trust at that time, the whole approach to the investigation of adverse events moved on a stage from where I'd been able to develop. Dr McBride introduced the concept of root cause analysis. So we were moving in the right direction. Families have, obviously, in these cases been sadly disappointed and let down. I accept that.
THE CHAIRMAN: Okay, we'll take a break for a few minutes. Sorry, Mr Hunter?
MR HUNTER: One point, sir, before you rise. Given Dr Carson's responsibilities as outlined by Mr Stewart this morning and given the fact that Adam was admitted to hospital to undergo a kidney transplant and that he was not remotely expected to die, given the fact that he did die effectively on the operating table, an event that would have very obvious implications for the clinicians involved and also would have very obvious implications for the hospital and indeed for the renal transplant programme in Northern Ireland, and given that it was the talk of the hospital, one wonders if that didn't get on to Dr Carson's desk. What was the benchmark of what did get on to Dr Carson's desk?
THE CHAIRMAN: Yes. We were told earlier, doctor, in the

spring when we were going through the primary evidence in Adam's case that Adam's death was the talk of the hospital. That might have been the talk of the Children's Hospital or it might have been the talk of the Royal overall. Your evidence is that that simply didn't reach you until some time --

A. I do not recall being informed about Adam's death at the time. My first recollection, I think, was at or around the time of the inquest when Dr Murnaghan briefed me on, I think, the outcome of the coroner's inquest. So that was to the best of my knowledge. Talk of the hospital? I can't comment on that. What I do know is that Adam and Claire's deaths were not the only incidents that took place. I'll go back to the -- for example, I remember in some of the early witness statements I was being asked about other deaths that were being investigated. I mean, we had incidents across our site happening, dare I say it, on a daily ... There were shooting incidents, I remember in the Children's Hospital an incident where there was a shooting in the grounds, patients falling off balconies. I'm exaggerating, Mr Chairman, but whenever people talk about the "talk of the hospital" there was a lot going on in that hospital and my responsibilities -- there has been a lot of focus in the last hour or two on the whole

area of risk management. My responsibilities were very much broader than just risk management. I took responsibility for it at Trust board level, but the breadth of my responsibilities was very much wider and I had a lot of other agenda items.

MR FORTUNE: Sir, that doesn't actually answer the question as to what is the benchmark, because that was Mr Hunter's question. What is the benchmark for a death coming to the attention of the medical director?

THE CHAIRMAN: I'm not sure that there is an identifiable benchmark, is there?

A. Well, I would suggest that any death where a doctor's practice is called into question or patients are put at risk, those are cases that quite definitely should have been referred to the Trust medical director. If any death or circumstance was going to cause public concern, brought to the attention of the media, there will be other -- I could broaden the criteria of cases: deaths that should have been brought to the attention of the medical --

MR STEWART: How do you know the clinician's practice or performance is brought into question? How do you know that?

A. I suppose that I would have relied heavily on other clinicians expressing concerns about the practice of

a colleague. Let's remember the GMC had given very good guidance through Good Medical Practice to all doctors about their professional responsibilities in that area. If there were issues --

THE CHAIRMAN: Sorry, doctor, I think we can shorten this. To put it bluntly, Adam's death did call into question Dr Taylor's clinical practice. Professor Savage believed so, Mr Keane believed so. Their views were known to Dr Murnaghan. And that should have gone to you very quickly, shouldn't it?

A. I would agree with that. But it should also have gone to the clinical director. I would have depended on both the clinical director of paediatrics and/or anaesthetics and Dr Murnaghan raising those levels(?) on my desk at an early stage.

THE CHAIRMAN: Okay. We'll break for ten minutes. Thank you.

(11.58 am)

(A short break)

(12.18 pm)

MR STEWART: Dr Carson, I wonder could we now spend between now and lunchtime, hopefully, just going through some of the risk management mechanisms and controls available to the hospital in the mid-1990s, just to sketch out the framework within which risk management was potentially

operable.

We've touched upon the complaints procedure and when that came in, there was guidance given to the Trust by the HPSS and a number of seminars were arranged so that people in the hospital knew about it and understood about it; is that right?

A. That would be fair, yes.

Q. Did you find resistance to the complaints procedure at that time?

A. I don't think so. I think there was a growing awareness and a growing understanding that it was beneficial for all parties to try and resolve a complaint at as early a stage as possible. So the concept of local resolution was very much in the thinking of everybody in the hospital. And that included the clinicians -- doctors and nurses -- against whom the complaint might have been made.

So while there was a general acceptance of that and the director of nursing investigated complaints very thoroughly across the service, across the Trust, if the complaint was in relation to a doctor then Dr Murnaghan would have probably followed through in conjunction with the director of nursing the facts pertaining to that aspect of the complaint. And if it was an issue that emerged that there were serious issues, then he would

have informed me and brought that to my attention.

What I would say about the complaints process and the inquiry may be aware that the complaints procedures in the NHS in general and in the Health and Social Services system in Northern Ireland has undergone a series of various changes and iterations from what was introduced in the early 1990s to where it is today.

There was a concern, I think, amongst doctors in particular that the whole area of complaints just provided an opportunity for fishing for potential pursuance of a negligence claim. So some doctors were of that mind, were of that view -- not all by any means, but there were views expressed that they could see where this was all going to go to. So a complaint, particularly when it emerged from a family solicitor and was lodged in the Trust as a complaint -- but when it emerged from a family solicitor, I suspect many doctors just had a question mark as to what was this all about, where is it going to, was it genuinely a pursuit to seek resolution through a complaints process or was it just the envelope opening for a future negligence claim?

Q. Would you describe that as having been an ethos of defensiveness?

A. Possibly.

Q. Was that something --

A. But that doesn't mean that for the vast majority of complaints that were lodged by families or family members or by patients about their treatment -- the vast majority of those patients were grateful for an explanation and apology.

Q. Yes. I can understand that. If there was a defensiveness, an ethos of defensiveness at that time, that would have been something that would have been important to address, would it not?

A. Um ... I'm not ... Could you elaborate, please, for me? I'm not sure where you're leading me.

Q. I'm going to read to you -- I'm going to ask that document 126-021-001 be shown. This is a letter dating from February 1996 from Mr George Brangam, solicitor, to Pauline Webb, who was the complaints manager. They're discussing the introduction of the new complaints procedure. He writes:

"I refer to our recent discussion concerning the forthcoming awareness training for clinicians and clinical managers in the handling of complaints. I know that we are to meet with Dr Carson later on in the week, however in the interim, I felt that it would be helpful if I might sketch out in outline some of the points which have occurred in the past and which are capable of creating difficulties in the future. These I would list

as follows:

"1. The ethos of the trust in relation to the handling of complaints. Too often in the past clinicians seemed to entertain the notion that the complaints procedure of itself was threatening, potentially hostile, and one where possibly too much information was given to complainants. As I know, both your predecessor ..."

And it goes on. Therefore he's identified that at least in the past, pre-1996, that possibility it's capable of creating difficulties in the future, there was this difficulty, which of course is really antithetical to the running of complaints procedure or resolution of difficulties. Did you identify that as a potential problem?

A. First of all, I think some doctors found whenever a complaint was being lodged about a service that a patient had received, some doctors found it uncomfortable to be questioned by a nursing colleague around their practice. So in that sense, they may have found that uncomfortable. Now, I wouldn't have thought they would have found it as being threatening, but I think they were more concerned about the potential of a negligence claim being brought against either the doctor or the Trust.

Q. Was that something that went away?

A. As I said, I think the whole complaints process has evolved over the years. But I also think that clinicians, doctors, nurses and other healthcare professionals have seen benefits from particularly early resolution of complaints, but also where patterns or themes emerge through complaints, efforts have been made by not just clinicians but by Health Service managers to address those.

For example, a very topical one would be waiting times in A&E departments, for example. The unavailability of a hospital bed and lying on a trolley for 12 hours. Those were the sorts of things that generated complaints and I think which the service has used, if you like, lessons learned from that to try and improve things for patients. So I think there has been a growing awareness that the complaints process is a fair and appropriate process to have in place and doctors have learned to work with it.

Q. Yesterday, you described some of the sort of attitude and perhaps resistance to the introduction of clinical governance from your colleagues and so forth. Did you feel at the time that you were really trying to change a culture within the hospital?

A. I suppose I would preface my remarks by saying that

everything I've done since I've qualified as a doctor has been to try and make a change, try and influence change, to try and make things better. That was the whole ethos behind my practice as a consultant anaesthetist in the cardiac surgical unit. I was very proud of the changes and developments we brought in the unit. We had very good results on the unit and a lot of the innovations and developments that were brought about were because of that personal drive that I had to improve things.

I hinted yesterday that senior colleagues, a senior surgical colleague, who would have been a close friend, had this concern that had I made the right decision in terms of my own career moving from being a clinician, developing my career professionally, maybe even down the educational route, Royal College influence, et cetera, et cetera, and making a move into hospital management. Well, that was a calculated decision. I felt there was an opportunity here for doctors to influence the quality of care and the system of Health Service management.

I said before that that doctors felt very isolated from managers -- and certainly the Eastern Health Board and the department were very distant from them. And the only time they ever encountered them was whenever they were looking for an additional colleague or more junior

staff or more beds or more nurses. And they often felt that management was part of the -- local management was quite often part of the problem. And again, the drivers in the Griffiths reforms for Health Service management were to bring clinicians into this management arena. Now, that obviously created tensions for those clinicians because they were working closely with colleagues who felt they'd gone to the other side.

So this was about leadership, this was about trying to infuse a new culture in the Health Service and to try and bring about improvements, and that was what drove me and why I stayed as a trust medical director for -- well, I stayed in management for about 12 years, three years as a clinical director and nine years as a medical director. And then my move into the department was again driven by the same -- I was concerned that there were lots of policies, lots of circulars arriving in trusts on a day and daily basis that might have been involved maybe with less-than-appropriate clinical input to the development of those policies.

If you take, for example, the circular, which I know is on the record, around safety that came from the Health Estates department in relation to safety around medical devices, for example. Now, obviously -- and they've had this catch-all phrase put in for all

incidents. Now, there was nobody in Health Estates that could deal with medical or clinical incidents; they were only interested in, I suggest -- and even qualified to deal with -- issues in relation to medical devices. So my move to the department was to try and influence the shaping and the development of policy.

Policy in the Civil Service is quite often developed by career civil servants, the role of professionals within the Health Service has been traditionally advisory. The Chief Medical Officer -- and I'll talk specifically about -- I know this is an issue maybe for another day. The Chief Medical Officer's branch within the department, with the exception of policy in relation to public health, was advisory. Policy in relation -- I've said to you in relation to risk management came from the finance directorate.

All the policies in relation to acute hospital services to primary care services were managed by a policy director that had very little input from professional civil servants. And again, if you come full circle, as far as I'm personally concerned, the reason in retirement that I'm involved in relation to RQIA is to measure, to assess the benefit or the effectiveness of a policy that has been put in place or the policies that are currently being involved in the

department: are they effective and working, are trusts following them there, are trusts adhering to them? The driver for me has always been about improving services.

Q. You used a phrase a moment ago about when you chose to follow the management, administrative path, about "the other side". You said "going to the dark side"; is that what you meant? Would that indicate that there was a sort of an us and them -- a gulf between the clinicians and people who were further up the clinical management structure?

A. I think that was well-known, not just in the Royal Hospitals, but in the NHS as a whole, that there were tensions, and managers were always seen as men or women in grey suits and they were not particularly interested in benefiting patient care. One of the things that I have always felt very concerned -- the vast majority of managers in the Health Service are actually clinicians, they're doctors and nurses, they're managing. And whether they have actually got a specific management role, they're responsible for managing their ward, they're responsible for managing their team. And doctors and nurses work together in clinical so they all -- and the GMC ... It's interesting if you look at the guidance that the GMC issued -- Good Medical Practice came out in 1995, it was about 1999 before GMC actually

issued guidance for doctors who have a specific role in management. But the most recent iteration of the GMC is for all doctors involved in management. And that goes down to what I would suggest is the clinical team concept.

So yes, there were views and sometimes those views could be expressed acrimoniously. There was tension.

Q. [Inaudible: no microphone] a team. You're charged with leadership, medical leadership.

A. Yes.

Q. And the question is: if there was a gulf between the leadership and the clinicians, perhaps a gap in understanding, was anything done to try to address that?

A. Well, as I've said, I met on a regular basis with my clinical director colleagues. I was out and about, I was giving presentations to medical staff committees in the Children's Hospital, medical staff committees in the maternity hospital and also in the Royal Victoria Hospital. I went to medical staff meetings as the Trust medical director.

THE CHAIRMAN: On what sort of issues would you be giving presentations? Just by example.

A. The introduction -- whenever the Trust developed its procedures for handling underperformance, for example, on the back of the GMC's new guidance on performance,

that was something that I had to communicate very clearly to the whole hospital. In fact, the document "Medical Excellence", you will see within that, not only did it contain a communication to the chairs of medical staff, but every doctor received a copy of that and they were asked to acknowledge and sign that they had received it.

I mean, I could never have got away with issuing a policy document without following that up with a very personal presentation, appearing before medical colleagues, trying to explain to them what were maybe some quite complex and unnecessary procedures.

MR STEWART: That post-dates the events with which we are concerned, but here's an example from the hospital council meetings. 305-117-036. And beside it, the next page, 037.

This is 29 April 1996. Hospital council meeting, Mr McKee is chairing it. You are second in the list of those present. If we go to the bottom of the second page 037, under risk management, paragraph 8:

"Dr Carson briefed members on some progress which has been made on risk management issues. He drew attention to a workshop which has been scheduled for September on medical negligence issues, which would address matters such as communication of information to

patients and how to reduce the Trust's level of liability. It was noted that to date three seminars have been held on complaints handling, which will be rolled out throughout the site."

So you're engaged in proactive steps there to arrange seminars, give workshops and so forth. And that was in the time frame with which we're concerned. So in other words, you're trying to get across the complaints procedure and the message.

Also, at that time, back in the mid-1990s, there was a thing called the quality steering group; does that ring bells with you?

A. Vaguely.

Q. WS061/2, page 25. This is taken from the annual report for that year. We find it at page 52 of that document. This is Ms Duffin's, the nursing director, report, and under the "Quality" subsection there where she writes:

"Quality is top of the agenda within the Trust. And in this directorate, personnel played a major role. The multidisciplinary quality steering group produced a strategy document which provides guidance on standards and measurements and independently-commissioned research has highlighted areas for action."

She goes on under "Focus groups" to describe patient satisfaction surveys.

What part did the quality steering group play in risk management issues?

A. I honestly can't remember. I know that Ms Duffin's title was director of nursing and patient services, I think that was --

Q. Yes, that's right.

A. So she had had this responsibility for not only the professional nursing advice to the board, but she looked after the quality experience of individual patients in care, and hence that's how she took responsibility for managing the complaints process.

The question you asked me was what influence did -- sorry?

Q. I think I have forgotten myself.

THE CHAIRMAN: It's on the transcript:

"What part did the quality steering group play in risk management issues?"

A. 1993 was right at the beginning of the Trust. I honestly can't remember. But what I do know, if we refer back to the document that you were showing me around the risk management steering group, for example, the director of nursing was a member of that. So intelligence, views, professional advice coming from the director of nursing and patient experience would have helped to inform the thinking and the deliberations

of the risk management steering group. So in that sense, there was a connection. But I can't remember anything more than that.

MR STEWART: It's simply that one is drawn to the existence at that time of a strategy document providing guidance on standards --

A. I honestly can't remember that.

Q. -- because that might be relevant to the issues of risk management.

A. Possibly. I honestly can't remember.

Q. At that time, also, in the mid-1990s, Ms Duffin was charged with the responsibility by the chief, Mr McKee, of obtaining the King's Fund Organisational Audit accreditation for the hospital, and an application was made in 1995, and I think provisional accreditation was obtained in 1996/1997; do you remember anything about that?

A. I certainly remember the decision to embark on King's Fund Organisational Accreditation. I would suggest that the vast majority of trusts in Northern Ireland in the Health and Social Service system at that time were pursuing that. There were many initiatives, what I would call quality initiatives, indicators, if you like, of organisational quality, that organisations were pursuing: Investors in People, ISO accreditation, et

cetera, et cetera.

Many organisations were embarking on these initiatives. I think the King's Fund Organisational Audit was different from some of what I'll call the other management process quality indicators in that it was -- it did engage different clinical professions: medical, nursing, as well as managers. So it was, if you like, maybe a more informative accreditation process for a Trust to embark on, and certainly at the time we undertook that, I do know that one of the reasons we did it was not just to have a Kitemark of quality for the organisation, but we genuinely were wanting to try and improve systems and processes -- and that included risk management -- and there were comments in that audit initially that hinted that improvements could be made and improvements obviously were made if they were able to give us full accreditation later in 1997.

So I would say it was, again, an organisational development step that the Trust undertook. I have to say it didn't -- for many doctors, they didn't really identify all that much with these things. They found them laborious, time-consuming and maybe didn't do what they were seeking to achieve. Again, it was an illustration of maybe this, to a certain extent, disengagement of doctors in particular.

Q. One of the purposes of obtaining the King's Fund accreditation was in establishing and implementing quality standard protocols. I take that from the annual report of 1995/1996, WS061/2, page 121.

Here we have in the right-hand side, penultimate paragraph:

"The Royal Hospitals applied to the London-based influential King's Fund Organisation ... experts in the field ... initiated a lead in a period of several months of intensive work in establishing and implementing quality standards and protocols."

If doctors weren't interested in that --

THE CHAIRMAN: To be fair to Dr Carson, some doctors; not everyone dismissed it.

A. Doctors participated in this, and there were enthusiasts. Maybe I've overemphasised the reluctant laggards, but I have to be frank and say we also had enthusiasts. Clinicians, doctors and nurses, basically they are primarily interested in the quality of care they give to patients. They're less interested in organisations, systems and so on. But I think for those enthusiasts that I say that were there, they embraced these, they saw these as opportunities to improve not only their own service, but the service that the Trust provided in totality.

MR STEWART: I bring it to your attention because clearly it indicates the existence of quality standards protocols in the mid-1990s. And indeed, we have an example of what that meant because Mr Ramsden, in his report to the inquiry, set out in an annex to the report at 211-003-024 and subsequent pages, extracts from the manual or the book that the King's Fund had given the hospital, which was a September 1994 third edition of standards.

A. Sorry, I can't ...

Q. You wouldn't recognise this because he has extracted this from the standards manual. And he's giving us some examples of the sort of protocols and standards that would have been expected of the Royal Hospitals at that time and which may be relevant to this inquiry's work.

What the King's Fund did was to accord each of those various standards a letter -- A, B or C -- grading its importance: A is essential practice, good practice; B, desirable practice --

A. I understand.

Q. Therefore, we go over the page to 026. We've got there:

"Standardised incident reporting system. Untoward incidents are individually investigated."

A. Yes.

Q. A, A, A. Go back a page to 025. We've got at

paragraph 2.2 the Department of Health guidelines -- that's the London Department of Health guidelines -- "Welfare of children and young people in hospital (1991)", that they be used:

"... to inform the way in which care is organised."

And again it is accorded category A.

Would you have expected these standards to have been embraced within the Children's Hospital?

A. King's Fund Organisational Audit obviously emanates from the King's Fund in London, and the standards which they have drawn up, they're drawn very heavily on DH or DoH guidelines. I'm not saying it was presumptuous, but when they did accreditation visits in Northern Ireland, they would assume that English guidelines would have been automatically cascaded down into the Northern Ireland Health and Social Care System. So in a sense, that was a presumption.

While I recognise that this guidance -- I have to say I wasn't aware of this guidance at the time in 1991. It's very interesting when you read it --

Q. 1995, I'm sorry to interrupt.

A. No, I'm referring to the Department of Health guidelines on the welfare of children. It's very interesting when you read the foreword to that document, they make reference to the fact that this was bringing together

a very diverse range of guidelines that existed in relation to children's services. So I think by its very -- the necessity to develop this particular document in regard to children's services, it implies that prior to that, coming out, that guidelines were very diverse.

I don't know whether this document, "The welfare of children", I don't know whether it was adopted by the Department of Health in Northern Ireland. I just don't know, I don't recall.

Q. I can assist you on that.

A. Good. Thank you.

Q. At 314-012-003, this is a later Royal College of Nursing publication. This is a little later, it's a Royal College of Nursing sheet, "Day surgery information". You can see at the bottom right-hand corner it references this document, "Department of Health, 1991: Welfare of children and young people in hospital", and it advises in parentheses:

"Endorsed by the DHSS Northern Ireland."

A. I accept that. I'm not quite sure what "endorsed" means. Does it mean that there was a letter of instruction that came from the managing executive, as it would then, to the Health Service? The other important thing in relation to that particular document, "The

welfare of children", it was developed by the Department of Health in London to cover a number of specific reasons. One of them being that with the development of the internal market -- and we touched on this very much earlier on, about standards for commissioners and purchasers of services. That was one of the principal objectives of that document being compiled because, again, in the foreword to the document it refers to the Department of Health's awareness of the development of district authorities and local health authorities in England and Regional Health Authorities.

So they were very keen, the Department of Health in England, to ensure that these standards in relation to the care of children entered into this dialogue between the purchaser and the provider. They also, I agree, said that these were standards that providers should seek to have in place in their organisation.

When it's endorsed by the DHSS, I'm not quite sure what that means. Did they put a circular out to the Health Service in 1991/1992/1993 to say that this is guidance that we want to see implemented in Northern Ireland? Did they send it to the Eastern Health & Social Care Board, who would have been our practical commissioner of services, to say these are the standards against which we want you to purchase from

provider units, paediatric and children's services?

So while I recognise that that was there, first of all I don't know precisely, and I can't recall anything more about the document itself than that. The other thing I was going to say -- it's left me. Sorry, I would have assumed that there would have been paediatricians and paediatric nurses working in the Children's Hospital who would have been familiar with this.

Q. It seems that's quite right. It seems likely, almost certain, that the paediatric nephrologists or Professor Savage would have been aware of this because the British Association for Paediatric Nephrology paid a visit to Belfast in 1994/1995 and produced a working party report, which is at 306-065-001.

This is a report which in part deals with the services available in Belfast at the time. And at page 015, it sets out requirements of service. At the top:

"Children with renal disease are first and foremost children. The BAPN [that's the British Association of Paediatric Nephrologists] would expect that any renal unit caring for children or young people with renal diseases should fully implement the Department of Health's guidelines 'Welfare of children and young

people in hospital'."

And so forth. So it looks as though it's coming to the hospital from this working party's report, from the King's Fund, and may even have been coming from the DHSS here if it was endorsed by them. So given that trail of clues, it seems likely that this English guidance would have been in place here, wouldn't it?

A. That is possible. Again, I don't know what instruction was given from the department to the service.

THE CHAIRMAN: Sorry, is there not a point that if you're seeking King's Fund Organisation accreditation, which requires you to comply with their standards and protocols in order to get the accreditation, and then presumably to maintain compliance in order to retain accreditation, then if they've built the 1991 guidelines or elements of them into their protocols, don't you in effect bring them in by that side route?

A. I think there would certainly be -- if you're seeking to satisfy the King's Fund that you are obtaining the standards that they set for organisational audit, that those are the standards you would work to. Whether there was a discussion that took place between ... What I vaguely recall in the feedback sessions from the team, the King's Fund team, is that there was always the opportunity to challenge their findings and maybe to

give explanation as to why certain standards were either not being achieved or were unachievable, whether it was due to staffing levels, whether it was due to other factors.

So I don't know how, in the context of that review that the King's Fund took place in 1995 or 1997, how that particular guidance was handled.

THE CHAIRMAN: Okay.

MR STEWART: We find in the health and safety report of 1995/1996 some reference to this at 305-007-196:

"King's Fund Organisational Audit: outcomes for health and safety."

And this -- this is the 1995 audit:

"... included criticisms of aspects of health and safety management. The criticism is reflected in the King's Fund criteria, which further action is required in order that we may obtain full accreditation."

And:

"The summary of essential A criteria and the surveyors' comments and recommendations are contained in appendix 2."

And the acknowledgment of the recommendations received:

"The medical director [yourself] is leading a review of risk management arrangements within the Trust. This

includes current arrangements for health and safety and the Trust had already recognised a need to 'close the loop' in risk management, ensuring that policies and procedures for health and safety are effectively implemented at directorate and departmental level. This requires mechanisms for communication, audit and monitoring and a commitment to training."

Did you close the loop?

A. I think there was a very determined effort to try and achieve that, and I think the progress that the Trust made in subsequent years -- obviously we satisfied them in 1997 when they gave accreditation. The effort -- and we've discussed this at length before the interval -- yes, we pursued that, we did.

Q. Why did the Trust choose to resign or leave the King's Fund Accreditation scheme in 1998?

A. I honestly can't answer that. I just don't know. I think there were a lot ... Um ... There was huge ... It's very difficult to explain why people are very busy or what other things needed to -- were consuming the energies and the activities of directors within the organisation. I just can't comment on that, I honestly don't know. I don't recall the background to that. I think there were other competing quality drivers around at that time as well. Further to that,

I can't --

Q. Such as?

A. Well, we had Charter Marks, we had Investors in People. All of these things were all taking place and they were consuming management time. Maybe the Trust felt that management time needed to be focused and concentrated on delivering services.

THE CHAIRMAN: Is there a point at which this becomes unfulfilling to maintain? In other words, let's --

A. I don't think any organisation, Mr Chairman, would say that they were unfulfilling. I think you would always aspire to make progress and to develop and improve. But to keep redoing something -- I think accreditation ... As I said, the whole approach to accreditation has not been an approach that has been endorsed in the NHS in the broad sense, whereas it is in the Republic of Ireland and it is elsewhere in Europe. And this is largely because of the drivers quite often by private insurance -- I mean, this is commonplace in North America, accreditation. If you're not accredited, you won't get cover from your insurers. So the whole basis of healthcare provision and cover for patients where it is based on an insurance-backed healthcare system depended on things like accreditation being in place.

MR STEWART: So in a sense, quality standards were driven up

and maintained by the whole culture of medical negligence cases in an sense, a roundabout sense?
A. I'm not sure that medical negligence was the sole driver for improving quality.
Q. Were all these other accreditation schemes also providing documents setting out standards, protocols?
A. I'm not -- this is not an area of expertise that I'm very familiar with and it certainly wouldn't fall within my area of responsibility. The answer to your question is: I would expect that they would be, yes.
Q. Because in the mid-1990s, not only were the Royal Hospitals undergoing the King's Fund accreditation, there was also something called the CHKS assessment.
A. Yes.
Q. What was that about?
A. CHKS were an organisation that worked with trusts to try and improve their information systems. Principally around the area of coding, improving the depth of coding, improving the quality and training of coding clerks working in the organisation. And I worked very closely with them because in fact the work that we were doing with them was -- doctors were very critical of the benefits for them individually of the Patient Administration System. There were very few indicators of any of quality within the generic Patient

Administration System that they could use for things such as clinical audit. But when CHKS became involved in the Trust, I think a large number of doctors were enthused and taken by the information that they could distill from the information system in the Trust, particularly whenever increased depth of coding became available. Because then information could be attributable to individual clinicians. In particular, surgeons were very interested in this because there were drivers within medical Royal Colleges -- and the surgical colleges in particular -- that were moving in the direction of being able to demonstrate outcomes for individual surgeons.

So CHKS was actually a very positive initiative and experience in the Trust, and I do know that the Trust was recognised by CHKS as being within what they call their top 40 hospitals, and that's across the whole of the United Kingdom.

THE CHAIRMAN: Is the value of coding, doctor, that it helps to establish patterns and causes, or is there more to it than that?
A. It can do that, chairman. I hinted earlier that maybe the initial enthusiasm and emphasis for increasing the depth of coding was to try and demonstrate that the Royal Hospital was treating more difficult, more complex

patients than anywhere else, and therefore we deserved, we warranted the increased resources that we kept asking purchasers for. That might well have been the initial driver. But it was apparent then that there was clinical information there that would be benefit -- particularly in the context of audit.
MR STEWART: A useful tool for analysis --
A. Yes.
Q. -- in the to identification of lessons --
A. Yes.
Q. -- patterns, education --
A. Yes.
Q. -- and, ultimately, the reduction of patient risk?
A. Correct.
Q. And would the engagement with CHKS have in fact been the driver for including quality assurance as a term of Mr McWilliams', the clinical coding manager's, contract of employment?
A. Sorry, could you repeat that?
Q. Mr McWilliams was appointed in 1996 as the clinical coding manager.
A. Yes.
Q. And in his job description, in his contract, was a term rendering him responsible for quality assurance. Would that have come from the engagement with CHKS?

A. I suspect it went wider than CHKS because obviously information from the Trust went elsewhere. I think there was a sharing of information, particularly around activity with the Health and Social Service Boards and also possibly in the department as well. I would not have been responsible for drawing up the contract or the job description for Mr McWilliams, so I can't comment specifically on why that clause was included in his contract. But I think the Trust recognised that we wanted to have better information, and that was why we were trying to improve quality of coding.
Q. Thank you. Another accreditation programme undertaken in the mid-1990s was with something called Junior Monitor; do you remember that one?
A. I've never heard of it.
Q. Mr Bates has informed the inquiry that in fact it was to do with the assessment of quality of care. No?
A. It doesn't ring any bells with me. Mr Bates was the director responsible for the information systems in their totality across the service, across the Trust.
Q. I'm just trying to gather up the various systems in place at the time for quality assurance and monitoring.
A. Sure.
Q. In terms of other drivers to better practice, the HPSS were issuing management plans with expectations at that

time; isn't that so?
A. Yes.
Q. I've got the management plan for 1995/96 through to 1997/98 here at 306-083-001. If we go on to page 017, this is what the HPSS thought ought to be attempted by the trusts. "Better practice" at 4.4.11:
"Providers need to continue to focus on improvement in standards of practice. The service they provide should also continue to achieve the best possible outcomes for patients and clients within the available resources, which necessitates a strategy aimed at sustaining a process of continuing quality improvement."
In other words, clinical governance by another name:
"Specifically, units should ensure that there is a clear policy on: clinical audit as part of a programme to improve all aspects of service quality, not just clinical outcomes; support and evaluation of quality improvement programmes; and multidisciplinary approaches to the development of best practice in service delivery."
A. Yes.
Q. So presumably this must have set in train a number of particular programmes to ensure that this was complied with.
A. Yes, and all of those activities were being undertaken

within the Trust, and the Trust was able to demonstrate that those activities were taking place, and every directorate would have had initiatives within it in terms of service development and service improvement. There has been reference already, in the context of the inquiry, to the children's strategy document, which I've now forgotten the title of, but I know that reference has been made to it before Christmas in the transcripts.
So the Children's Hospital, the paediatric directorate, were very keen to develop and improve services within that, and I put that, again, in the context of the perception that the budget that was being devolved or allocated to the Children's Hospital was insufficient to meet the initiatives that they wanted to address. This was then entered into the contract negotiations between purchasers and providers, whether they were the local health board or the regional consortium for regional specialties. So these initiatives were in place.
Q. Adverse incidents. There was guidance from a document called PEL(93)36. This is 210-003-1132. This dates from 1994 and is in relation to incidents principally involving equipment, medicinal products, drugs and so forth:
"Reporting of adverse incidents and reactions,

defective products relating to medical and non-medical equipment, supplies, buildings."
Clearly, in relation to these particular types of incidents, reporting procedures and investigating procedures would have been in place?
A. Yes. And I have to say that at that time there would have been what I would call a high level of compliance with reporting adverse incidents associated with devices, medical devices.
Q. Yes.
A. This is one area where doctors were quite good. The other area where doctors were quite good at reporting was the so-called yellow card scheme, whereby if there was an adverse reaction to a drug, that would be reported. There was a high level of compliance with that.
Q. In the case of Adam Strain, there was an attempt made to pursue an independent inspection of medical equipment, which directed two gentlemen in the employ of the trust to examine a Siemens monitor, which wasn't present, and allowed them to present a report, which referred to protocols which didn't exist. Is that something that would be familiar to you?
A. I am aware that the coroner wrote to Dr Murnaghan -- I think I'm correct in saying that -- asking him to

carry out an investigation in relation to the equipment. I think he was concerned that a hypoxic episode or something in relation to the anaesthetic equipment might have contributed to Adam, so he sought that and asked Dr Murnaghan to undertake that, and that was done, to the best of my knowledge.
Q. In the manner, I think, as I've just described to you. And there would also, you say, have been --
THE CHAIRMAN: Sorry, just for clarification, what that means is what was reported was -- the report was prepared on the wrong monitor.
A. The report was?
THE CHAIRMAN: Prepared on the wrong monitor.
A. I understand that was what happened, yes.
THE CHAIRMAN: But the general point that you made a few moments ago is that doctors are good at reporting adverse incidents involving devices or defective devices and they're good at reporting adverse incidents or drug reactions. But it just begs the question, doesn't it, that they're not necessarily terribly good at reporting themselves or each other?
A. I think that would be -- I accept that.
THE CHAIRMAN: Partly -- that's maybe a bit closer to the bone to do that, but --
A. And I think it was the culture of the time, Mr Chairman.

I think if you look at the various iterations of Good Medical Practice that have come down from the General Medical Council from 1995 onwards, the responsibilities are now very explicit about what is expected of any doctor who's on the register in relation to reporting concerns.

THE CHAIRMAN: I think what was suggested to us -- we had this debate quite intensively particularly during the evidence about Adam -- was that the GMC requirement hasn't changed, but what has changed is the way in which it is met by doctors. In essence, what I was told from the floor, I think by Mr Fortune, is there simply wasn't a culture in the mid-1990s of doctors reporting each other to the GMC, despite the fact that the provision for that to be done was there in the mid-1990s as it is now.

A. Yes.

THE CHAIRMAN: What he suggested -- and what seemed to be accepted generally from the various representatives of doctors and the Trust was that the culture has changed so that there is now a greater likelihood of a doctor reporting another doctor to the GMC; is that what you mean by the change in culture?

A. Yes, I would concur with that. I would recognise that doctors were not good and were very reluctant, dare

I say it, to even report a colleague directly to the GMC. I suspect that happened very, very, very seldom. But I have to say that in the mid-1990s, doctors came to me expressing concern about other doctors. They were by and large always -- not always, but virtually always -- in relation to doctors in training.

The areas of risk for an organisation in relation to medical practice: junior medical staff, locum doctors. Those were the two areas in terms of clinical practice where an element of risk -- and there's a greater level of risk. And certainly, I had senior doctors in the organisation come to me about a concern, expressing concern about the clinical practice of doctors in training and/or locum doctors, and I took the appropriate action in each case.

MR STEWART: Did you ever have junior doctors coming to you complaining about the actions of senior doctors?

A. Interestingly enough, a situation I do recall where a junior doctor felt he was being bullied or harassed by a senior consultant and I had to deal with that. Those issues relate to personal conduct.

Q. It's really performance and competence issues I was thinking of.

A. Well, the concerns that were expressed to me in relation to -- and I can think of a number -- two or three

situations in particular -- were about capability, competence issues of junior doctors.

THE CHAIRMAN: This is junior doctors and locums?

A. Yes. And this has a big bearing on out-of-hours cover, the risks associated ...

THE CHAIRMAN: I think we're going to touch on cover later on this afternoon.

MR STEWART: Can I, if we go to page 1137, just simply ask a question to assist us in understanding this document? At the top it says:

"Other actions/responsibilities. This reporting system does not affect the duty of staff locally to take other actions as required legally and/or by line management as a result of an adverse incident."

Paragraph E:

"Refer to the coroner in the case of unexpected death. See paragraph 3 below."

Paragraph 3:

"If a patient dies unexpectedly, the clinician in charge of the case must report the death immediately to the coroner."

And then it goes to describe what must be done in addition if the death is thought to be due to a defective product. How do you read that? Is that limited solely to deaths involving medicinal and

non-medicinal medical equipment, or does that relate to death?

A. I suspect this circular was written -- I mean, I know the circular was written in the Health Estates department. It was primarily targeting issues relating to medical devices. There are one or two catch-all clauses that have been incorporated in there. It's interesting: that particular directorate and department would have been in no position to deal with non-device related incidents.

Q. Yes.

THE CHAIRMAN: But they're not far wrong when they refer to an obligation to refer an unexpected death to the coroner.

A. I mean, I think, for example, when Mr Leckey wrote to Dr Murnaghan, it was that sort of -- was there an association between medical equipment or devices that contributed to Adam's death? So I think that was the context for that circular.

MR STEWART: Yes. Other circulars and guidelines, some came from directly from the DHSS. There was a DHSS guidelines on drugs administration. And the necessity to comply with this is in fact contained as a term in Sister Angela Pollock's job description. So that's another piece of guidance that would have been directed

at quality assurance at that time.
A. Yes, I would have to say yes to that.
Q. We're just having a run-through them all.
A. There were many, many circulars, guidance notes. I mean, I suspect the chief executive's office -- those landed on his or his PA's desk on a day and daily basis. They were disseminated down to the clinical director, I know efficiently, and I know there were times an element of exhaustion -- yet another circular coming through that needed a hard-pressed clinical director and his management team to make sure they were in place.
Q. All these protocols are telling people what to do, all these protocols require implementation and monitoring, and that's the system.
A. Okay. Right.
Q. In relation to the effective implementation of these things, they were received in the chief executive's office and the idea was that they should then come to you and go to the various directorates.
A. The chief executive's office circulated directly to the clinical directors any circular that was felt relevant to that directorate. Children's services would have gone to the paediatric directorate. If it was of a broader nature, if it was in relation to the patient records, it would have gone to every clinical director,

for example.
Q. We've heard evidence from Ms Duffin about a system she had in place whereby her nurse managers would take the guidance, take it to the coalface, as it were, and then report back through meetings with Ms Duffin that the guidance was in place.
A. Mm.
Q. We've had cause to look at a particular item of guidance. It's what was known as HSS(GHS)2 of 1995. It's at 306-058-002. This is the covering letter. It's 6 October 1995. It's just before Adam Strain was admitted. It brings to the attention of the chief executive the new guidance on patient consent and consent to treatment. The evidence has been that the requirement -- I think on the next page, 003 -- from the chief executive of the HPSS asks the chief executive of the boards to confirm by 31 December 1995 that this has been done, that the policy's been put in place. Can we go back a page to 002?
THE CHAIRMAN: Do you want the two pages up together?
MR STEWART: If we could, just so we can see exactly what confirmation was required:
"The trusts are asked to ensure that procedures are put in place to ensure that consent is obtained along the lines set out in the handbook and to introduce

revised documentation, preferably based on the new model consent forms, with adequate monitoring arrangements and asked to confirm by 31 December that this has been done."
Evidence has been received that that wasn't done, and that furthermore, the new model consent forms were not actually used until the year 2000. I wanted to ask you about the system that permitted that to happen.
THE CHAIRMAN: Can I say, doctor, just as a preliminary, this is something I'm particularly interested in and it's specifically why we're looking at, in a limited way, at Conor Mitchell's death in Craigavon Area Hospital after the hyponatraemia guidelines came out. Because I'm conscious of the fact that, as you mentioned a few moments ago, there can be an exhaustion with endless circulars and guidelines and protocols coming out from the department. And it has seemed to me that one of the risks is that if endless documents are issued, the prospects of them being followed diminish with the increasing volume.
A. Yes.
THE CHAIRMAN: But there are some which are clearly particularly important. For instance, if there's a more detailed consent procedure, that's significant. If there are hyponatraemia guidelines, that's significant

against our local context of hyponatraemia, and I'm sure you can think of a number of others which might have greater significance than others. So the point here isn't that this circular was not implemented at the time that Adam was treated and died because that is not the timescale for that circular. But this is a general governance issue about when circulars or guidelines are issued, what was done then and what is done now to make sure that they are implemented. I think Mr Stewart's question was -- we'll focus on what the system was in 1995 for that to be done and then we'll break for lunch and we'll come back, and if you can lead me on about how things might have improved or changed since then.
A. Well, I think this is an important circular to come from the management executive. There might have been others that doctors might have considered to be less important. This is an extremely important one because the principles that underpin it are extremely important. They're principles that were embraced very clearly and very strongly by the General Medical Council.
One other comment I will make in relation to the circular: for anybody in the management executive to expect or anticipate that an organisation as complex as the Royal or even some of the smaller organisations, dare I say it, to have implemented the circular in the

way that they have -- between 6 October and 31 December, was living in cloud cuckoo land. This was quite complex, and I think, Mr Chairman, you'll recall from your work with the human organ inquiry, that similar concerns related to the consent form for post-mortem.

And also, it was apparent whenever I was responsible for implementing the recommendations of the human organ inquiry that not only were there differences between organisations across the system in Northern Ireland, there were even differences in the documentation that was being used within hospitals. And certainly with regard to the human organs, we created a suite of new consent forms specifically for Northern Ireland that were to be used region-wide.

One of the real problems -- and I've hinted that locum doctors and junior doctors were a greater risk area than maybe more experienced doctors. Doctors move between hospitals on a maybe -- on a three-monthly rotation or an annual rotation. They had to work with different systems within different institutions. One of the things that we were very keen, when it came to the post-mortem consent forms, was to get standardisation that could be consistently applied across Northern Ireland.

Even at that time, I think around 2002, we were

conscious that despite this guidance that had been issued by the management executive and the requirement to have it in place by December, there were still concerns around the issues for consent to treatment, and shortly after, we issued guidance and new consent forms for the region in relation to human organs or to post-mortems. We also issued new guidance in relation to consent for treatment and examination.

So why did it take so long for the Royal to have a consistent compliance, if you like, with this circular in relation -- I can't answer that, I don't know. What I do know was -- and this would have been discussed by clinical directors at hospital council or with myself as medical director trying to encourage and implement this guidance. It was apparent that there were views that the situation in the Children's Hospital might have been different from elsewhere, the situation in the maternity hospital, there might be different aspects of consent that were necessary there. In the care of the elderly unit or whatever, there might be particular issues in relation to competence in terms of consent.

So there was a lot of discussion, I know, around trying to get consent forms that complied with the principles of consent that were developing quite significantly at that time and to try and get

consistency across the organisation.

THE CHAIRMAN: Sorry, doctor, would that not have been done by the group which brought out this new form? I can understand the issues that you're talking about, particularly in the Children's Hospital there's an issue about the competence of a child and what age the child is. Would the issues that you've just discussed not have been part of the consideration of whatever working group or party drew up the new consent form?

A. One would have hoped so, Mr Chairman, but I actually -- I can't remember, I mean, I would be much more familiar with the development of any arrangements for consent for post-mortem and the guidance that we issued to the service. The department at that time -- certainly during my time there, there was extensive consultation with clinicians in trusts and a working group, a reference group, and we would have shared draft documentation with reference groups in trusts. Maybe that happened more effectively around 2000 than it did in the mid-1990s, I just don't ... I honestly don't know. Certainly as Trust medical director I was not involved or asked to be involved in the development of this guidance in relation to consent. We might have thought that would have been useful for the department.

MR STEWART: There are a range of points that arise from

that. Perhaps, Mr Chairman, you would like to address those after lunch.

THE CHAIRMAN: Mr Fortune?

MR FORTUNE: Sir, before you rise, you mentioned a referral to the General Medical Council originating on the floor. You'll recall that Mr Koffman was asked to deal with this matter back on 16 May. Would you consider inviting Dr Carson to read, and if necessary I will provide my copy, of the transcript, albeit slightly highlighted? But it's at page 150, it starts with your question at line 23. Effectively, it's four pages down to the bottom of 154. What Mr Koffman was being asked was:

"If you were told what had happened on that day, in other words how Dr Taylor had performed, the inquest had been held, the verdict had been returned, what would you do?"

Then you might consider inviting Mr Stewart or indeed asking Dr Carson yourself for his comments because that part of Mr Koffman's evidence is certainly pertinent to the responsibilities of a medical director.

THE CHAIRMAN: Okay. What we'll do is we'll arrange -- if you'd be kind enough to give Dr Carson a copy or we will photocopy your copy just for speed, and we'll resume at about 2.15.

(1.30 pm)

(The Short Adjournment)

(2.15 pm)

(Delay in proceedings)

(2.20 pm)

THE CHAIRMAN: Just before you resume, Mr Stewart, we've looked at the timetable over lunch. It's 2.20. I think Dr Carson, I should say to you that you're probably going to be the rest of the day's hearing, but we will finish you today. Okay?

I think, Mr Simpson, Mr Stewart has spoken to you and we won't start Mr McKee this afternoon. What I would like the parties then to consider is we'll have Mr McKee tomorrow morning. As this has developed, a lot of the same questions could be asked either to Mr McKee or Dr Carson, and we think there's probably limited value in asking the same questions again to Mr McKee. He's the chief executive, but we've got the medical director who's the deputy chief executive, and I don't think there's much value in going over all the same issues, but Mr McKee will have to give evidence tomorrow.

What I would then like you to consider, perhaps overnight, is that we have Professor Mullan coming to give evidence after Mr McKee and I'd like the parties overnight to focus on what areas of questioning need to

be developed with Professor Mullan from his report, if any, subject to the point which DLS have made to us in submission that you're anxious to reinforce to me that I consider by the standards of 1995/1996 and not later standards.

MR SIMPSON: Yes [inaudible: no microphone] range of topics that Mr McKee would like to have the opportunity to deal with. We, for our part, wouldn't require the attendance of Professor Mullan as long as the Trust's position is put to Mr McKee.

THE CHAIRMAN: Okay. Right. I would like all of the parties to think about that later on. Okay?

Just one second, Dr Carson.

Mr Fortune, the point that you raised about the transcript and Mr Koffman, that's going to be -- we're going to come to that later this afternoon.

MR FORTUNE: Thank you, sir.

THE CHAIRMAN: Dr Carson, you wanted to say something?

A. Yes. I just wanted to make a comment in reference to your comments vis-a-vis Mr McKee and myself: you're quite correct, I was the deputy chief medical officer, but I was not the accountable officer for the Trust so far as the department was concerned.

THE CHAIRMAN: Thank you.

A. That's actually an important distinction in terms of

governance for the organisation.

MR STEWART: Thank you. That was accountable officer for finances in the mid-1990s --

A. He is accountable for everything to the department.

Q. I see. Thank you for that.

THE CHAIRMAN: Mr McKee was?

A. Yes.

MR STEWART: We were looking at the complaints procedure. You made the point that in fact it would have been wholly unrealistic to expect this to be implemented by the time Adam Strain was admitted to the hospital. But in terms of --

THE CHAIRMAN: Or even by the end of December, I think.

A. Yes. Consent -- you meant ...

MR STEWART: Yes. What about the general proposition that it would have been quite straightforward and quick to photocopy a whole pile of consent forms and go out around the wards taking out the old ones and putting the new ones in place?

A. Yes, a good idea, but you need to get doctors to comply with that and to use them, and to use them appropriately. What I was suggesting that there were particular issues that doctors felt that needed to be addressed that were -- to make the consent form relevant to their work to their department.

Q. I am assuming that at the time Adam was admitted to hospital there were no policies within the Royal group for the taking of consent; is that correct?

A. I think that's probably incorrect. I can't stand over here now, but I know that from certainly when I was practising as an anaesthetist in the cardiac surgical unit, there were appropriate consent forms in place for work. The guidance and the supporting documentation that would illustrate how they should be used and how extensively a doctor should share issues that relate to consent, probably less so. But I'm quite convinced that there were appropriate consent procedures in place. Now, did they comply with everything that was there in the guidance? Probably not.

Q. Okay. Just one final point on this, and it comes back to our earlier discussion of the applicability of the "Welfare of children and young people in hospital" guidance. That is that that guidance, which was endorsed by the DHSS here, whatever that means, was highly commended by both the King's Fund and the British Association of Paediatric Nephrologists. It in fact sets out, at page 314-004-012 at paragraph 3.3, consent to treatment. It sets out its expectation that:

"Districts and provider hospitals should ensure that good practices are followed on seeking consent for the

treatment of children. A guide to consent for examination and treatment published by the NHS management executive in August 1990 will be of assistance here."

And the question really is to what extent hospitals should have been guided by something like that. Because what we know is that the 1995 consent guidance that came to the chief executive on 6 October 1995 was in fact based, via a 1992 amendment, on the 1990 regulations. Having this advice from the "Welfare of children and young people in hospital" booklet, to what extent would it be feasible for this them to say, "Let's get a copy of the English consent guidelines"?

A. I can't say that that did not happen. I would actually go as far to say that the guidance contained in the English document was familiar to -- disseminated across the Trust. What was not in place were the model consent forms.

Q. I see.

A. I think there was in place procedures to obtain informed consent from patients and, in the case of children, parents or guardians. The extent and the depth to which the discussion that took place with the patient -- it is well-known that at that time -- not only locally here in Northern Ireland, but across the UK -- that was not as

good as it could have been. And a huge section of cases that came eventually to litigation hung on whether or not consent was obtained or not obtained.

Q. It's a legal issue in many senses, and the law presumably also provided guidance to those charged with policy making. Many of these questions are asked because the inquiry has not seen a copy of the Royal Group of Hospitals' consent guidelines applicable at the time. And if there is such a copy, doubtless it can be supplied.

Other standards and guidelines from England were adopted straightforwardly. The UKCC, the nurses and the midwives, produced a series of standards in the mid-1990s, and their standards for records and record-keeping produced in 1993 that were seemingly adopted in toto by the hospital at the time, according to Ms Duffin; do you remember that?

A. If she said that, I would have to go with that. I cannot recall. I'm not familiar with that.

Q. Can you think of other examples where guidelines were simply adopted wholescale?

A. I'm sure there were other examples, but I can't vividly recall. Let me put it this way: many organisations, professional bodies, the BMA likewise, would have adopted and disseminated to their members standards and

guidelines on issues such as consent and record keeping. Every Royal College worth its salt would have had a statement, which encapsulated, if you like, their scholastic thinking on these areas. So there was no shortage of guidance around.

THE CHAIRMAN: I think, to be fair, there's a difference between a UKCC guideline, which applies to nurses, because it effectively more or less binds them, doesn't it? Sorry, let me ask it differently. Is there a difference between a UKCC guidance on the one hand and an English Department of Health policy document on the other?

A. Well, I think the significance of the UKCC issue would be that if nurse was found to be underperforming and was referred to the professor regulatory body, the adjudication on her performance would have been against the standards that the profession have endorsed, it'd be the same for doctors if it was an issue in relation -- and the GMC were handling it.

THE CHAIRMAN: Right. So there's some distinction between UKCC and GMC on the one hand and --

A. A departmental ... Yes, I think so. And I think one of the things that myself and others have been at pains to try and stress is that in the early 1990s, in particular, it was extremely difficult to assume that

circulars that were issued in guidance were actually not just endorsed, but were adopted and implemented by the management executive in Northern Ireland.

THE CHAIRMAN: What does endorsed mean?

A. I think it says, "Yes, I think those are good standards", "Good idea, excellent standards". But it doesn't go as far as saying: these are what we expect an organisation to put in place. As far as I'm concerned, these standards are adopted and they need to be implemented and they need to be implemented by such-and-such a date. You have illustrated very clearly in relation to consent that: here is a set of guidance in relation to consent, we want this to be put in place and to inform the department that it is in place by December 1995.

MR STEWART: If you had received a set of guidelines which set out best practice, which had come from England, and you looked at them and thought, "Yes, that does look like good advice, sound advice, best practice", what would stop you implementing them?

A. Nothing would stop you, and I think I indicated yesterday that in fact in many areas of clinical governance, the Trust did adopt and adapt English guidance and put it in place in Trust policies without it actually formally being adopted by DHSS.

Q. So did you have criteria therefore for the ones you would ignore?
A. No, I don't.
Q. So you could, for example, have best practice guidance coming to you, which you wouldn't adopt?
A. That you'd ignore, no, I wouldn't have thought it would be as cold-blooded as that.
Q. It could happen?
A. A lot depends on the capacity and the capability of the organisation to handle issues like that and maybe even the capacity of my office to handle it.
THE CHAIRMAN: Mr Fortune?
MR FORTUNE: Could we come back to this topic of guidance and protocols? Perhaps a suitable alternative phrasing might be considered. Was the guidance or were the protocols directory only or mandatory in terms of implementation? Because if it was directory only, it would be up to the individual trust to decide whether or not to adopt them. If it was mandatory, coming from the department, albeit originally from England, then there would be no alternative but to adopt them or, to use Dr Carson's verb, endorse them.
MR STEWART: And further categories, whether it's wise to embrace it or unwise to ignore it.
THE CHAIRMAN: The consent guidelines, in effect, were

mandatory in the sense that the department said: implement them by 31 December. We know that didn't happen. You say the starting point is it's entirely unrealistic for the department to have put that time frame on them. But is your issue there with the time frame that the department put on it, rather than with the fact that this new consent form was mandatory?
A. No, I think that circular from the management executive is quite clear. There's an expectation that what they're issuing by way of guidance has to be put in place.
THE CHAIRMAN: When you said they were living in cloud cuckoo land, I understood that you meant that by reference only to the timescale within which they wanted it to be done --
A. Yes.
THE CHAIRMAN: -- not with the substance of what was to be done.
A. Absolutely not. The substance should be adhered to.
THE CHAIRMAN: This question might be too sweeping, but was that typical of some document issued by the department, that it was mandatory and that there was a compliance date? I'm thinking of the other category that Mr Fortune and Mr Stewart are referring to, which is advice and guidance rather than something which is

directory.
A. There was an awful lot of advice and guidance came down, and it was quite difficult for the Trust to know precisely what to do with that, whether it should be -- whether it was wise to put this in place or unwise to ignore it. I would have liked to have seen much more instruction from the management executive in 1995 along the lines of what they've issued in relation to consent. I think, also -- and I stand to be corrected here, we need to determine elsewhere -- for a circular to be issued in October requiring it to be in place by December, who followed up on that from the department? Was there compliance within the trusts? Trusts plural. If there was not compliance across the service was there a follow-up guidance to say: we recognise there's been difficulty in implementing this for X, Y, Z reasons? Here is further advice or guidance and we would like that to be done by December 1996.
So there was a lot of guidance came down without this mandate to have it implemented, and also I think there was guidance that came down that was never followed through in the way that it should have been followed through.
MR STEWART: Nobody in the Trust was writing back to Mr Lunn to confirm that this had been put in place. There was

nobody in the Trust making sure that this was implemented. Not in 1995 or 1996 or 1997 or 1998 or 1999 and not until 2000. That's the point. Not whether the department had somebody monitoring, but whether there was somebody in the Trust doing it and monitoring it.
A. Well, the circular was -- could you go back to the first page?
Q. 306-058-002 and 003.
A. "To the general manager, chief executive."
Q. "Chief executives of HSS trusts."
A. Yes.
THE CHAIRMAN: Sorry, it also goes to the chief nursing officer of each trust, chief executive, and then there's a cc on the second page to everybody. A unit general manager: would the paediatric director, anaesthetic director and so on, would they be unit general managers?
A. No, no. You see, even the language of this is inappropriate for -- sorry, correction, sorry. In 1995, not every hospital had embarked on self-governing trust status. So there might well have been some hospitals in the province that were under what I'd call direct management from the relevant health board. The Royal, the City, the Ulster, certainly the larger hospitals had all become trusts. So that letter would have been

circulated to the chief executive of the trust. You'll notice that the -- and a general manager would have been those in administrative charge of hospitals that had not become trusts.

THE CHAIRMAN: Right.

A. I would have assumed that the responsible person here would have been the chief executive to respond to that by some mechanism or other.

MR STEWART: Is there a sense from the fact that written confirmation by a certain date to a certain person implies that in the past perhaps these things have been ignored, but on this occasion they wanted confirmation?

A. It would be unreasonable to assume that circulars were ignored.

THE CHAIRMAN: Or maybe, to put it slightly differently, there's an emphasis on the significance of this circular, which is why they're looking for a written response to confirm that it's in place?

A. I think that's correct, yes. I think this was viewed by them and there was a lot happening at a national level on the whole area of consent. This was, if you like, one of the prominent issues that were being addressed within the NHS.

MR STEWART: What about attempting to benchmark the patient care services against those elsewhere to see how you

were doing at the time; was that undertaken?

A. Well, I mean, I mentioned earlier on that we undertook close liaison with other large teaching hospitals in Leeds, Manchester and Birmingham, and we'd have shared practice and learned from each other. Benchmarking was a theme, I have to say, at that time. I can't remember how the Trust -- I can't recall how the Trust undertook benchmarking exercises. But it was aware that it was, in management, was being used a lot.

Q. Yes. I mention it because the annual report from 1995/1996 makes reference to it, and specifically in relation to benchmarking patient record services --

A. Yes.

Q. -- against cross-channel teaching hospitals. It says it was likely to lead to further improvements.

A. Yes. Individual directors might have taken forwards particular initiatives in that regard.

Q. You mentioned a moment ago the Royal Colleges and the individual guidelines they produced for their members, which would of course have governed the professional practice of the clinicians.

A. Mm.

Q. And there were a lot of those around in the mid-1990s, were there not?

A. There were, yes.

Q. And they covered a range of things from record keeping to communication with patients and so on and so forth.

A. Yes.

Q. And we find on looking at the openings for these hearings, which are online, reference to seven separate colleges that we've drawn attention to. To what extent were they woven into the fabric of internal controls at that time or was it simply left to the clinicians' own individual practice to adopt?

A. It wasn't as loose as that. I think maybe I'll preface my remarks by saying that the medical Royal Colleges, as a group of professional bodies, had difficult or sometimes strained relationships with government in that they set high standards for lots of things, they would have looked for those standards to be put in place, and yet they could call on these standards to have them put in place, and yet they had no powers to implement them, and they would have looked to government departments to put them in place.

The primary purpose, I think, of their standards were to assist the colleges in hospital training visits, recognition of hospitals for training purposes. So if the college was coming to visit a hospital, take the Children's Hospital as an example, the Royal College of Paediatrics and Child Health, they would have used their

standards to benchmark or to assess how well the Children's Hospital and the Trust met those standards. They would have used those standards to make decisions on appropriateness of training or not. Royal medical colleges could say that we would recognise this training as excellent, supervision as excellent, all the standards are in place, we think you can train more specialist registrars or more senior house officers. On the converse, they could say: the standards are not being achieved, we're going to de-recognise this hospital for training.

So they had -- and I would have to say that the medical Royal Colleges in the context of postgraduate training worked through postgraduate deaneries. Northern Ireland had a single deanery covering all the training hospitals in Northern Ireland. At this time, it was the Northern Ireland Council for Postgraduate Medical and Dental Training or Education, I mean. It's changed its name since then.

It was an arm's-length body from the department, responsible for overseeing the quality of postgraduate education across the totality of Northern Ireland. Royal Colleges, when they were coming to visit a hospital to see was it meeting the standards that they expected for training, would have, through the

postgraduate dean, conducted a series of regular visits every three years, every five years, depending on the college or the specialist body that was coming to visit. So those standards that they put out would be primarily for that purpose.

Q. So in the short term, it acted as a sort of mini-accreditation scheme for training?

A. Correct, yes, you could call it that.

THE CHAIRMAN: Just to put it on the record: am I right in remembering, doctor, that at various points in the 1990s, in some of the rural parts of Northern Ireland, services were discontinued because colleges declined to continue to approve -- I think, elements of Omagh were one for teaching or training purposes --

A. I've hinted at this tension that existed between Royal medical colleges and government departments because it applied in Scotland, Wales and England as well as here in Northern Ireland. There were tensions whenever a college visit, for example, considered that the training hospitals, like South Tyrone Hospital, Dungannon was one, Omagh and Downpatrick. The smaller rural hospitals in Northern Ireland were very vulnerable to not being able to attain training recognition.

THE CHAIRMAN: Is that because they didn't have enough patients for the junior doctor or the argument was they

didn't have enough patients for the junior doctor to attain experience?

A. Yes.

THE CHAIRMAN: And the effect of that, if that training accreditation was withdrawn, that jeopardised the --

A. The whole service became non-viable.

THE CHAIRMAN: -- of service of that particular specialty in that hospital?

A. It rendered it potentially non-viable.

In relation to junior doctors' hours, there were lots of initiatives put in place to try and address things like that, but the working time directive was another factor. And I have to say that Health Service planners -- and I'm talking here about Health and Social Care boards -- were very reluctant to be seen to be compromising local services on the back of training visits -- and this is an ongoing debate today as we know today in the centre of Belfast.

MR STEWART: So individual clinicians were not only subject to the advice and duties imposed by their own Royal Colleges but also, of course, to the GMC, the umbrella organisation.

A. Yes.

Q. What about things like the national confidential inquiries? Would those reports have come to doctors

working in the Royal Hospitals?

A. In fact, in particular regard to the NCPOD and also the confidential inquiry into stillbirths and deaths in infancy and the maternal confidentiality -- those were actually endorsed, adopted if you like, by the department locally. So doctors were participating in those confidential inquiries. It's interesting that in context of a lot that has gone on within the inquiry, the word "confidential" features prominently in those national inquiries. The other thing was they were voluntarily: there was no mandatory requirement for every doctor to report every incident that might have been of interest to the confidential inquiry. So they were voluntary and they did not capture -- I think the maternity one was probably better than most. I'm less sure about some of the others.

Q. Thank you. The reports themselves, when they came out, of course, had encapsulated in them key elements of advice.

A. Yes, absolutely, and they were, generally speaking, very good.

Q. And --

A. Professionally driven. They were professionally driven, and I think that's one of the reasons why the profession were more accepting of them than maybe in some other ...

Q. We've touched on disciplinary procedures, and there were, of course, guidelines and circulars dealing with that, back in the 1990s as well.

A. They were very, very inadequate. The disciplinary procedure that was in place in 1991 through to 1995 was a very complex and difficult circular to work with. That's acknowledged not just -- it's not just my comments; others are on record as saying that the arrangements for handling disciplinary procedures were inflexible, difficult to interpret, difficult to apply.

Q. This was one of your key areas of special interest given in your CV:

"Special interest in the development of medical appraisal and handling of doctors with performance difficulties."

There's also guidance that was circulated in relation to the preservation of hospital service records. Guidance, which we've heard, that was not followed. We find that at WS251/1, page 9.

This is guidance which dates back to 1962. It's circular HMC75/62, and essentially it deals with service records and in relation to this inquiry what is relevant is that which appears at page 12 at the top, "1, minute books". These are classes of documents which are not to be destroyed:

"Minute books, including minute books of governing bodies and their sub-committees and minute books of hospital committees and sub-committees, are included in this category and must not be destroyed."

And we debated that earlier in the inquiry hearings. But the question that arises out of it is that this documentation, this circular, appears still to have been in force in the year 2000. And there's a letter to that effect at WS251/1, page 20. This is in relation to this particular circular. Number 2:

"I can confirm that parts of HMC75/62 are still current."

And that's the year 2000.

I wanted to ask you, what circulars dating from before the time of the Trust remained in force through the 1990s and which circulars became moribund?

A. I couldn't possibly answer that. In relation to the discussion we were having immediately prior to this, I know that the disciplinary procedures which came into effect in 1990 or 1991 were in place up until, I think, 1995 or 1997. That would have been a procedure that was pertinent to me, but a lot of this 1950s and 1960s information, I have to say, was probably lost in the ether. I honestly can't comment on that any further.

Q. Like the documents?

A. Guidance on what documents should be kept, minute books and so on.

Q. This is leading to asking you about circular ET5/90 --

A. It certainly wouldn't have been my responsibility as Trust medical director to ensure that this sort of instruction or guidance was being adhered to.

Q. But this circular, I think, would have fallen within your general remit. It's ET5/90. It's WS061/2, page 321. This is:

"The reporting of untoward incidents by a hospital to the board."

I think Mr McKee refers us to this circular, but suggests that it would have not been followed after 1993; can you recognise this?

A. Um ...

Q. This is about notification, as I say, to the board of untoward incidents.

A. Yes.

Q. Section 1:

"Summary of current notification procedures. The board currently has notification procedures in place in regard to notifying the coroner in relation to any death."

Over the page to 322, down to paragraph 10 at the top:

"Reporting of untoward incidents through administration or professional network."

Going on to section 2:

"A proposal regarding notification of untoward incidents. The board wishes to ensure that it receives prompt notification of any untoward incident. Unit general managers [that would have been the predecessor, I take it, of the chief executive] are therefore requested to ensure that appropriate arrangements are made in the units in accordance with the following guidance line:

"1. An effective reporting system should be maintained in the unit to ensure that all untoward incidents are notified to the UGM and that staff in basic and supervisory grades are familiar with the procedure."

Following on down:

"2. Criteria for assessing those cases which should be reported include any incident which might: (a) suggest there has been a failure in professional standards of care and treatment."

That, according to Mr McKee, seems not to have been followed after 1993. So I want to know why is the preservation of documents circular in force after 1993, but seemingly this is not.

A. Well, I can't give any further elaboration on that than what Mr McKee has said. I would elaborate further by saying that a lot of these procedures that should have been -- that were in place, one has to assume they were in place in the late 1980s and the early 1990s before trusts came into existence, that these procedures ... Either the responsibility to transfer them from the Eastern Health Board, as the organisation that was directly managing trusts, into the new trust arrangements. I don't ... There should have been some continuity, there should have been some connection there in relation to this circular. I am not familiar with that circular, I don't recall that circular and I'm not sure that the detail of that circular ever got translated seamlessly into the Royal Group of Hospitals as a trust.

But what I do know is -- and again, I use this word "convention". Because the medical advice, if you like, within the Eastern Health Board -- let's take an example. Dr McKenna, I think, was the chief area medical officer -- CAMO, as he was known. It would have been not uncommon for the unit clinician, when the organisation was a directly managed unit, to communicate issues with the chief area medical officer in relation to professional matters. I certainly adopted that

approach when I became Trust medical director. Maybe in ignorance of this circular, but I would have lifted the phone, not infrequently, to either Dr McKenna when he was still there, Dr Gabriel Scally when he succeeded him and then, more recently, Dr Stewart when he was there.

THE CHAIRMAN: Sorry, that's director of public health in the Eastern Board or in the department?

A. In the Eastern Board. This related, I think, to procedures that were in place when hospitals were directly-managed units.

THE CHAIRMAN: Sorry, the purpose of this is that at that stage the Royal is not a separate legal entity; it's part of the Eastern Board.

A. Correct.

THE CHAIRMAN: That is why the legal entity which is responsible for the Health Services in the Eastern Board area requires that its different components -- the City, the Royal, the Mater, and so on -- to report untoward incidents to it because it is the responsible body.

A. To the Eastern Board, correct.

THE CHAIRMAN: From that perspective, I can understand why Mr McKee might say this doesn't survive 1993 because, from 1993, the Royal Group of Hospitals is its own legal body; right? The Eastern Board is then the

commissioning body; is that right?

A. Yes.

THE CHAIRMAN: Do I understand you correctly: you have said that you still reported adverse incidents?

A. The distance between a commissioner/purchaser and the provider wasn't ... We were separate entities. But professionally, there was a lot of -- I'm talking now as a Trust medical director.

THE CHAIRMAN: Yes.

A. There was a lot of experience in the Eastern Board. Dr McKenna was a very experienced public health doctor and the directors of public health -- many issues, I would have lifted the phone. Remember where I'm coming from as a trust medical director without any of this background, so I would have lifted the phone and I would have shared issues with the director of public health or the chief area medical officer, as it was. Likewise, the same would have happened with nursing and other professional lines. So although they were at a distance from us, communication still took place, and certainly whenever critical issues were coming to the fore like issues about whether a doctor's professional competence was being called into question, whether we needed to institute disciplinary procedures or make a referral to a regulatory body or whether there was

issues in relation to publicity that might adversely affect on the Eastern Health Board, those communications did take place.

MR STEWART: Those criteria you draw upon there seem to come directly from the 2004 serious adverse incident circular.

A. I'm suggesting that --

THE CHAIRMAN: 2004?

MR STEWART: Yes. What I'm asking about in relation to this circular is this: in 1993, we've seen you chairing the risk management group under the health and safety policy. In 1993, maybe these arrangements for untoward incident reporting had fallen into abeyance. But according to this, there should have been procedures up and running and known to all basic supervisory grades. What remnants of that system were left? Why did you allow --

A. I think this is where Mr McKee's comments are pertinent. There would have been no obligation to formally -- once the organisation became a trust in 1993, there was no obligation on the Trust to refer that information. That's different from me lifting a phone to either get advice or to share knowledge with my counterpart in the Eastern Board.

Q. I'm pursuing a different point and that is: in order to

report an untoward incident, you have to have a system in the first place for information to come to you. There has to be an internal untoward incident reporting system before you can have brought it to the board. That system must have been in place in 1993 when the hospital became a trust, and I'm asking you, as the person who had responsibility for untoward incident reporting in 1993 under the health and safety policy, what you did with that system, if anything.

A. I'm not sure what reporting mechanisms, incident reporting mechanisms, documentation, was in place prior to 1993. All right? Now, what I have said at length, prior to this, is that from 1993, right through to my departure in 2002, we continued to develop and refine and extend our incident reporting machinery within the Trust.

Q. What I'm getting at is this: on the face of these documents, it would appear that, up until 1993, there must have been an internal system --

THE CHAIRMAN: There should have been.

MR STEWART: There should have been, and if there was, all you simply had to do when you were charged with the responsibility of adverse clinical incident recording was to allow that system to continue or to build upon it. There appears to be no evidence that any of this

was done.
A. And I do not know what was there prior to 1993. I was not in post.
MR FORTUNE: Sir, forgive me. If that was the case in 1993, at the time when trust status came about, surely -- and perhaps Dr Carson can help us -- somebody must have said, "What are we now going to do when we have an adverse incident? Is there a procedure?"
THE CHAIRMAN: I think that's what Mr Stewart was asking. Dr Carson -- I think he had given his evidence yesterday afternoon and this morning about what he would have expected to be done if there was an adverse incident; is that right? I think we've been over this ground.
MR FORTUNE: Mr Stewart is looking at the paperwork at the moment.
THE CHAIRMAN: Yes. It looks as if there's a gap. There's a procedure. Whether the procedure was activated from 1991 to 1993, I don't know, and you've said bluntly that you're not sure what procedure was followed up to 1993. But from 1993, it's unclear if there was an equivalent procedure introduced within the Royal Group of Hospitals to mirror this document which is on the screen at the moment.
A. I suspect what I'm suggesting, Mr Chairman, is that whatever was in place from 1991 through to 1993, it was

probably even worse than what was in place from 1993 onwards.
MR STEWART: Mr McKee, in his statement, has led us to believe that there was nothing in place from 1993 onwards. This circular was in place until 1993 and, from your evidence, you're not aware of any replacement.
A. I can't comment on what Mr McKee has said. Mr McKee, in fact, was the unit general manager prior to the organisation becoming a trust; he would be in a much better position than me.
Q. Thank you.
THE CHAIRMAN: Sorry, just to follow on, to nail it maybe: the result of that is that there isn't a formal procedure in place; you're therefore dependent on the convention --
A. Of whatever system was in place.
THE CHAIRMAN: -- and the history of what was in place and people doing what they did. But as you acknowledged before lunch, doctors might be good at reporting incidents arising from defective equipment or from reactions to drugs, but not necessarily on their own or the failings of their colleagues.
A. I think that's fair.
THE CHAIRMAN: Thank you.
MR STEWART: If we can move now to a subject very much

closer to your area of particular expertise, and that's your own publication, "Medical excellence". I wonder, can I ask you a few questions about the genesis of that? Can we go to WS062/1, page 480?
This is a letter of 1997.
THE CHAIRMAN: Whose statement is it?
MR STEWART: It's an exhibit to 062, which might be departmental, it might be Mr Gaudy, I'm sorry. It's in relation to a report entitled "Maintaining medical excellence" from August 1995; do you remember that?
A. Yes, I do.
Q. It's about the responsibility to monitor the standard of doctors' professional performance.
A. Yes.
Q. And it seems that that went out for general consultation and the British Association of Medical Managers, the association to which you belonged, amongst others, made comment on it. And it seemed that in the view of the British Association of Medical Managers and others:
"The right way of tackling situations of doctors' performance issues is to rely on the professional obligations laid down by the GMC to report colleagues to relevant authorities when they have reason to believe that there is evidence to suggest that conduct performance or health is a threat to patients, coupled

with clear reporting arrangements."
Was that the background to your own paper on medical excellence?
A. The background to this was the development of new procedures within the General Medical Council for handling performance issues. Performance procedures within the GMC were generally recognised to be inflexible and very difficult to work and, certainly for trust medical directors, they were an absolute minefield. Sir Kenneth Calman was the Chief Medical Officer in England at that time -- and he published, I think, this document called "Maintaining medical excellence". That was endorsed, adopted, by our own chief medical officer, Dr Campbell at the time, and she communicated with trusts, I think, to say that the thinking that underpinned "Maintaining medical excellence" should be put in place. And it was on the back of that work and the work that I knew that was happening through my contacts in the association of trust medical directors across the water that I developed the document for our own trust, called "Medical excellence", which put in place the procedures that would be used in the Royal Group of Hospitals Trust to manage performance issues within the Trust.
Q. Yes, that of course post-dates the cases with which

we're immediately concerned here, but there are a couple of things I would like to ask you about. The cover page is WS077/2, page 86. Could we also have a look, maybe beside it, at page 92? Because you describe here the old procedure known as "the three wise men".

A. Yes.

Q. That received a little bit of attention in the hearings relating to Adam Strain. This procedure:

"The three wise men. For the management of the sick doctor or dentist whose clinical performance was well below accepted standards was established by the Department of Health in 1982. Details were contained in a circular. The procedure was designed to function within the old NHS management structure prior to the establishment of trusts. The procedure was not well understood and was not always effective. The new GMC performance procedures effectively replace the three wise men, although the concept may be adopted by the medical director, where appropriate, at an early stage of the informal local mechanism."

Was this a mechanism? Was this a tool that would have been used by you or others in the hospitals to approach a clinician whose performance was felt to be wanting?

A. I would not have adopted the procedure as described

in that 1982 circular. I think there was a view that doctors -- with the expectation for a doctor who has a performance difficulty, that maybe two or three of my senior colleagues would get together with me and try and resolve the difficulties or whatever, and that that would be a very informal, and as I said in the document there, the procedure certainly wasn't well understood and it certainly was not very effective. It was designed primarily for doctors with health problems, particularly mental health problems or addiction problems. That's what that procedure was put in place in 1982 for.

What I'm referring to in the last paragraph there -- so there was some ... Within the profession there would have been some adherence to that as a methodology or an approach to handling doctors with performance difficulties.

What I'm saying in this document is that that procedure is now defunct, it is now out of date, it has been replaced not only by the GMC as an appropriate and acceptable way forward, but I was also hinting in this second paragraph that as far as I was concerned as a trust medical director, I was also replacing that with these new performance procedures.

However, what I was saying was that in the initial,

very early stages, it would not be inappropriate for me to ask a number of other senior consultants to advise me as to what the facts were and what steps they felt were necessary. It did not necessarily mean that their recommendations would be adopted or followed; it was a source of advice to me.

Q. Of course.

A. And actually, in practice, I hardly ever used it. I don't think I -- I doubt if I used it as an instrument.

Q. Amongst the other mechanisms available to you then that we haven't touched upon are, of course, inquests. The actual hearing of an inquest and the outcome could make a contribution to risk management.

A. Agreed.

THE CHAIRMAN: That was rather your point yesterday afternoon, wasn't it? In the mid-1990s, rightly or wrongly, there was a view taken that the inquest was really the arena at which these issues would be thrashed out.

A. Independently.

MR STEWART: And in relation to the inquest pertaining to the death of Adam Strain, we talked yesterday about when you might have been informed about this by Dr Murnaghan. We read Dr Murnaghan's transcript of evidence where he

said it was before the inquest and he thinks he told you about the differences of opinion.

You yourself have referred to it in your own witness statement at WS077/1, page 2. In the first paragraph at the top:

"I am unable to recall any notification to myself as Trust medical director at or around the time of death. However, on reviewing documents submitted, my understanding is that Dr George Murnaghan, director of medical administration, and I had discussed the findings of HM Coroner's inquest on or around 17 June 1996."

Apart from the documents, do you have recall of being told about the case or the inquest?

A. I cannot recall precisely whether Dr Murnaghan spoke to me before or after the inquest, and I cannot recall precisely the issues that he may have raised with me at that time. I honestly cannot recall that.

Q. Okay. The document I think you're probably referring to is 059-001-001, which is the note --

A. 002?

Q. And 002, yes.

A. Sorry.

Q. The next page, side by side. Is this the document that --

A. I was aware that this evidence had been forwarded to the

inquiry.
Q. So this was Dr Murnaghan making this note -- I think it's an aide-memoire -- and he said:
"Generally, outcome satisfactory. Fair write-up in the newspapers. Other issues identified which relate to structure and process in paediatric renal transplant services. Agreed with IWC [that's yourself] that should deal with as a risk-management issue and arrange a seminar with Messrs Mulholland, Hicks, Gaston, Taylor Savage, O'Connor, Keane, [yourself] and Dr Murnaghan present [underlined] as soon as possible."
A. Agreed.
Q. Dr Murnaghan has told us that he intended this seminar, which sadly never took place, to discuss the totality of the issues raised at the inquest. Would that have been your understanding of the matter?
A. My interpretation -- this is his note of the inquest proceeding or a note made after the inquest proceedings. He certainly did speak to me about the need to convene a meeting to discuss issues in relation to paediatric renal transplant services. I do not recall him saying to me that the meeting was to address issues of disagreement or whatever you would like to describe that as. In fact, I would have -- and I think I mentioned this yesterday. In addition to the names that

Dr Murnaghan has identified there, I think I would have involved others as well. Principally the commissioners, the people who were responsible for setting standards for the paediatric renal transplant service and the commissioning of that, whether it was the Eastern Board or the regional consortium on behalf of the four boards.
Q. The first point is you don't recall these discussions at all.
A. I don't recall which discussions?
Q. Any discussions with Dr Murnaghan about the inquest or the findings or the death; is that correct, at that time?
A. It is very hazy here. I think I recall Dr Murnaghan coming into my office after the inquest to say basically the inquest went all right or whatever you want to -- satisfactory. He then made reference to how it would be a good idea to have this seminar to discuss the points that he has made.
THE CHAIRMAN: Doctor, what does that mean, "the inquest went all right?" In what way? Because I'm not sure if Adam's mother is here, but I know she is following the evidence. When she hears a doctor say that "Adam's inquest went all right" or --
A. Sorry, it's inappropriate for me to use that.
THE CHAIRMAN: You're reporting what Dr Murnaghan said to

you. Dr Murnaghan was actually pleased with it because he said ... You're only saying what he said:
"The outcome was satisfactory with a fair write-up in Friday's Evening's Telegraph."
But what was satisfactory about the outcome of an inquest which effectively concluded that Adam died because of below-par medical treatment? What can possibly be satisfactory about that for the Royal?
A. Absolutely nothing.
THE CHAIRMAN: Well, then, I don't understand what this note means.
A. I mean, Dr Murnaghan can only interpret that, really, rather than me try to interpret what Dr Murnaghan was saying to me. What we're talking about here --
THE CHAIRMAN: Let me put it another way: how could it have been worse?
A. How could it have been worse? I think what we're talking about here is reputational risk, being damaged by an adverse outcome in an inquest, loss of confidence in the public in relation to services that are generally supplied by the hospital, the potential for any further adverse publicity, and in that sense, Mr Chairman, I think that's the only way he could have interpreted the outcome of those proceedings.
MR FORTUNE: Sir, can we ask Dr Carson to consider this

proposition? Because Her Majesty's Coroner, even then -- and in Northern Ireland -- had the power to make recommendations if he considered that there was a risk of a recurrence and a threat to patient safety. So if you recall, we have the statement -- and it's in draft form at 011-014-107A, this is what was put in front of Her Majesty's Coroner, with a view to avoiding such a recommendation.
MR HUNTER: Sir, can I just add that the family's legal representative at the inquest actually submitted to the coroner that he should make recommendations?
THE CHAIRMAN: And this draft statement, which I think you know the background to, was prepared, effectively collectively, by the paediatric anaesthetists. They shared the drafting of it, but it was only circulated to them. And this was -- you adverted to this yesterday, to the extent there was any learning, it was learning that was far too narrow. But there's at least -- it's at least open to me to infer from the evidence that the purpose of this statement was to dissuade the coroner from issuing recommendations.
MR UBEROI: If I might rise, sir? It's open to you to infer that. I don't represent the original drafter of this document, but I would urge caution in the way that Mr Fortune just phrased what is really a potential

submission by him or a theory by him about the bottom line to be inferred from this statement when it hasn't actually been spoken of in those terms in evidence by the people who drafted it.

THE CHAIRMAN: Okay, thank you.

A. Mr Chairman, I am not familiar with the precise background to the preparation of this draft statement. I see George Brangam's initial and George Murnaghan's initial, and I presume that's the date of 20 June 1996. The only signature on it -- I am assuming that is Bob Taylor's signature.

THE CHAIRMAN: Yes.

A. I honestly don't know anything of the background to this document. Mr Fortune is quite correct: under Coroner's rule 23, he has, within his powers, the opportunity to recommend. I would have to say to the best of my knowledge -- I may be proven wrong here, there may be evidence somewhere to say contrary to this -- but during my tenure as Trust medical director, between 1993 and 2002, I do not recall ever once receiving instruction directly from John Leckey or any of the other coroners in Northern Ireland in relation to the care that was delivered by the Royal Hospitals Trust.

THE CHAIRMAN: Thank you.

MR STEWART: Did Dr Murnaghan tell you what transpired

at the inquest hearing?

A. Not in detail. He basically came into my office late on one evening, I can't remember what day it was, and basically almost regurgitated what's on that little note. I had no further --

Q. Did you ask him why it was necessary, what parts of the evidence had made him think it necessary to convene a seminar?

A. I assumed that it was in relation to the planning of and the conduct of Adam's transplantation and some of the issues that emerged contributing to the cause of death. But more than that, I had no further information.

Q. Did you ask him whether the finding of the coroner implied any criticism of the professional handling of the patient?

A. I did not enquire of that in that way.

Q. But when he told you the seminar had been necessary as soon as possible, did you not think that was a clue?

A. Possibly, yes.

Q. Looking at that seminar note 059-001-001, what is suggested here is that issues identified relate to the structure and process of paediatric renal transplant services.

A. Mm-hm.

Q. It doesn't say there that an issue identified was the

excess administration of fluid, which may have played a part in the death of a patient.

A. Agreed.

Q. Do you not think that Dr Murnaghan, having come straight from an inquest where that was the specific finding of the coroner, might have thought that an appropriate thing to discuss at a seminar or even sooner with Dr Taylor?

A. I cannot speculate what Dr Murnaghan thought.

Q. Would you agree that, if that was the case, that is exactly what you'd have thought at the time?

A. Um ... I think there were -- and again, I'm ... My comments are possibly coloured by what I have learned through the course of the inquiry. I think there were a whole range of issues that, if this matter had been brought to my attention at the time of Adam's death, that would have been looked into.

Q. But it was brought to your attention at this time.

A. Yes.

Q. It was specifically brought to your attention.

A. Yes.

Q. Let's have a look at the coroner's finding at 011-016-114. Did you ever ask to see a copy of the finding or the verdict?

A. I didn't ask for a copy, no.

Q. The bottom of page there:

"Findings: the onset of cerebral oedema was caused by the acute onset of hyponatraemia from the excess administration of fluids containing only very small amounts of sodium and this was exacerbated by [other features]."

THE CHAIRMAN: Doctor, as an anaesthetist, you would know particularly the significance of that finding.

A. Yes.

THE CHAIRMAN: Is it your evidence that you weren't aware at the time of this finding, even in this very summary detail?

A. I can't recall, Mr Chairman, what my awareness was or was not at that time. I honestly can't recall.

THE CHAIRMAN: Can I ask you another way: were you aware that there was a specific concern about what Dr Taylor had done?

A. No, I was not, and I was not aware that he did not accept the findings of the coroner's verdict, if that's the way of putting it.

MR STEWART: Did you ask if he did?

A. I wasn't aware that he didn't accept.

Q. Did you ask if he accepted?

A. No, I didn't, because I didn't know he didn't accept it.

THE CHAIRMAN: Have you ever known a doctor in the Royal not

to accept an inquest finding?
A. I don't know whether that had ever happened before. I don't know whether it has happened since.
THE CHAIRMAN: I take it from that, that in your experience then, it would be unique that Dr Taylor --
A. No, I'm not saying --
THE CHAIRMAN: Sorry. To the best of your knowledge, since you don't know of any similar rejection of an inquest finding before or since, the fact that Dr Taylor didn't accept this inquest finding would be unique in your experience?
A. I wouldn't go as far as saying that, Mr Chairman. I think the issue for me here -- and I suppose there are some parallels to medical negligence cases. In fact, dare I say it, all cases that get into a court situation. A verdict or a decision taken by a judge or, in this case, a coroner is based on the balance of probabilities based on opinions expressed. And in this case, professional opinions expressed. So it would not have come as a surprise. I've seen this in medical negligence cases where a decision was taken in a high court to make an award on the basis of expert opinion, which convinced the jury or the judge that compensatory payments of such-and-such were ... And the doctor trying to defend the case would have disagreed

with that.
THE CHAIRMAN: But the difference here is that other doctors who were involved in the treatment of Adam agreed with it, specifically the two doctors who were most closely involved in this attempted transplant for Adam: Professor Savage and Mr Keane both thought that Dr Taylor had made the crucial error. The coroner decided, having heard expert independent evidence, that that was right. But from what you're saying, that fundamental fact did not reach you.
A. It did not. And certainly, subsequent to that -- and I don't know whether this has been influenced by my reading of transcripts of the outcome of the inquiry -- I'm not sure what Dr Taylor agreed to and what he disagreed with. I know that he -- my understanding is that he contested, if you like, the pathophysiological process of and the contribution that hyponatraemia made to the ultimate cause of death. And if we listen to the discussion yesterday morning, there was still a bit of a dispute around the role of hyponatraemia per se.
THE CHAIRMAN: He did, but that's a fresh debate. And what happened, as you'll have seen, when Dr Taylor came to give evidence here in April or May was that he accepted then that the series of statements he had made in the

interim were indefensible and outrageous, to use his words.
A. I understand that he made that statement.
MR STEWART: The background is that Dr Murnaghan has told us that he had never, in his experience, seen an external expert witness criticise one of his clinicians at an inquest. That was therefore, for him, a unique experience. This finding of the coroner is nothing less than a direct quote from that external expert witness, Dr Sumner. Did Dr Murnaghan not tell you that?
A. No.
Q. Would you have been interested to know that?
A. Yes, it would have an influence, yes.
Q. An influence? Because the proposition is very simple: if a doctor doesn't accept that he has made a mistake, he might do it again.
A. I understand that. But am I not right in saying that the paediatric anaesthetists took steps to change their policies and procedures and that those were put in place within the Children's Hospital?
Q. There is a matter of debate there. Those draft recommendations produced by those four anaesthetists -- that's Gaston with Messrs McKaigue, Taylor, and backing it up, Dr Crean -- produced a set of guidelines, which was a statement of the completely startlingly obvious,

for dissemination to no one, which was trousered by them on the spot. It got nowhere.
A. Can we assume that they followed those guidelines subsequently in their clinical practice?
Q. Interestingly, they referenced a paper, the Arieff paper, about which you've heard so much, which was not relevant to Adam's case, but was relevant to hyponatraemia and the cases that followed.
A. I accept that.
Q. So dissemination was not, I think, on their minds.
A. What I'm trying --
Q. But what I'm asking you --
THE CHAIRMAN: I don't think Dr Carson is making a different point about whether the fact that the particular mistake which was made in Adam's transplant by Dr Taylor has not been repeated since, whether that illustrates that, at least to that extent, something was learned from Adam's death. Is that your point?
A. Yes, that's the point I was making, yes.
MR STEWART: Back then in 1996 you wouldn't know what lay ahead. You had a situation with potentially -- unknown to you, but known to Dr Murnaghan -- where a doctor was not accepting the error of his ways and that further paediatric renal transplant operations were performed with the anaesthetic performed by Dr Taylor.

A. Satisfactorily.
Q. That was unknown at the time. There was a risk, potential risk, to patients. We know that Dr Murnaghan did nothing about that; he reported the matter to you --
A. Yes.
Q. -- and you did nothing about it because you say he didn't tell you. He has told us that he brought the difference of opinion to your attention. I want to know what attempts you made to find out anything about this case.
A. I do not recall the difference of opinion being brought to my attention. It is a matter of regret -- and I think Dr Murnaghan has said that -- and I would reiterate that that seminar, which would have discussed not only the findings potentially of the inquest, but other issues in relation to the paediatric renal transplant service would have been discussed. It's a matter of regret that that did not take place.
Q. Do you think that the matter should have been investigated at that time? Looking back, did you think now that --
A. At the time of the inquest?
Q. Yes, immediately after the inquest.
A. I assumed that Dr Murnaghan was going to do that.
Q. Were you aware that the coroner himself --

THE CHAIRMAN: I'm sorry. I'm not sure where that assumption comes from, doctor. Because what this note indicates is that Dr Murnaghan has spoken to you and it's agreed you're going to bring together a group of people to talk about the paediatric transplant service. That's one important aspect, but it's a limited aspect of what there was to investigate. On what basis were you assuming there would be an investigation?
A. Well, I'm assuming that in the course of that potential discussion, issues around fluid management would have been raised, and in that context then the potential for the disagreement, the difference of opinion between Professor Savage, Mr Keane and Bob Taylor, I would have assumed there was potential for that to emerge, as well as what I will call general issues in relation to how the paediatric transplant service should be delivered, designed and conducted. So I would have assumed, Mr Chairman, that there was every opportunity there for those other consultants to raise those sorts of issues, albeit a year -- or whatever it was -- after the event.
MR STEWART: Did Dr Murnaghan tell you that the coroner himself had suggested that this case, along with others, be formally investigated?
A. That's the first time I've ever heard that.
Q. That appears in the almost verbatim note of the evidence

given at the inquest taken by the Trust solicitor, Mr Brangam, and his office, and that appears at 122-044-051. This is the coroner's summation, and you see, two-thirds of the way down the page, a paragraph which commences:
"Death was a rare occurrence, even worldwide. Nine other cases in the United Kingdom. Agree and support that these should be formally investigated. Any common denominators with view to preventing further occurrences."
It looks as though the coroner is saying, "I suggest to you maybe investigate it."
A. This is Mr Brangam's note, is it?
Q. I think so, yes.
A. Mr Brangam certainly did not communicate his view that these cases ... [reads sotto voce].
THE CHAIRMAN: This might be an investigation, not just into Adam's case, but to see if there are any common denominators between deaths during transplant to see if there's an improvement [OVERSPEAKING] --
A. Transplants within Northern Ireland?
THE CHAIRMAN: No, not in Northern Ireland, thankfully. Nine other cases in the UK.
A. I have to say that an investigation of that nature would not have been conducted or managed or delivered by the

Trust medical director. That would have had to be referred to the department and, dare I say it, across departments.
THE CHAIRMAN: That's perhaps something for the nephrologists to take a lead on because they're the lead carers for the children involved.
A. I would agree with that.
THE CHAIRMAN: Again, what Mr Stewart has just highlighted to you, that is news to you?
A. That is absolutely news. I have never seen that document ever.
MR STEWART: There are other portions of this document we're going to come to in a moment. But did you at any time at that time give any thought to having a review or investigation of any sort into this case?
A. I personally did not, no.
Q. And you didn't feel it was necessary to be able to reassure the board that this sort of thing wouldn't happen again?
A. Um ... I put this in the context of a lot of other deaths that happened, many of them requiring coroner's inquests. Personally, no, I didn't follow it any further on that.
Q. Did Mr Brangam or Dr Murnaghan suggest to you that the coroner had suggested that the matter might be

reported up further, I think to the department? Can we look at 122-044-037?

A. I mentioned earlier that I do not recall ever receiving communication from any of the coroners to me as Trust medical director. When I moved to the department, I was aware that John Leckey in particular would have exercised his prerogative under rule 23 to communicate to the Chief Medical Officer, and she would have quite often copied cc to Dr Carson, and I think he wrote to me directly in relation to one matter. So I'm aware that he did do that.

Q. Yes. But the prerogative was also with the hospital, with the Trust, to report such matters. The final paragraph of this page:

"Coroner: would it be useful if monitoring body looked at these deaths? I will write if you feel it would strengthen case. Perhaps instructing solicitor could let me know."

In other words, the coroner is asking Mr Brangam if he would let me know, suggesting to him that it be reported to the monitoring body to look at the deaths.

A. What is the monitoring body?

Q. Well, I don't think any of us know of anything called the monitoring body. And I think it might be reasonable to suppose that it is reporting it upwards and, for the

Trust, that would presumably mean the department.

A. This illustrates how poorly developed in 1995/1996 the systems of clinical governance, as they existed at that time -- what would happen today is ... Quite often, issues like that would have been brought to the attention of the body which I currently chair, the Regulation Quality Improvement Authority, which if you like could be described as an independent monitoring body. And similar action has taken place most recently, for example in the context of four babies who died in the Royal maternity neonatal unit following an outbreak of pseudomonus. That was referred by the minister to our organisation to conduct an independent inquiry.

Q. But we're interested now in the information that was in the possession of your left-hand man, Dr Murnaghan, and the Trust solicitor, Mr Brangam. If you had been told that the coroner said, "I'll write if you want me to, we should investigate these and it would be useful if the monitoring body looked at them", what would you have done if you'd received that information?

A. Difficult to speculate, with retrospect, as to how it would have been handled, I have to say. And I'm going by what would have been likely to have happened at that time. I think there were serious issues here that

related to the quality of the service and the way the service was delivered. I think -- in 1995 or 1996, I think that what would have been likely -- there would have been a meeting of senior officers within the Eastern Board and possibly with representatives from the department. So the meeting that Dr Murnaghan has talked about could have been escalated to a much more high-level discussion at that time, and a decision maybe taken that a broader investigation, maybe involving other national bodies, could be -- to determine or ascertain the extent of this problem and so on.

THE CHAIRMAN: When you have told us yesterday and today that you think you would have involved others in this seminar as well, is that something, looking back on it now, that you think would have been better had that seminar taken place or is that something which you might have said to Dr Murnaghan at the time?

A. I think at that time ... If Dr Murnaghan -- and it's a regret that the seminar didn't take place. But my expectation of that -- when George Murnaghan came to say, "Dr Carson, we have to set up this seminar, where are we going to hold it, who are we going to invite?", I think I would have been very keen at that time, based on the way things ... Because there were discussions taking place in relation to paediatric cardiac surgery,

there were relations -- other service initiatives that involved commissioners. So I would be confident in saying that at that time I would have expanded that meeting to involve others, on the basis of what would have been custom and practice at that time, not where we're at now.

MR STEWART: And further --

A. I think it would have been handled completely differently now.

Q. And further, if you'd been aware that the coroner had suggested that a monitoring body -- presumably the department -- you presumably then would have thought, "We'd better do that".

THE CHAIRMAN: It can't be the department. If this reference is because there were nine other transplant deaths in the UK --

MR STEWART: There's a separate reference, sir.

A. I'm not quite sure --

MR UBEROI: If I can assist, I think that's right, sir. I think it probably picks up on the evidence Professor Savage was giving about introductory research which he had conducted, inferring that there are potentially nine other deaths UK-wide.

THE CHAIRMAN: I think, Mr Stewart, it can't be just Adam's case because Mr Brangam's note was: I think it would be

useful if the monitoring body looked at these deaths. It's not the single death of Adam.

MR STEWART: With respect, the coroner says at page 37:

"It would be useful if a monitoring body looked at these deaths. I will write if you feel it will strengthen the case."

He does say "deaths", that is true. And the reference furthermore to the nine other deaths appears much later in the proceedings at page 51. The coroner does return to the issue even before that reference at page 51 on a further occasion at page 50 to say:

"Can understand need to closely examine, especially with other deaths. Would be happy to write letter if need be."

It's the paragraph there:

"Don't think so either."

THE CHAIRMAN: Thank you.

MR FORTUNE: Sir, on the subject of the monitoring body, you will of course recall -- and my learned friend Mr Uberoi has just mentioned it -- Professor Savage wrote to Dr Postlethwaite referring to Adam's death, and of course bearing in mind that he represented the British Association of Paediatric Nephrologists, there was an audit, the audit results were published, so at least there was some reference to a monitoring body.

Whether it's the monitoring body that the coroner had in mind is another matter.

THE CHAIRMAN: Thank you.

A. Mr Chairman, I would have thought, at that time, in 1995, that's where that level of expertise would have existed. I can only think of parallels in the area in which I worked in relation to cardiac surgery, The Association of Thoracic and Cardiovascular Surgeons might have been a similar sort of body that would have been able to bring together the collective experience across the UK.

THE CHAIRMAN: Okay, thank you.

A. But I don't think they could be called, in the current context, what we understand "monitoring bodies" to be.

MR STEWART: The coroner has, in fact, told the inquiry that he would have assumed that the Children's Hospital will have, in fact, done some dissemination, and that appears at WS091/1, page 3:

"I had assumed [this is in relation to the inquest finding] that the Royal Belfast Hospital for Sick Children would have circulated other hospitals in Northern Ireland with details of the evidence given at the inquest and, possibly, some best practice guidelines. Children are not always treated in a paediatric unit and, in the event of surgery, the

anaesthetist may not be a paediatric anaesthetist."

If you'd been told then what you know now, would you have hoped that it might have gone further?

A. Yes, I think that would be a fair point. I think it would not have, however, been the responsibility of the Children's Hospital to do that. I think it would have been cascaded upwards, escalated from the paediatric directorate through to myself, probably, as Trust medical director to raise that issue formally with the Chief Medical Officer. In the same way that the chief executive of the Altnagelvin Trust raised Raychel Ferguson's issues with the Chief Medical Officer subsequently in 2001. That's what should have happened.

Q. That raising of the issues in 2001, that was your counterpart, the medical director at the Altnagelvin Hospital, who wrote --

A. In fact, my ... The medical director, Dr Fulton, in Altnagelvin Hospital, certainly raised the issue with me and with the Chief Medical Officer. But more importantly and more significantly, the chief executive of the Altnagelvin Trust wrote formally to the Chief Medical Officer, suggesting that guidelines needed to be issued.

Q. There is a little exchange of correspondence, I wonder if we can look at it, at 012-039-196 and 197. This

is May 2002 and it's the medical director of the Altnagelvin writing in relation to the death of Raychel in Altnagelvin, which is thought to have followed severe hyponatraemia:

"Many steps have been taken to ensure that such an event does not occur again. We are all anxious to learn from what was a tragic experience and to share vital information with others. Guidance issued from your department will help in this regard. We are grateful for the recent posters ... I am interested to know if any such guidance was issued by the Department of Health following the death of a child in the Belfast Hospital for Sick Children, which occurred five years ago, and whose death the Belfast coroner investigated. I was unaware of this case and I am somewhat at a loss to explain why."

This is Adam's case and the inquest we're talking about:

"I would be grateful if you could furnish me with any details of that particular case for I believe that questions will be asked as to why we did not learn from what appears to have been a similar event."

And Dr Henrietta Campbell responds on 10 May:

"Your letter referred to a coroner's case five years ago in which the cause of death of a child was reported

to be due to hyponatraemia. This department was not made aware of the case at the time either by the Royal Victoria Hospital or the coroner. We only became aware of that particular case when we began the work of developing guidelines following the death at Altnagelvin."

That seems to highlight the importance of reporting these matters to the department, doesn't it?

A. Yes, I agree with that. I apologise, I've made reference to Dr Fulton, but I think Dr Nesbitt must have taken over at or around this time as the Trust medical director in Altnagelvin. I want to correct my previous statement.

Q. One can only speculate what might have happened if Dr Murnaghan had told you that the coroner was interested in a monitoring body looking at the cases and if you'd then reported them to the department.

A. I think if Dr Murnaghan ... If the seminar had taken place as outlined by his brief note, I indicated that I would have involved a wider field of Health Service managers, let's call it that, in the context of the circumstances around Adam's death. That would have involved not only the Eastern Board, but I would have thought it would have been appropriate to involve directly the Department of Health, and they may have

seen the wisdom, even at that time, albeit on the basis of one child, to issue guidance on that.

It's sad, I have to say, that so often in relation to untoward incidents and even fatal untoward incidents that it takes more than one case to trigger. I can think of a similar situation that occurred across the water in England whenever cytotoxic drugs were injected by mistake into the cerebrospinal fluid of children. It took several of those to trigger departmental guidance which was shared across the UK. So it's a sad reflection that it takes more than one incident to trigger appropriate action.

Q. The case that the consultant paediatrician anaesthetists referenced in their recommendations and the case that the pathologist referred to in her evidence to the coroner and the case that Dr Sumner referred to the coroner, it was all to do with a paper called Arieff, which referenced 16 cases of death. I'm going to bring you to page 122-044-028 and 122-044-029. Again, Mr Brangam's transcription of the evidence at inquest.

This is Dr Sumner talking. At the third line, at the bottom of 128:

"Arieff paper, very important benchmark. Adam's death several years after this. Look at it in

conjunction with paper. Parallels with some of these cases. Dilutional hyponatraemia/cerebral oedema. Is there a method of disseminating this?"

A. You're referring to the Arieff paper?

Q. Yes. He's referring to the Arieff paper.

A. Okay. And this is George Brangam's note; is that correct?

Q. It is, the Brangam Bagnall note.

A. Certainly it was never raised. The question of disseminating a single piece of medical literature was never raised with me. I'm not aware -- I cannot recall after any inquest where evidence used from the medical literature was asked to be disseminated. I have to say, as a practising anaesthetist, an anaesthetist involved in looking after children with paediatric congenital heart disease, I was not aware of the Arieff paper. And there is no way, I think, that every doctor can keep abreast of every piece of medical literature that's --

Q. Absolutely not. But if the doctor upon whose opinion the coroner completely agrees and makes his finding says, "Is there a way of disseminating this?", if you'd had your seminar, if you'd known about this information, you might have done something.

A. It is quite possible that the Arieff paper could have been disseminated after the seminar. And it might even

have been -- I mean, there are other vehicles to do this, whether it's the Northern Ireland Society of Anaesthetists or the Northern Ireland Paediatric Society or whatever the equivalent is.

THE CHAIRMAN: It can be an attachment to a general note, can't it?

A. It could be, yes. There's absolutely no reason why it couldn't have happened. I cannot recall any other similar situation where that might have happened. I think actually what would have been far more important would have been to try and bring forward the guidelines that were developed by the department in 2001 to bring it closer to the deaths of Adam and Claire. And in that context, yes, other deaths might have been prevented.

MR STEWART: You agree there was learning to be had from Adam's case?

A. Absolutely. I said in my -- in every death, there is learning of some note.

MR FORTUNE: Could we approach this matter from a slightly different direction? Just pausing there, Dr Carson referred to incidents involving cytotoxic drugs. He's probably referring to the Vincristine cases. Coming back to the point, and the monitoring body, if hyponatraemia was an issue to be addressed, did Dr Carson consider -- as in Adam's case, this was

a renal transplant -- referring the matter to the United Kingdom Transplant Service, which of course would have monitored and had involvement with the British Association of Paediatric Nephrologists?

A. The direct answer to your question is, no, I didn't consider doing that. But I would have been aware that transplant coordinators were in place within the service and there was every opportunity for an audit, if nothing else, of transplant procedures being reviewed at some stage or other, and that may well have escalated it to a national level.

THE CHAIRMAN: Okay. I want to pause for the stenographer. I want to see where we are progressing this afternoon.

MR STEWART: I would think that there may be a further half an hour to 40 minutes.

THE CHAIRMAN: Okay, we need to break for the stenographer, so we'll take a ten-minute break.

During this break, if there are any issues that anyone wants Mr Stewart to raise on the questions asked so far, could they contact Mr Stewart, please?

MR QUINN: Sir, there's an issue I want to raise.

Mr and Mrs Roberts looked at original case notes in Claire's case yesterday, the original case notes, and another issue has arisen in relation to the notes. I understand you are giving judgment tomorrow morning on

Mr Green's application in relation to Dr Sands. If you could maybe get access in the next 10 minutes to the original notes, I want to make a very short submission in relation to a point that has arisen in relation to another entry on the notes that looks as though it's not timed correctly.

THE CHAIRMAN: I will do that, thank you.

(4.00 pm)

(A short break)

(4.10 pm)

(Delay in proceedings)

(4.15 pm)

Submission by MR QUINN

MR QUINN: Mr Chairman, if you do have the original notes, which you now are getting in the envelope, and if we can have on the screen reference 090-022-053, we can then see where this is going.

The point I'm making is that when one looks at the original notes, you can see that Dr Webb's notes come in at -- that's actually "22/10/96, 4 pm". It is clear when you look at the original notes that he is writing in green ink. Your recollection will be that because he identified green ink as traditional for neurology. And you'll see that when one looks through all of the rest of the pages of notes that all of Dr Webb's notes are in

green, and all are written in the same pen.

When one looks at the original notes, you'll see that the "4 pm" reference in the column to the left of the commencement of the notes is in black ink.

THE CHAIRMAN: Right. So what we knew before was that it was the wrong time.

MR QUINN: Yes, we knew it was the wrong time. And I'll just refer you to that. At WS138/1, at page 10, you'll see at subparagraph (d):

"Explain why you came to time the note of your attendance at 4 pm and you now consider that the entry was actually written at around 2 pm. I cannot recall why my note is timed at 4 pm, but I believe I did attend at 2 pm [et cetera]."

And he refers to the nursing notes. On 30 November, at page 196, he confirms that when asked about this by Ms Anyadike-Danes, and he confirmed on that note that, again, he assumes it is 2 o'clock because of the nursing note.

So the following questions need to be addressed. Why is 4 pm not written in green ink? Secondly, if one looks at the next page -- and if that could be put up instead of the page of the WS on the right -- if one looks at the next page, 090-022-054, you'll see that the next entry by Dr Webb is not timed. That's his entry

appearing at the top of the page.

THE CHAIRMAN: Sorry, that's not the next -- is that not a continuation?

MR QUINN: You're correct. That's a continuation. The point I'm making is: when one looks at page 055 of these notes, you can see that Dr Webb uses a 24-hour clock at 17.50, and again in his next note which then appears at 057 of the same records and at 058. It is clear from those notes that Dr Webb continues to use a 24-hour clock, yet in this record someone is obviously using a 12-hour clock.

THE CHAIRMAN: No, no, sorry. On the subsequent ones that I have in front of me, for instance on 23 October, he says 6 am, which is consistent with him somebody writing on 22 October "4 pm".

MR QUINN: But he's using "4.40 am", et cetera, and what I'm saying is that that is indicative -- particularly the note of 055 ...

THE CHAIRMAN: What time is that?

MR QUINN: That's at 17.50.

THE CHAIRMAN: Right. 17.50.

MR QUINN: He may have used "am" for early hours of the morning, but everything seems to be timed on the 24-hour clock except the entry that's made in the black pen that appears on the first page of the notes that I referred

to.

It's clear that none of the other notes are in black ink whatsoever, so Dr Webb somehow has made a note, if it is his note, in black ink, whereas he uses green ink and he has made that note on a 12-hour clock. What I'm instructed to say about this --

THE CHAIRMAN: What I hope you're coming to is: in terms of the ruling which I have to give tomorrow morning, is this more than a curiosity?

MR QUINN: Well, it is more than a curiosity because potentially what I would say -- it's a minor addition, it's difficult to understand the clinical impact of it and we can't see how it impacts on the records, but the point is this: it doesn't fit, and perhaps it does improve the notes in some way by adding a time. What the parents say about this is they see this as another entry that is added later and they would like an answer to this, and perhaps at the very least, Mr Chairman, we could refer a coloured photocopy to Dr Webb in Dublin and ask him for a comment on it.

And why I say that's an addition is this. If we can then turn up the addition to Professor Rooney's notes, and that is the patient journey compiled by Dr Steen, and if one looks at WS117/1, at page 34 ... (Pause). It's attached to Dr Rooney's statement.

THE CHAIRMAN: These are the documents which are attached to her statement, the toing and froing of the draft note?

MR QUINN: Yes, it's the patient journey, it is the draft notes of the minutes, it's the letter and it's Professor Young's e-mails. What I can do, I can pass --

THE CHAIRMAN: Hold on, we are coming to it now. There's 117. Maybe for speed, could you give me the point, Mr Quinn?

MR QUINN: The point is this: when one looks at the patient journey compiled by Dr Steen, which we only recently looked at ourselves, we can see that the date and time is in the left column. The clinical information is in the centre column. And then there are other columns deals with "therapy" and "bloods". The third entry on that reads, and it's the ward round:

"Approximately 11.30."

If the ward round original note can be brought up -- we've got these notes up, it's 090-022-052. One can now see the ward note starting at 22/10/96 and it's not timed. And because it isn't timed, Dr Steen has made an entry saying, "Approximately 11.30".

THE CHAIRMAN: Okay.

MR QUINN: She follows that in the next entry by discussing Dr Webb's entry and discusses it in detail. What she puts in the same column for date and time is

"approximately 12.45". That fits with nothing, Mr Chairman.

So it would look as though Dr Steen has had a look, a thorough look, through these notes, has come up with a patient journey reflecting what is in the notes. In fact, when one looks at it, you can see there are other approximations in the notes. And because there is no time against the ward round, she uses an approximate time, one would assume, after discussing this perhaps with Dr Sands or Dr Webb or any other person who was at the ward round. She does the same thing, if one turns up again page 053.

THE CHAIRMAN: Give me the reference again.

MR QUINN: 090-022-052 and 053 together. The point I'm making here is that it's clear from Dr Steen's analysis of the notes for the patient journey that she is forced to put in an approximate time for the ward round because it is one of the untimed notes, and she does that throughout when there's no timing on the note. She also makes an approximation of Dr Webb's first visit, as appears on page 053.

There's only one reason for doing that, in my respectful submission, and that is because when she saw that note, it wasn't timed. Don't forget, she looks at the notes for the first time in 2004.

THE CHAIRMAN: So your point is: if she had taken that from the notes as they appeared, then her entry for Dr Webb shouldn't have been 12.45, it should have been 4 pm.

MR QUINN: Yes, because she's actually copied out verbatim a complete section of Dr Webb's note, as appears in the clinical records at page 053. And it would seem rather odd, to say the least, if she had copied that out and copied other sections -- if one looks right through the clinical journey, there are three pages of it. When one looks through that, one can see the next untimed note is in relation to starting midazolam, which appears at WS177/1, page 35. That's the only other approximation she gives because it is an approximation because there's no direct note as to when midazolam started. But in relation to all the other notes, you can see from Dr Steen's hand that she follows a path through the notes with precise timings as they appear in the notes, yet for the two, what I submit are untimed entries, she makes an approximation. And her approximation in relation to Dr Webb's note is so far out that the 4 pm simply could not have been in the column when she made the note.

What I'm saying is the parents are very distressed that this seems to be another addition to the records after the time, and I put it no further than that.

We are not identifying anyone who put the note in, we're not saying -- but what we are saying is that it's very unlikely to be Dr Webb because of the points I've made earlier: the 24-hour clock and the green pen.

MR FORTUNE: Forgive me, sir, I'm not quite sure what my learned friend is actually saying. Is my learned friend actually saying that the entries or the entry in particular for the Webb entry has been made by somebody other than Dr Webb, or by Dr Webb in a different coloured pen?

THE CHAIRMAN: I presume the answer is you don't know who made it.

MR QUINN: We don't know who made it, but --

THE CHAIRMAN: But you know that if it is made by Dr Webb, it's the only entry made by Dr Webb which is not in green pen.

MR QUINN: And not in the 24-hour clock.

THE CHAIRMAN: The timing is wrong. When Dr Steen does the clinical journey, she doesn't follow the time in the note at 4 pm, she doesn't put it to 2 pm, she puts "approximately 12.45". So on what basis was she going to 12.45 since that doesn't otherwise appear in the records.

MR QUINN: It doesn't fit anything.

THE CHAIRMAN: I think Mr Quinn's being deliberately

careful. He's not saying that Dr A or Dr B made this entry at 4 pm; he's querying on behalf of Mr and Mrs Roberts whether it was actually made by Dr Webb at all.

MR QUINN: Yes.

THE CHAIRMAN: And, if it was made, when it was made.

MR QUINN: Yes. And why I'm making the point is that it seems to the parents and to their legal team that it was made some time after Dr Steen saw the notes.

THE CHAIRMAN: Well, to date we've gone on the assumption that Dr Webb was working on a 24-hour clock and meant to put 2 pm, which is 1400 hours, and had put "4 pm" by mistake. You now say that's an unlikely assumption to make.

MR QUINN: I say that that is very unlikely.

THE CHAIRMAN: He's unlikely to have made the entry about the time of his attendance on Claire in a different pen to everything else that he wrote in relation to that particular attendance on her and in relation to every other note of his, which appears in the records.

MR QUINN: Because he's still writing in green ink when he's in the PICU at 4 and 5 o'clock in the morning.

THE CHAIRMAN: I understand that point, but is there a reason why that is relevant to me giving a ruling tomorrow morning?

MR QUINN: Yes. It's another entry that is made after it should have been made in the notes. We know that it's good practice not to make entries in the notes that are not made at the time. And we know that people shouldn't go back into the notes and make a further -- even should it be a full stop. Notes should not be altered after they're made.

THE CHAIRMAN: Well, they can be added to on the general basis that you then initial and time the addition.

MR QUINN: Exactly. Sign it and time it. It looks as though -- what I'm saying is that it looks as though the notes have been gone through again and somebody has added a time. What the time means I can't say. What the significance of it is from a clinical point of view, I can't add any weight and I can't help the chamber on that point. What I say is that, on the balance of probabilities, it looks as if there has been an addition to the notes.

THE CHAIRMAN: I think this is the first time that anybody's raised a point that the pen is different.

MR QUINN: Yes. It only becomes apparent -- when I looked at the notes early yesterday morning, it became apparent to me and to Mr Roberts that something is not right about the notes. Then I did a bit more researching in relation to the patient journey and when I turned up

the approximation by Dr Steen, it then began to make sense. That is why it's such a late submission to make. I apologise for that, but it wasn't until we were looking at the notes for another point that this suddenly occurred to us.

THE CHAIRMAN: Thank you very much. Mr Fortune?

MR FORTUNE: Let me say at once: I have no instructions on this point because I've only just literally heard my learned friend and, as you'll observe, Dr Steen is not here. But if one looks at the journey -- and let's keep our feet firmly on the ground -- with reference to the ward round by Dr Sands, there is, on the fourth line of the entry in the journey, "rectal diazepam". We know from looking at the prescription that rectal diazepam was administered at 12.15 because, of course, there is a signature, that of Dr Stewart for the prescription, that of Nurse Linskey for administering it. So we can see that the prescription was written on or certainly before 12.15. It's unlikely to have been after 12.15.

So it's going to be some time between 11 o'clock and 12.15. Is that in itself significant? That would be a matter for you, sir. But there is clearly no further evidence at the moment. Insofar as the next entry on the journey is concerned, approximately 12.45, the penultimate line for that entry refers to "hourly CNS

obs". And we know from the chart, which is 090-039-137, that the observations start, if I've got the right date, at 1 o'clock. And my learned friend agrees --

MR QUINN: I agree with all that. That's why I think it's so significant that the approximate time has been put in when we know that there's a time on the chart at 4 pm.

MR FORTUNE: Well --

MR QUINN: She should be writing in 4 pm. I don't want to delay any more, but that's the ...

THE CHAIRMAN: I'm conscious of the fact that we've got Dr Carson in the witness box and he's waiting to finish his evidence and I have promised he will finish this afternoon.

MR FORTUNE: I'm sorry, sir, to have intervened.

THE CHAIRMAN: No, I'm not complaining. Unfortunately, we can't bring up the patient journey on the screen. It's 4.35. We'll have to pick this up tomorrow at some point, Mr Quinn. I will postpone the ruling I was going to give tomorrow morning, okay? I'm sorry about that, for putting that off again. After tomorrow, I'm sitting again on Monday week for the start of Raychel and we'll pick this issue up tomorrow when we've got hopefully a little bit more time and I will give the ruling on Monday week. Thank you.

Mr Stewart?

DR IAN CARSON (continued)

Questions from MR STEWART (continued)

MR STEWART: Thank you, sir.

Dr Carson, back to the aftermath of the inquest hearing. We've seen the note made by Dr Murnaghan in which he notes that he agreed with you to deal with matters as a risk management issue and to arrange a seminar. When the seminar didn't take place, did you think to remind him?

A. Regrettably not. Other pressures, presumably, intervened and I didn't. I know he said that he was off on sick leave at that period of time. So I suspect I was fairly pressed in other areas.

Q. Did you share a secretarial staff?

A. No.

Q. Mr McKee has told us that Dr Murnaghan was charged with disseminating lessons from inquests internally. He doesn't seem to have done anything. Does that surprise you in this case?

A. To the best of my knowledge, there was very little dissemination, if any, following inquests at that time. Certainly, as we started to develop the contribution that negligence cases could bring to governance in its totality, but also to the learning, then certainly Dr Walby had refined a process so there was learning at

that stage, and that information was shared within the Trust, yes.

Q. And would you agree with me that now, having come to understand the case rather better, that there was indeed much learning to be derived from it?

A. I would agree, yes.

Q. And can I ask for 023-045-105 to be shown? This is an e-mail from Christine Stewart, who is a press and public relations officer, to an individual in the department in September 2004. This is in the run-up to the broadcast by UTV of their documentary. She tells him:

"I have just spoken with Dr Bob Taylor, consultant anaesthetist in PICU, who was involved in the management of Adam Strain and gave evidence at the inquest. Following a detailed examination of the issues surrounding patient [Adam Strain], there were no new learning points, and therefore no need to disseminate any information."

What do you think about that?

A. Can I ask, was this record of the 20 September -- I've forgotten the timeline here. Was that before or after the TV programme?

Q. It's about a month before.

A. A month beforehand?

Q. Approximately.

A. I am afraid I would have to disagree with Dr Taylor there.

THE CHAIRMAN: The other point is, with all due respect to Dr Taylor generally, he's the last person to ask about whether there's any learning points from the inquest. Sorry, he could either be the first or the last.

A. Agreed, yes.

THE CHAIRMAN: This is just another unhappy contribution, I'm afraid, isn't it?

A. I accept that. I think, you know -- I have mentioned -- and I'm on record as saying -- that we don't learn very well. We all know that speeding kills, but we still -- unfortunately, despite all the improvements in car safety and so on, people still unfortunately suffer road accidents and deaths. But the people who learn most out of these are probably the families and the people immediately involved, either those who are permanently injured ... And to a certain extent I think there's a correlation in the Health Service as well: the people who learn most are probably those most directly affected. I'm surprised at Dr Taylor's comments at that time, although I think he obviously, in the context of his subsequent evidence to the inquiry, has recognised that his judgment was incorrect.

MR STEWART: But further than that, it seems that he's

saying that there has been a detailed examination of the issues surrounding Adam Strain. That isn't just perhaps avoidance; that is an outright lie. There was no detailed examination --

MR UBEROI: I'm not really sure that this generalised comment on this document is intended to assist the inquiry. The document was put to Dr Taylor, he doesn't remember it, I can see the observations you have made, sir, on it, but what is this witness expected to add to that position?

THE CHAIRMAN: If he's referring to the inquest as the detailed examination, then there was a detailed examination at the inquest; there was no other detailed examination.

MR UBEROI: I accept that, sir. The point is really that, as far as it can be taken, the point was put to Dr Taylor and he answered it as best he could in evidence before you.

THE CHAIRMAN: Thank you.

MR STEWART: In short, there was no detailed examination -- apart from the inquest -- by the hospital either after the death or after the inquest or after the settlement of the medical negligence claim; is that correct?

A. That is correct.

Q. And there should have been.

A. I would agree.

Q. And who is responsible for that?

A. I suppose I am ultimately responsible for that.

Q. We'll change the subject now.

Staffing levels. You were responsible for staffing levels, your professional responsibilities are stated so:

"Advise the Trust on medical workforce policy, including staffing levels."

Was there much in the way of discussion of resource and staffing issues in the mid-90s?

A. Oh yes, absolutely. I have indicated that that was an issue in the Trust right from the establishment in 1993. Staffing levels were a constant debate. I hinted also that it was a source of irritation and frustration to senior doctors in particular because they were constantly looking for additional staff, either additional consultant colleagues or to strengthen their junior staffing establishment. The same applied to nursing, same applied to access to beds. There were huge pressures in the system.

Q. It's come into particular focus in this inquiry, most especially in relation to Claire's case, most especially in relation to the workloads expected of the staff on duty on the evening of 22 October. Dr Bartholome, who

was the sole registrar on duty that night in the hospital, had to cope with the entire hospital of 114 patients and 12 wards, in addition she had to look after the Accident & Emergency department, it was felt that that was a wholly unrealistic workload.

A. I think there was also a registrar covering the surgical side as well. I don't demur from what you're saying.

Q. If that was the case, would that have posed a patient risk at the time?

A. Yes, it does. But I have to say that the Children's Hospital was not the only area of our hospital where junior medical staffing was under pressure. A&E units, surgical units across the Trust, hugely. And junior doctors' hours were a persistent challenge to the Trust for many, many years, long after even this particular issue.

THE CHAIRMAN: Let me bring this forward now because it's clear beyond doubt that this actually may have been a factor which contributed to Claire's death because when Dr Bartholome was called to see Claire after she had had a seizure at about 11 o'clock, she didn't actually get to see her at all. There is a debate about the extent of Claire's condition at 11 pm, but unfortunately, because Dr Bartholome was preoccupied elsewhere, she just didn't get to see Claire so Claire

was left without a doctor's attention for the last four hours before 3 am. I have then heard that there are now three registrars on duty rather than one. Am I right in understanding that's mostly as a direct result of the working time directive or is there more to it than that?

A. There may be more to it, but I suspect the working time directive was a significant contributing factor to that. I think also possibly there may well have been changes in postgraduate medical education that have necessitated an increase, there may have been some centralisation of services from other smaller hospitals that no longer provide out-of-hours cover for paediatrics. I'm not up-to-date on that.

THE CHAIRMAN: That's one point. The second point I want to ask you is this: Dr Bartholome on that night and, I think, Dr O'Hare on the Monday night into Tuesday morning, they'd worked all day from 9 o'clock. They're then on the overnight cover and then they work on maybe until midday or 1 o'clock the next day, so in fact it ends up as a 28 or maybe a 30-hour shift. Even though there are now more doctors, are there still doctors who are working that length of shift or something like it?

A. I honestly don't know. I am not close enough to the -- that would be something that would be better addressed directly to the Trust currently. But what I would

say -- I mean, I've been there, done that, got the scars from doing that sort of pattern of work myself. The other issue that we would need to ascertain would be the intensity of work that the doctor is involved in over a protracted period of time.

And I know this was one of the things that when the task force was established in the department to try and address regionally the issues around the working time directive, there were all sorts of schemes put in place to try and rectify the problem, removing from doctors unnecessary tasks like clerking and filing and stuff. Inappropriate duties like venesection, these were added to the clerical staffing levels. We trained assistants to do venepuncture and so on and so forth. As well as that, there would have been a restructuring of the way in which on call was delivered, partial shifts, full shifts. So all of these steps, as well as creating additional consultant posts to try and address the issues. But that's got to be seen in the context of a 3 per cent per annum efficiency target for the Trust. There were huge pressures there, and I indicated as well that the oversight and the other avenues that need to be pursued is first of all getting college approval, college recognition for additional posts and then getting the funding and the resources in place. So

these would not have been able to have been addressed very quickly by the Trust.

THE CHAIRMAN: The point I'm getting at is that it's one thing for there to be one or two extra registrars on duty overnight to assist somebody like Dr O'Hare or Dr Bartholome from those years ago. But if you're still working the night cover having done a day shift, then let's take an example, by 3 or 4 in the morning, when you've been on duty, when your body is naturally very tired, your judgment isn't going to be anywhere near as sharp as it is even between 9 and 5, is it?

A. That's been well recognised for many years, chairman. Errors and risks are associated with prolonged periods on duty.

THE CHAIRMAN: And it comes back -- it even plays into Adam's case where perhaps the last thing that Dr Taylor ever wanted to receive on that Sunday night was a call to ask if he could do a transplant in the early hours of Monday morning. He'd been on all week and he'd been covering the weekend. And to do something as intricate as a transplant operation in the early hours of Monday morning was an extra call.

A. I think that would have been an example of some of the issues that I would have liked to have explored if there had been an in-depth analysis or assessment of what

happened at the time of Adam's death.

If I could make --

THE CHAIRMAN: If you can hold your point in mind. The families are trying to salvage some consolation from their losses. And if that consolation is it's very unlikely that this sort of accident could happen again, if you can't help me with this, if somebody in the Trust could help me about this, we might do it later in the departmental end when we reach that in the spring.

MR SIMPSON: That might be more helpful.

THE CHAIRMAN: Okay.

A. Mr Chairman, your point -- workforce planning was ultimately the responsibility of the department and it was based on advice obviously from trusts and from specialists within their different groups. Could I, however, add to the situation? I recognise the clinical pressures situation that many junior doctors experienced. But I would have to say that the General Medical Council have made it quite clear to all doctors -- and that includes junior doctors: if a patient is outside their area of clinical competence and skill or if they are under undue pressure, they should seek help.

I'm not attempting here to apportion blame to any junior doctor, but if -- and I put this in the context,

Mr Chairman, that very often in my own clinical practice that is where I was: I was called into hospital, out of hours, to deal with emergency situations, I was called in by nursing staff, staff nurses, sisters, junior surgical staff, junior anaesthetic staff, or by other consultants. So the -- and this goes back to a certain extent to the point that was raised earlier on around consultant-led services and consultant-delivered services. At the end of the day, if a doctor is under pressure and feels that they cannot deliver a safe service, they are obliged professionally to seek help.

THE CHAIRMAN: Okay. But that's easier said than done, isn't it? When the department is saying to the Royal, "This is your budget for the next three years", you're distributing that as best you can between the competing interests. As you said, every directorate feels it's under-resourced, so on a practical level there may be little or nothing that can be done for a doctor that comes to you seeking help.

A. What I was suggesting -- and I emphasise I'm not apportioning blame here to the junior doctors who were very stretched that night -- but they could have lifted a phone to a consultant who was on call. Every consultant had on-call responsibilities. So why was a consultant not asked to come and help out if pressures

were too much for Dr Bartholome or the other SHOs?

THE CHAIRMAN: Okay, thank you.

Mr Stewart?

MR STEWART: Can we move on, please, to 2004/2006? You're now in post in the department, you are deputy Chief Medical Officer. The UTV programme is broadcast in the October of 2004. Had you heard of Claire Roberts and her case before the time of the broadcast? I know she wasn't part of the broadcast, but were you aware of her death before --

A. I was not aware of Claire's death and I did not know about it until after the televised programme.

Q. At that time, in 2004, the Trust was obligated to report the matter to the department pursuant to the circular HSS (PPM) 06/2004, which is reporting on the follow-up of serious adverse incidents.

A. Yes.

Q. And you are aware of that?

A. Yes.

Q. You are aware they didn't actually report it to you pursuant to this circular; it wasn't reported until 2006.

A. Yes.

Q. Did that have any consequences? Would the department have done anything if a report had been made?

A. Um ... Possibly, yes. They could have, yes.

Q. What type of things?

A. Well, I think -- I suspect then that was an opportunity to make a link with the Adam Strain case and potential for early learning in terms of relation to the future development of guidance. There's a possibility that that could have happened. I have to say that from my awareness of the type of incidents that were being reported to the department, again they were being inundated with what I would call -- not trivial in the sense that they weren't important, but the sort of incidents that were being reported to the department ... I think there was a genuine concern in the department that they were being increasingly referred cases that probably didn't meet the criterion of a serious adverse incident.

Q. Claire's case clearly did.

A. I accept that.

Q. And it was of huge public concern, it was a major issue and the public inquiry was called. When it eventually was reported, I think a further background briefing was requested by you; is that correct?

A. You'll need to remind me.

Q. It's not a note of yours, but it's at 139-046-001. It's an e-mail and it's the e-mail at the top. It's from

Michael McBride, then medical director, to a number of others, saying:

"The department has been informed [this is March 2006] as per circular of 2006 and have requested a further background briefing, which I will provide."

Do you have any recollection of that?

A. I have a recollection of being notified by Dr McBride, yes.

Q. Do you have a recollection of requesting a further background briefing?

A. Um ...

Q. We haven't seen any such briefing paper.

A. Sorry, can you flag up to me where this background briefing is?

Q. It's in the top e-mail:

"Dear all, for information, the department has been informed as per circular 2006 and have requested a further background briefing."

A. I honestly can't remember precisely what's happening there. But what I do know is that when the adverse incidents reporting system to the department took place, if the civil servant who administered the scheme felt that there was insufficient detail included on the form, he could have -- he or she could have followed that up

by asking the Trust to provide further details.

Q. Yes.

A. But I wasn't aware of that.

Q. Okay. The department could, in fact, according to the 2004 circular, under which the report should have been made -- it's at WS061/2, page 426 -- do you see there paragraph 17?

"Action by the department. The department will collate information on incidents reported to it through this mechanism [that's the reporting mechanism] and provide, if relevant, analysis to the HPSS and may also, where appropriate, seek feedback from the relevant organisation on the outcome of the incident to determine whether regional guidance is needed and may, in independent reviews, provide guidance in relation to determining specialist input ..."

Those are all options which could have been considered.

A. Agreed.

Q. Can I ask you: the matter seems, however, to have been reported to you somewhat earlier by the coroner; do you have any recall as to that?

A. You need to remind me. Can you put up the document?

Q. It's at 139-057-001. This is one portion only of a correspondence. I'm afraid that's the wrong

reference. Just allow me one second.
THE CHAIRMAN: Just while Mr Stewart is looking for that: from your CV, I think you were the acting CMO from January to April 2006; is that right?
A. Yes.
THE CHAIRMAN: And then there's a bit of a break and you pick up with the RQIA from 1 June.
A. Yes.
THE CHAIRMAN: So this particular reference is coming just, what, a few weeks before you leave the department?
A. My responsibilities will have continued up to the day I left, Mr Chairman.
THE CHAIRMAN: Yes.
MR STEWART: The correct reference is 139-089-001. There we are, 15 September 2005. That's the preceding year. And Mr Leckey, the coroner, is writing to the associate medical director, Mr Peter Walby. He is enclosing a medical report, an independent report commissioned by the coroner. He is describing Dr Bingham's involvement, another independent expert, and you can see at the bottom that copied into it is:
"Dr Ian Carson, deputy Chief Medical Officer."
A. Yes.
Q. Do you remember being notified by the coroner of the Claire Roberts case?

A. I would have to say yes. But I can't recall what steps or action I took personally following this being copied into this correspondence.
Q. Well, looking back now, would you agree that perhaps you should have asked for further information and perhaps asked for some sort of investigation into it?
A. This was after the inquest?
Q. This was before the inquest. The Roberts brought the matter to the attention of the hospital in late October 2004. It should, of course, have then been reported to the department by the hospital, but they didn't do that until 2006.
A. Yes.
Q. But before they reported it to you, in fact the coroner had taken that step, and the question is: did you not consider doing anything in response to that notification?
A. I suspect ... I honestly don't know how to respond to that. I suspect I would have awaited what I will call due process through the coronial system rather than the department maybe interfere or getting in the way of the coroner's inquiry. I'm finding it very difficult to contextualise things.
THE CHAIRMAN: That may very well be what happened, Dr Carson, but when you were giving evidence earlier

today and yesterday afternoon, you said that the attitude in the mid-1990s was very much that the coroner was the investigative process and I gathered, perhaps wrongly from the way that you said that, that since then things have moved on, that one doesn't wait for the coroner to investigate and sort it out. If what you did in 2005 was actually wait for the coroner to investigate it, has the mindset about investigating independent of the coroner actually changed?
A. I understand the point you're making, Mr Chairman. I suppose what I'm hinting at is that it is ... I'm finding it difficult to see what investigation the department would have triggered or carried out. What could have been ...
THE CHAIRMAN: Could you say to --
A. Do you understand?
THE CHAIRMAN: Yes. Could you say to the Royal: look, the inquest is coming up whenever it's coming up, but what's going on here, what have your investigations turned up?
A. Obviously, Dr McBride, as the medical director at that time, did conduct some sort of an investigation, if you like, so we could have asked for that. But whether they would have -- well, we could have asked for it, yes, is the answer.
THE CHAIRMAN: I have to say, I don't think they really did

do an investigation. And subject to Mr McAlinden correcting me, I don't think they conducted an investigation along the lines of the --
A. I'm only referring to the work of Professor Young.
THE CHAIRMAN: The work Professor Young did with Dr Rooney and Dr Steen was not actually an investigation.
A. No. I would accept that. Yes, it's possible that more could have been done.
MR STEWART: If lessons weren't learnt from either of these deaths, who bears responsibility for that?
MR McALINDEN: Mr Chairman, just in relation to that and the steps which Dr Carson should have taken in light of being served with a copy of Dr Maconchie's report, I think it's important to remember the conclusions reached by Dr Maconochie in his report. It's 091-007-034:
"The management plan to treat the possibility of non-convulsive status epilepticus was correct at the time of practice. Claire's subsequent management was correct and her course of treatment on the ward and PICU was appropriate [et cetera, et cetera]."
So it would appear that there would be very little that he could be expected to do in light of that report.
THE CHAIRMAN: Well, it might trigger an inquiry from him to say: well, since hyponatraemia is a pretty big issue

in the early 2000s in Northern Ireland, could I see Dr Bingham's report, which has addressed the hyponatraemia?

MR McALINDEN: Yes. It's certainly not highlighting deficiencies in the management in the context of the field of expertise that Dr Maconochie holds.

THE CHAIRMAN: Yes.

MR STEWART: This is a case referred to the inquiry, this inquiry, by that stage. It's brought to his attention in the context of hyponatraemia, so quite how far your point about the treatment of status epilepticus gets us, I'm not sure. But can I get back to the question that I was posing?

If no lessons were learnt from either of these deaths, who bears responsibility for that?

A. Sorry, before I answer that question, can I say the question you were addressing to me previously, was that before or after the inquiry was announced by the then minister?

THE CHAIRMAN: Sorry, was what before or after the inquiry, the 2005 note? The inquiry was established in November 2004 and this report of Dr Maconochie's was sent to you in September 2005.

A. I suspect, Mr Chairman, that in the light of the pending inquiry, the department were unlikely to require

a further investigation and would have left it to the good offices of yourself and this inquiry to pursue that. Sorry, can I -- do you want me to return to the second? Remind me again -- who was responsible?

MR STEWART: To this case, who bears responsibility?

A. In terms of ... I mean ... I think, system-wide, there is responsibility here. Individuals -- you can ultimately say if one is designated as X, Y and Z, then one bears individual responsibility. I think it's quite difficult in all of these cases to apportion blame or responsibility in that context.

Q. Is there blame to be apportioned?

A. I think we should be getting away from apportioning blame.

Q. Is there responsibility to be apportioned?

A. Is there responsibility? Responsibility to follow through on due process, yes. Processes, yes.

MR STEWART: I see.

THE CHAIRMAN: Thank you, Mr Stewart.

Dr Carson, this morning you had made a point to me about how things are very different now about learning lessons from events, and I said that, before you finished, I would like to come back to you on that. I'm happy to do it now or I'm wondering, since we're going to come back to the Royal as part of the departmental

wrap-up in the spring, is that a better time to do it?

Because it's the reassurance bit, Mr Simpson, for the families and for the public to say: look, certain things went wrong in these cases. What reassurance have you that things are better in place now?

MR SIMPSON: I would expect there to be other witnesses dealing with that generally, who would be -- I don't mean this in any pejorative way, but more in touch with what's happening today than Dr Carson.

THE CHAIRMAN: Subject to that developing -- and it will develop, Dr Carson -- if you want to say anything in particular on that area, but without going into the detail on it, I'm quite happy for you to do that now.

A. Well, I would like to respond to that, because I firmly believe, not only did the Trust, the Royal Group of Hospitals Trust, improve its systems and processes from the mid-1990s right through to the end of my tenure as Trust medical director in 2002, they were even taken on to a further level by Dr McBride when he replaced me. I'm happy at a subsequent date to illustrate the steps that were being pursued, even during my tenure when I was still Trust medical director and adviser to the Chief Medical Officer at that time on clinical governance issues because I think we were developing not just within the Trust, but within the service as

a whole, the Health and Social Care system in Northern Ireland, we were making progress around the whole area of managing performance of doctors, improving systems and processes for clinical risk management, for improving the focus of audit.

One of the issues in relation to clinical audit was that lots of people were involved in it, but was it really focused? Were there aspects of clinical audit that should have been seen as being priorities? Were there regional priorities in relation to clinical audit that should have been cascaded down into trusts specifically rather than letting the trusts just come up with very extensive wide-ranging audit agendas?

While I'm on this bit about audit, I detect -- and this is my personal interpretation -- that the way audit has been viewed by the inquiry, to a greater or lesser extent, is that every adverse event would result in a clinical audit. A clinical audit did not work in that way. It was not the same as putting in an auditor to determine what lapses were in place. It was broader than that and it was looking at many other types of issues.

But I suppose, Mr Chairman, if you are inviting me to make some closing remark or statement, I would like to make some.

For the families, I think I would like to give an assurance that governance arrangements in all trusts have improved, and they've improved significantly. In my present role in RQIA we are constantly reviewing in our review work and when work is commissioned from us by the minister, we are looking at the governance issues, and I would wish to give an assurance that the evidence that we are gathering would substantiate the fact that governance arrangements are improving and continue to improve.

I would go further than that. In relation to the whole area of scrutiny and accountability, this has also increased over the years that we're looking at, and that's not just professional scrutiny, through the development and introduction of appraisal systems for doctors, but also in the context of their professional registration with the GMC, the introduction now of re-validation is a very significant step forwards. So scrutiny and accountability at a professional level is in place.

I would also say that scrutiny and accountability as far as the system is concerned has also improved. I think the department would point to strengthened accountability arrangements between the department, the Health & Social Care Board and individual trusts, and

you will have seen evidence of that in recent times with the minister putting special measures in place in trusts.

In addition to accountability frameworks between the department and trusts, I think also, in the context of regulation with the establishment of the Regulation Quality Improvement Authority, there is system-wide scrutiny taking place, which did not take place in the mid-1990s or even up until 2005.

As far as the inquiry is concerned, I would want to acknowledge the remit that the inquiry have been given. I commend the rigour and the thoroughness of the proceedings. I also acknowledge the stress, not just for the families and the length of time that this has taken for them to get answers that they could have been given -- and should have been given -- at a much earlier stage, but I'm also conscious of the stress that this has placed on staff working within the Health and Social Care service, not least within the Royal Hospitals.

Also I am sure that the Health and Social Care system will benefit ultimately, Mr Chairman, from the recommendations that come from the inquiry in due course. That has been the pattern from previous public inquiries, not least the one that you previously chaired. I think the system has benefited and things

have definitely moved forwards.

However, I think as far as -- there's one other aspect that I think does need to be ... And I've attempted to do this, I think, during my evidence. I think there is an issue of context here and proportionality and balance. And I think the inquiry should recognise in all of its deliberations that alongside these particular failings -- and there is no other way to describe them -- there was at the same time excellent care, excellent safe care, being delivered by the Trust, by highly-qualified, highly-committed and caring nursing and medical staff to the vast majority of patients who were under their care. And also that the Trust board, in its development through the period of time that we're looking at, the Trust board and its officers were committed not just to important service in the public interest but also to the delivery of high-quality health and social care.

For the system -- and I'm conscious of the recommendations possibly that you will be seeking to develop over the next few months -- I think we need to ensure that the system of governance that develops and continues to be rolled out across the service -- we need to ensure that that does not become so severe and so rigid that it results in doctors specifically practising

defensive medicine, which is not necessarily to the benefit of patients and will add significantly to the cost of healthcare systems. Or that the system becomes so risk averse that developments in clinical practice are not encouraged. I think this is actually quite a difficult and a delicate balance.

I would press, Mr Chairman, and maybe as an outcome from this, I think that further work needs to be done in the whole area of redress. I personally find it disappointing that the work which was led by Sir Liam Donaldson in his publications "Making amends" and the document that was circulated around being open, those were two important documents that came out of the NHS in England, which pointed to a new way of communicating with families, relatives, patients, and also the system trying to develop new mechanisms other than negligence litigation specifically to compensate for damage to patients.

So I think there are models of redress that do need to be explored. I would go on. Reference has been made, in the context of the inquiry, to the coronial system. I co-chaired with David Lavery and the Court Service aspects of the reform of the coronial system in Northern Ireland alongside the work that was conducted as part of the Luce review. But I think there are

opportunities, Mr Chairman, for further development and further progress in that area -- I think specifically in the area of investigation of death.

It was my anticipation, certainly whenever we were doing work on the reform of the coronial system, I had anticipated that there would have been more work emerging, both in England, but also in Northern Ireland in the regard to advice and guidance given to the service as to how deaths should be investigated. And I think, if anything can be done in that which would, first of all, improve learning, obtain answers to give assurance to patients and to the public as a whole, that would be beneficial.

I think, in addition to that, I have hinted that we are not good at learning lessons. I think more needs to be done on how the system learns from adverse incidents. I say this in the context of Northern Ireland specifically because this is a very small place. The possibilities of significant learning from maybe rare conditions such as we've been discussing within the inquiry -- I think it's difficult to gather that learning in a Northern Ireland context and responding promptly and quickly and with appropriate measures, putting them in place.

I personally find it -- when I was working in the

department, disappointment that the National Patient Safety Agency and its attempt to put in place a national reporting and learning system, I was disappointed personally that that wasn't rolled out in Northern Ireland. I was very pleased that the department actually, in contradiction to that, did roll out arrangements with the National Clinical Assessment Authority, which later became known as the National Clinical Advisory Service. We did tie into that and that was very beneficial for trust medical directors in terms of assisting them and helping them how to handle issues of underperformance within the Trust.

I think interestingly, in Northern Ireland, as well -- in England, the NHS litigation authority is managed on behalf of NHS Trusts ... issues in relation to clinical negligence, they manage the process, but they were also a repository of knowledge and learning. And it is disappointing that something like that was not put in place in Northern Ireland. And I think there are also opportunities such as that that would strengthen and improve systems. I think the work of IHI, the organisation based in Boston, USA, which has a particular interest in patient safety and learning from accidents and incidents -- it's interesting that, in Scotland, the Scottish Health Executive have embraced

fully the work of IHI and have rolled that out across trusts in Scotland.

So I think there is a necessity in the -- within the context of the smallness of Northern Ireland for Northern Ireland to be linked to other organisations so that learning can be disseminated more effectively than it currently is.

The final point I would make, Mr Chairman, and maybe this comes as no surprise, and I make it in the context of being chairman of RQIA -- and this is a personal statement, it's not a statement that I have sought the approval of my own board on. But I think there are issues about strengthening the role of the regulator in regard to safety and other adverse incidents. The powers that RQIA currently have -- we have extensive powers as far as the regulated sector is concerned: nursing homes, children's homes, residential homes. We can, on the evidence, based on the evidence of failings, issue a number of enforcement -- take a number of enforcement steps going up as far as prosecution.

As far as the statutory sector is concerned, the hospital service in particular, we do not have the same powers. We don't even have the same powers that the current regulator in England, the CQC, have. The system in England is different. The CQC have powers. All NHS

organisations are required to register with CQC. Potentially, CQC could remove recognition from a trust or a PCT. I'm not seeking for equivalence there because -- I need to be careful how this is recorded.

CQC have suffered from failings, have been accused of failings themselves and have not delivered maybe systematically with the effectiveness that I think was -- and for example, the inquiry into Mid Staffordshire may bear this out in due course.

But the point that I'm really making here is, as far as the hospital sector is concerned in Northern Ireland at the moment, there seems to be nothing in terms of strengthening enforcement between local action being taken in a trust and special measures being instituted by the department, by the minister. And I think there is something in between that. I think implementing special measures is -- "heavy-handed" is not the right word.

THE CHAIRMAN: Is it a last resort?

A. A last resort, yes. And there's only two things can happen. Either the trust complies and special measures are removed, or other measures -- if they cannot comply, then other measures can be put in place. But I think there's something short of that. I am aware, for example, in England that CQC, before Christmas --

in November I think, or December -- of last year, on the basis of investigations that they were carrying out as part of their routine regulatory function, they became aware, for example -- and this is only an example -- in the Basildon & Thurrock NHS Foundation Trust. They required that trust to carry out an independent investigation into children's services in that particular trust.

Now, RQIA would not have the powers currently to do that. The way we conduct our programme of work as a regulator is we have a programme of systematic reviews that we carry out and the only additionality to that is that the minister can commission work from us, such as he did for Clostridium difficile for pseudomonus or the reporting of radiological X-rays. This is again, I have to say, a personal view. I think this could be strengthened in due course. So with those possible recommendations, I would close my statement.

THE CHAIRMAN: Thank you very much indeed.

MR FORTUNE: Sir, you said you would deal with the Koffman point.

THE CHAIRMAN: Yes. Could you bring up for me, please, the transcript of 16 May, page 150?

MR FORTUNE: You'll recall it was Mr Koffman who was the surgeon at Great Ormond Street and Guy's Hospital.

MR UBEROI: Sir, may I rise to make this observation? Obviously, it's a matter for you whether you're interested in Mr Fortune's point. I just wish to set out this query as whether to nor this extract has in fact been overtaken by the work of the inquiry subsequently. Mr Koffman in his question and answer exchange is offering a view about matters long in advance of the governance evidence, which you have taken in the Adam Strain hearings, and specifically in advance of the evidence offered by Dr Murnaghan.

So he's talking about the situation whereby there's a discussion and then, after the coronial verdict, there may be a more formal meeting and what steps would be taken if, after that meeting, it becomes apparent that a clinician does not accept the verdict. What I mean by suggesting that the evidence has overtaken this extract is a reference to the evidence of Dr Murnaghan, where he said that the system breakdown really was in him never convening that meeting, and the evidence he offered was, I think, words to the effect of "mea culpa" and "I regret to this day that I didn't". So I do query whether we've already got the answer in fact to the sorts of issues that are being explored in this extract.

MR FORTUNE: I'm invoking the power of the medical director because of course this is a matter of governance. It's

not seeking to ...

THE CHAIRMAN: Am I right that the point from this extract, is if you have an issue whereby a doctor has appeared to be vulnerable to criticism -- appears to have made an error, to put it bluntly -- whether or not he accepts the inquest verdict is an element of it, but not decisive. But whether he appears to have made an error, it's aggravated perhaps by not accepting the inquest decision. The gist of this is that that should make its way to you, and I think you have accepted that. This should have made its way to you and not just in the general sense about, "Let's look at the renal transplant service provider from the Royal", but specifically about Dr Taylor's position. And the issue then is -- sorry, the graduation was: well, first of all, you need to make sure, you need some reassurance that a doctor, let's take it away from Dr Taylor for a moment, but you need to make some reassurance that the doctor involved was safe to practice. And if he wasn't accepting an inquest verdict, that would certainly raise an issue about that. That's not to say that every inquest verdict has to be right, but it makes his position more difficult, doesn't it?

A. Yes, I think I would concur with that. I think there are difficulties around it. In the context of ...

I would have to say that if the conclusion of the verdict from any inquest -- I, as a trust medical director, would have to accept that verdict. That's different from me, if I was the doctor involved, whether I did or didn't agree. But I would have to say that in terms of the system and the governance responsibilities of the trust, then the trust would be obliged to accept the independent --

THE CHAIRMAN: Yes. In this instance, from one point of view, it doesn't matter whether -- sorry, it matters less whether he accepts the verdict. But the fundamental question is: does he accept he made a very serious error?

A. Mm-hm.

THE CHAIRMAN: And what reassurance have you that this will not happen again? That's a fundamental point, isn't it?

A. It is, and it's difficult to ascertain the way forward on that.

THE CHAIRMAN: Ultimately, if you don't have that reassurance, are you in a position that you have to consider whether it's safe for that particular doctor to continue to work?

A. Yes. The judgment that I would have to exercise there would be based -- I would have to seek the opinions, the advice of other doctors. And in relation to what

Mr Koffman, as I've read this transcript -- he is a practising surgeon. Would he have been happy to work with a doctor who had singularly failed in one aspect of care? And he said -- um ... I think he was looking or expressing the view that maybe that doctor should not continue to practice.

Now, the extension of that thinking is if other doctors did not express a concern about the practice of the doctor, would I have done anything further. What I'm hinting at here -- it's difficult not to apply this to the specific case, but if Professor Savage and the surgeons and the other anaesthetists had not expressed a concern about Dr Taylor's practice, current practice, practice to date, practice currently, then it would have been quite difficult for a trust medical director to take any specific action.

THE CHAIRMAN: I think my problem with that is that -- I think it was even before the inquest -- Dr Taylor had been involved in another transplant. Now, in effect, therefore, he was involved in another transplant at a time when he was not accepting what had gone wrong with Adam. Now, I'm not sure -- and I know that he could not have continued to do that or it's unlikely he would have continued to do that had Professor Savage strongly objected.

A. I agree.

THE CHAIRMAN: My query with Professor Savage is where did he get his reassurance? You'll have seen this in the transcript. The concern is that if you have a good doctor who makes terrible mistake, in a sense that's almost harder to deal with than one of the underperforming junior or locum doctors who you were talking about earlier.

A. And I don't know where the quotation comes from, but some of the best doctors make the biggest mistakes. I don't know who that's attributable to, but that is a fact and that's the history of it. I suspect, chairman, in the context of this case, what I would have expected to have happened -- I made reference to the convention that I was familiar with in the 1970s and 1980s and 1990s. What I would have expected as a trust medical director here, putting myself in the position in 1995, I would have expected an early local discussion, investigation, whatever you want to call it, to take place, to be undertaken by the team. And to a certain extent, I think the evidence, as I read it -- to a certain extent, that did take place.

That was an opportunity for concerns to be raised about any doctor's practice within that, and that should have come -- and there was an opportunity with two

clinical directors, both Dr Gaston as the clinical director in ATICS, and Dr Mulholland to, if you like, escalate any issues or concerns. And in their judgment then they would have to professionally decide whether this was a matter that needed to be brought to the trust medical director.

THE CHAIRMAN: The trouble about that, of course, is that Dr Mulholland didn't know about it and Dr Gaston appears from his evidence here to have been influenced by the fact that he was terribly short of paediatric anaesthetists, and if Dr Taylor was stood down, even on a temporary basis, his service would have been in crisis. In fact, I'm not sure his service wasn't already in crisis from time to time. But his service would have been in crisis if he had lost Dr Taylor.

A. Mm.

THE CHAIRMAN: So what you have there is -- I mean, in a perfect world this doesn't happen, but in the imperfect world you have the continuation of Dr Taylor without resolution of the issue which had at least contributed to Adam's death on most approaches other than Professor Kirkham's and which was left unresolved. That's not reassuring.

A. It's certainly not ideal, chairman, certainly not ideal. It is gratifying that Dr Taylor was able to return to

continue with his clinical practice without putting patients at risk.

THE CHAIRMAN: Okay.

MR UBEROI: Sir, if I may say, that is a better way into it, in my submission, in terms of the totality of all the evidence referred up to this date, the way you've handled it. Thank you.

THE CHAIRMAN: Mr McCrea?

Questions from MR McCREA

MR McCREA: Doctor, yesterday, and again this morning, you conceded that in your opinion the system had failed Claire in 1996. The question I wanted to put to you -- well, there are two parts to it. The first part: why in your opinion do you believe the system failed Claire? And the second question would be: do you believe there's anyone in particular that was responsible for that system's failure in 1996?

THE CHAIRMAN: Well, I'm not -- I understand why the Roberts are concerned about that, Mr McCrea, but is that not the area that we've gone over at some length? I think the system failed in --

MR McCREA: He set out this afternoon or this morning, later on this morning, in his opinion what the failures were, but didn't -- the question wasn't asked, I don't think, why. Why was that?

A. Well, I mean, chairman, I would answer by saying the inquiry has uncovered a lot of the factors that led to those failings, whether it was workload, whether it was poor communication, whether it was administration of drugs, or the fluid situation. I think those have all been brought to the attention of the inquiry. Why did the system fail? Well, I think professionally it failed, I think system-wise much more could have been done to provide information, better information, clearer information to the family at the time, and I would have thought that that would happen nowadays compared ... It's difficult. I don't know.

Who takes responsibility for this? I think individually, professionals do. Whether they're individual consultants, individual doctors, whether it's doctors involved -- clinical directors, medical directors or the trust as an entity takes responsibility. What is quite clear with the introduction of the 2003 order, ultimately the chief executive now takes responsibility for quality of care. That is the duty of quality that came into being with the 2003 order. So in that sense, the ultimate responsibility is now -- is clearly defined as to who takes ultimate responsibility on behalf of an organisation. That was much less clear in 1995/1996.

THE CHAIRMAN: Okay, thank you.

Mr Hunter?

Questions from MR HUNTER

MR HUNTER: Dr Carson refers to Dr Taylor carrying on without incident after Adam's death. Is that based on what he knew at the time that he says that?

THE CHAIRMAN: Let me slightly re-frame that. You didn't know that there was a particular issue about Dr Taylor at the time. But when you say now that he carried on without incident and you're gratified and relieved about that, is that on the basis that no other incidents in which he was involved were ever drawn to your attention?

A. I was never aware of any complaints from patients, relatives, nursing staff, medical staff. No complaints about his practice, his behaviour, his performance. That was never brought to my -- and I wasn't aware of any.

THE CHAIRMAN: Okay, thank you.

A. In the context no other issues were ever drawn to my attention in regard to Dr Taylor, and in fact he continued to make a very valuable contribution to the work of the hospital and to the work of the Children's Hospital in particular, and to the trust as a whole in his involvement in areas around clinical ethics and so on and so forth.

THE CHAIRMAN: Yes. I'm really not trying to be clever, but the point is that the original mistake that he made was never drawn to your attention either.

A. No.

THE CHAIRMAN: So it's not necessarily a safe assumption that because no further complaints were made about other incidents that there weren't any. Because the one major error that he made in Adam's case didn't reach your ear at all.

A. No.

MR HUNTER: I think Dr Carson referred to these deaths as being extremely rare or rare. It's just to say that the Secretary of State in 2005, in answer to a parliamentary question, gave, I think, a figure of 60 hyponatraemia or hyponatraemia-related deaths here over a 20-year period.

THE CHAIRMAN: Yes, but I think if my understanding is right about that information, Mr Hunter, hyponatraemia is a complication which frequently arises and is very difficult to manage in elderly patients because as we get older and sicker and our bodies begin to fail, hyponatraemia becomes more difficult to manage. But in the context of children, I don't think that's what that reference to 60 deaths was referring to at all.

There's nothing further from the floor, Dr Carson. Thank you for your time. Your last contribution may

earn you a recall in the spring or summer, but we'll see about that. Thank you for your time.

We'll start tomorrow morning at 10 o'clock with Mr McKee and then I have asked you to think about Professor Mullan.

What outstanding issue did you want to ask me about, Mr Fortune?

MR FORTUNE: It's only a matter of housekeeping as to whether you anticipate finishing tomorrow.

THE CHAIRMAN: Yes. I understand that from some preliminary discussions between Mr Stewart and Mr Simpson and Mr McAlinden that it's anticipated that Mr McKee will now be a comparatively short witness because the vast majority of the ground has been covered by the deputy chief executive and medical director, so much of this territory doesn't need to be gone over.

There are some issues that Mr Stewart will want to raise and I think there are some issues which Mr Simpson has specifically indicated he wishes to be raised. I don't think there's much disagreement on that. I will leave you to resolve between yourselves the extent to which, in light of Dr Carson's evidence and tomorrow morning's evidence from Mr McKee, Professor Mullan is required. Professor Mullan will be here tomorrow, so if he is required to give evidence, he will do that, but

the extent of that evidence can be considered between tonight and tomorrow. Thank you very much.

(5.45 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X