Thursday, 17 January 2013

(10.00 am)

(Delay in proceedings)

(10.17 am)

THE CHAIRMAN: Good morning.

MR STEWART: Good morning, sir. I call William McKee, please.

MR WILLIAM McKee (called)

Questions from MR STEWART

MR STEWART: Good morning.

A. Good morning.

Q. You were good enough to furnish the inquiry with a number of statements, being WS061/1, 25 June 2005, and WS061/2, 25 May 2012 -- in relation to Adam's case -- and WS271/1, 14 September 2012 -- in relation to Claire's case -- together with three letters addressed to the secretary to the inquiry of 26 July 2005, 5 August 2005 and 15 August 2005. Are you content that they should all be adopted by the inquiry as part of your formal evidence?

A. Yes, chairman.

Q. Thank you. You've also supplied a copy of your CV, which appears at page 306-078-001. We find, after your introductory paragraphs, the penultimate paragraph:

"... [working] in a sequence of posts and being

appointed in 1989 as general manager."

You held that post for a number of years. Is that the same post as the UGM we heard about yesterday, the general manager of a hospital?

A. I believe so, chairman.

Q. After that, you went on to become a chief executive in 1992, and as the first founding chief executive of the Trust in 1992, and you continued to lead the Trust until its conclusion in 2006, when you went on then to become a chief executive of the overall Belfast Health and Social Care Trust; is that correct?

A. Well, it's a minor detail, but I suppose I was -- I took up post as chief executive designate of the Belfast Trust six months before the Royal Hospitals were dissolved.

THE CHAIRMAN: Is that the same way as you became chief executive from 1992, which is a bit before the Royal Group Trust was --

A. No, chairman. The Royal Group of Hospitals obtained self-governing hospital trust status in 1992, but it was deemed not to go operational until 1993.

THE CHAIRMAN: I see, okay. Thank you.

Am I right, there's one typo on the first page of your CV, Mr McKee?

A. Only one?

THE CHAIRMAN: I think, on the fifth paragraph, it says in 1970 you took a gap year. I presume that's 1980; is it?

A. No, I'm afraid it's 1970, chairman.

THE CHAIRMAN: Sorry, okay.

A. It was a gap year between school and university.

THE CHAIRMAN: Got you. Thank you.

MR STEWART: When the Trust was formed, did you play a role in appointing the executive directors to the board?

A. No. The practice at that time was that if a trust senior team was deemed capable of preparing a successful application for trust status, then by and large they were transferred to the trust. My post was the only one in the history of establishing trusts in Northern Ireland that was advertised nationally and openly.

Q. The Trust was formed on the basis of the 1992 order, the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust Establishment order, Northern Ireland, 1992. It's a minor point, but I wanted to ask you why, on the board, there were four executive directors and four non-executive directors when the order suggests there should be five of each; are you able to assist?

A. Well, my memory is failing on this, but I believe that we had five and five. Sorry, you're not -- I presume

that the chairman is not being included as a non-executive director.

Q. Yes.

A. Conventionally, there are a chairman and four non-executive directors -- or five, is it? -- and four executive directors, including the chief executive. In other words, the key to this is that there is a built-in majority, including the chairman, of non-executive directors on a board.

Q. 305-160-022. This is article 4.1 of the order, which says:

"The Trust shall have, in addition to the chairman, five non-executive directors and five executive directors."

I'm looking at the annual report for 1995/1996, which sets out the Trust board membership. And that's at WS061/2, page 90. We see the four executive directors: you, with your finance director, medical director and nursing director, making four in all. We see the non-executives being George Baird, John Carson, Sister Turley and Dr Wilson, with Sir George Quigley chairing it. I was simply asking why you appear to have four executive and four non-executive when the order seems to specify five of each.

A. This is a particular snapshot in time. We changed

chairman at the turn of the year, so we had to report two chairman, but one of those chairmen, Paul McWilliams, had been a non-executive director and there may still have been a vacancy at that point of that particular snapshot in time.

Q. Your duties and responsibilities were both in relation to the operation of the Trust and, of course, the finances of the Trust. First of all, in relation to the finances, I wonder, could page WS061/2, page 139 be shown? This is part of the financial report from the 1995/1996 annual report. We see here on the right-hand side of the page how the chief executive of the management executive of the Department of Health, as accounting officer, has designated you, Mr McKee, of the Royal Group of Hospitals Trust as the accountable officer for the trust:

"His relevant responsibilities as accountable officer, including his responsibility for propriety and regularity of the public finances for which he is answerable and for the keeping of proper records, are set out in the accountable officer memorandum."

Can I ask: does that memorandum cover your duties and responsibilities apart from the financial responsibilities that you bore?

A. Chairman, I can't recall the detail of it, but I would

make two points. The first is that in 1993/1994, the first year of the Trust, and subsequently for many years, I was specifically not held responsible for clinical safety, clinical quality, clinical matters. But if you go back to that, I suppose if you had looked at the detail, it would have talked about those responsible for the organisation acting legally, acting with proper propriety, protecting the public purse, et cetera. But they would have been confined to financial and general administrative or general managerial functions.

Q. Would those general functions have included a responsibility for the provision of hospital services in the broader sense?

A. In the broader sense, yes.

Q. And for the efficient and effective management of the hospital?

A. Well, I'm not sure it specifically says that in the accountable letter. I can't recall the accountable letter.

Q. Could I ask you to use your best endeavours to see if you can find a copy of the accountable officer memorandum?

A. I'm retired now, chairman. I don't think it's reasonable to ask me to search for it.

Q. Very well. I'm sure the DLS will undertake to. I'm most grateful.

THE CHAIRMAN: The other source is the department, isn't it? Because if it's the department which designates the chief executive's accountability, it should have the --

MR SIMPSON: [Inaudible: no microphone] we'll ask whether it can be done.

THE CHAIRMAN: Okay.

But, Mr McKee, your important specific point for the purposes of this inquiry is that you were specifically not held responsible for clinical safety, clinical quality and clinical matters.

A. Well, a circular was issued, dated January 2003, if my memory serves me right, entitled "Governance in the HPSS", and there is a specific paragraph that says:

"You now have this duty of quality and you must take due regard to quality as much as in the past you've been held accountable for financial matters."

I think it's pretty unequivocal.

MR STEWART: Let's explore what in fact you were accountable for.

THE CHAIRMAN: Sorry, Mr Stewart.

I think you said:

"... from 1993/94 and for a number of years."

A. Yes.

THE CHAIRMAN: Did it then change later?

A. The circular was dated January 2003, so that becomes the point at which the duty of quality passed to the chief executive and the board, or a duty of quality was given to the chief executive and the board of directors, and that signalled the start of the introduction of guidance from the Department of Health Northern Ireland around clinical governance that we may or may not come to.

THE CHAIRMAN: Okay.

MR STEWART: But in broad governance terms, you were nonetheless, in 1995/1996, responsible for the effective management of the core business of the organisation, which was running the hospital?

A. I see, I can't be sure. In fact, I suspect it doesn't -- it didn't actually say I was responsible for hospital services in the accountable officer letter. But I will stand corrected if a copy is obtained.

Q. Did you also sign up to the code of conduct and a code of accountability at that time?

A. Well, I'm not sure I was asked to sign anything in that regard, chairman. I can't recall whether you had to acknowledge receipt of your accountable officer letter, and I'm not sure if those codes of conduct and accountability were in the accountable letter. But I'm

aware of the code to which I was expected to operate.
Q. You were aware of both the code of conduct and the code of accountability?
A. Yes.
Q. Can we have a look at them? It's 306-096-001. Sorry, sir, there seems to be a service delivery problem. (Pause).
THE CHAIRMAN: You've been too long in the inquiry, Mr Stewart!
MR STEWART: Perhaps Mr McKee, if you allow, we'll return to that in due course.
A. Of course, chairman.
Q. That sets out in broad terms what might have been expected of those serving on the boards in terms of their accountability, probity, general principles of openness and so forth. And they are couched in broad terms, but clearly you were to serve within the principles of the NHS at the time.
A. Well, Health and Social Services in Northern Ireland, because I think there is a nomenclature problem, chairman, that the NHS is a social construct and is used generally for publicly provided health services in England, Scotland, Wales and Northern Ireland. Northern Ireland has had a devolved administration of some sort or other since 1922 and has had continuously

a Department of Health and Social Services and Public Safety, as it's called now. And it is that department that has been responsible for health services, health and social care services in Northern Ireland.
So yes, the NHS is a is a loose term used to describe that, but it will become important, no doubt, in giving evidence to make that distinction.
Q. I wonder, can you assist with the interpretation of this document? It's the 1993 health and safety policy, which appears at WS061/2, page 232. November 1993. If we go to page 235, we'll find your introductory statement where you commend the policy and you say there, just above your signature:
"This policy has my commitment and I expect all employees to give their commitment too."
The document proceeds via the usual risk management, health and safety, clinical risk management sections, to the responsibilities of individual officers, appearing at page 244. The responsibilities of the chief executive are stated to be:
"Being responsible to the Trust board for the effective management of health and safety by the Trust and for achieving the aims of the health and safety policy statement. He will: (a) report at regular intervals to the Trust board on health and safety

performance through the organisation and set targets ..."
In terms of your responsibility for health and safety policy -- and this is the policy here (indicating) -- how did you interpret that at the time?
A. Chairman, could we return to page 235, please?
THE CHAIRMAN: Yes.
A. I haven't seen this document since it was written, and I would have used it, but I'm glad to see it. I think the key to this is the chief executive's statement where I make it clear that this is a policy and that the arrangements contained in it are required by the Health and Safety at Work (NI) Order 1978 and the Management of Health and Safety at Work Regulations (NI) 1992. So this is a conventional employer responsibility for health and safety, it does not cover clinical safety or quality. So it meets the requirements of these two particular pieces of legislation, which are wider.
THE CHAIRMAN: In other words, this is the sort of policy that we could expect to find in a factory?
A. Exactly, chairman.
MR STEWART: Can you explain the relevance of page 241 to a factory, please? This is the medical risk management group, which has responsibility for clinical risk management in the Trust and its undertakings, and the

medical risk management group, you'll see halfway down the page, has specific responsibilities for:
"Clinical audit, research register, untoward incident reporting (clinical), medical negligence and complaints."
That's part of the policy. Then there are arrangements for the coordination of this group with other groups for the overall administration of health and safety in the Trust.
A. As chief executive, at the date of this document and for many years subsequently, I didn't have responsibility for clinical safety or quality. However, it was reasonable to incorporate the work that was being done and led by clinicians into this document to try to make it more holistic. But you can't infer from that that I was assuming responsibility or, more importantly, had responsibility for medical safety or quality. And in fact, it identifies the director of medical administration as the key person who would act as a hinge between this self-regulating zone under the GMC and the work of the Trust to try to comply with its statutory responsibilities around health and safety. I think, looking back, the Trust is to be commended in trying to bridge those two pieces.
Q. Well, with respect, what this page says is that the GMC

does not have responsibility for the clinical risk management in the hospital, but rather the medical risk management group does. And with respect, what page --

A. Where does it say that?

Q. The top of the page.

THE CHAIRMAN: The opening line.

Before we develop this, just to make it clear, when you say, Mr McKee, that you were not responsible, you were not held responsible for clinical safety. Just to make it clear, who was then responsible for clinical safety?

A. I have to really say that the last 20 years of the history of the various components of the National Health Service across the United Kingdom have been a steady shift from relying entirely on professional self-regulation under the auspices of the GMC established by the Medical Act in the 1850s and managerial and corporate responsibility for medical health and safety. And the key milestone is a circular dated January 2003, from the department, that said from now on the chief executive and the board of directors must take on the duty of quality. In that context, they meant clinical quality.

Until then, no duty or responsibility was placed on a chief executive in Northern Ireland or a board of

directors in Northern Ireland.

MR STEWART: Well, I understand --

A. In England it had slightly pre-dated that.

THE CHAIRMAN: When your evidence explained, for instance, why there are so few references in the board minutes to issues about incidents involving patients or patient safety, that was because that was not a board responsibility?

A. Yes, chairman.

MR STEWART: Patients were not a board responsibility; is that really your evidence?

A. No, no, forgive me, but you are misquoting the chairman. He said: is that an explanation as to why there was so little reference to issues of patient safety in the board minutes.

Q. I don't wish to be deflected from the question I'm asking you. Prior to 2003, the chief executive had no responsibility for clinical --

A. It's more fundamental than that: no responsibility or authority had been given to chief executives until the document dated January 2003.

Q. That's why I'm putting this document to you, a document which bears your signature and commitment --

A. Yes.

Q. -- and in which it clearly sets out, at page 244, your

responsibilities:

"The chief executive is responsible to the Trust board for the effective management of health and safety by the Trust and in achieving the aims of the health and safety policy statement."

This is the health and safety policy statement and you were responsible for achieving its aims. And those aims are specifically set out as being the aims of the medical risk management group.

A. I'm sorry, we are going around in circles. I thought we'd established that this was a document to show how the Royal Group of Hospitals would give its commitment to two particular pieces of health and safety legislation that would apply to any organisation above a certain size employing workers.

Q. Well, then, why does it contain the entire section on medical risk management and why does it set forth a structure of committees that will deal with this if it is to be ignored?

A. Because there's a world of difference between encouraging your medical staff to take a system approach to undertaking their responsibilities under the GMC and then saying: so this is evidence that, in spite of what I say about the legislation, I was taking responsibility for clinical quality.

THE CHAIRMAN: Sorry, can I ask you this: whatever about you personally, did the board generally or did the board collectively have a responsibility for clinical safety?

A. No. No, chairman.

THE CHAIRMAN: So it was entirely a matter for the individual doctors and nurses?

A. "Entirely" is a big word, but ...

THE CHAIRMAN: If you didn't as chief executive and if the board of the Royal Trust didn't have that responsibility, is it then that the only other people with that responsibility are the individual nurses and doctors who are treating patients?

A. Nurses have their own code of conduct and managerial and professional body. I think in this case we're talking about individual qualified doctors who come under the aegis of the GMC and they have been giving guidance and instruction to doctors about their duties. But essentially, in 1994/1995, we relied ... Okay, I'll say "entirely" -- because I can't think of an exception on professional self-regulation -- to take responsibility for clinical safety and quality.

MR STEWART: Who was responsible for clinical safety in the Royal in 1995 and 1996?

A. Individual qualified doctors who came under the aegis of the GMC, who were on the register of the GMC.

Q. And your evidence is that neither the board nor yourself had any responsibility for the healthcare and the quality of healthcare given to patients in the hospital?
A. I have to answer that question, chairman, yes, that was the case.
THE CHAIRMAN: And your evidence is that that was the same in the Royal Trust as it was in the other trusts in Northern Ireland and the same as the various trusts in Great Britain, although the position changed here in 2003 and changed in Great Britain slightly earlier?
A. I think 1998, there was definitive guidance given to English, I think I have to say, rather than Great Britain -- English trusts to begin introducing a system of clinical governance.
THE CHAIRMAN: Okay.
MR STEWART: Can I ask that we have a look, please, if that policy of the Royal Group of Hospitals is not clear enough, at this policy: WS061/2, page 228? This is February 1997.
A. Yes.
Q. It's a risk management policy.
A. Yes.
Q. You'll see it's signed by your medical director, Dr Ian Carson.
A. Yes.

Q. Turn the page to 229:
"The purpose of the risk management strategy is to [second bullet] improve the safety of patients affected by the Trust's work."
And you move down then to "Accountability and authority":
"The authority and responsibility for the establishment, maintenance, support and evaluation of the risk management programme is vested in the board of directors."
Can I suggest to you that that looks as though the board of directors has responsibility for the risk management programme, which has, as its purpose, the safety of patients?
A. Yes. Chairman, again, I haven't seen this document since it was promulgated. Most of this document comes under the purview of this health and safety legislation that we've referred to before. So there is a safety issue in relation to patients that is not directly clinical safety or quality. So, for example, I think the inquiry had been led off the scent by reference in documentation that had been referred to by Aidan Mullan as an expert witness, for example, that talked about the death of a patient elsewhere, that resulted in it being reported, among other things, to the board of directors

at a Trust board meeting. That was an adult male patient who fell from a balcony of the Royal Victoria Hospital on the same site, and it was reported to the board of directors under health and safety legislation. It wasn't part of the clinical duties of clinical safety and quality responsibilities of the board of directors.
The reference here to "patients alongside visitors, staff and others" is in relation to ensuring that there is a safe physical environment for patients who might be walking about the hospital, just as a visitor or a member of staff would be.
Q. So in fact, this has no relevance to patient care?
A. I would have to read it from end to end. I'm sure there may have been --
Q. Perhaps I can assist you. Turn the page to page 230 where this document, the policy of the hospital, sets out clearly what the risk management functions were:
"The risk management programme encompasses all aspects of healthcare risk management, including professional, general and product liability. The programme will be comprehensive, integrated and systematic. 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."
That seems very far indeed from the sort of site safety issues that you seem to be describing. Can you comment on that?
A. Chairman, I disagree with that statement. Loss control programme? That's about loss of property and valuables or buildings or equipment. A claims management system? That can be across a whole range of things, not necessarily a clinical claim. I'm simply stating that this is a much wider document than simply clinical safety. It is still an attempt to comply with the health and safety legislation that pertained in Northern Ireland.
THE CHAIRMAN: And then do you say then that the fact that you, on that interpretation, go beyond it by introducing risk management in the 1993 policy, it cannot be used against you for going beyond what is required?
A. Thank you, chairman, yes.
THE CHAIRMAN: That's your approach?
A. Yes, exactly.
MR STEWART: But this, you will concede, I hope, encompasses patient care issues.
A. Well, it says that.
Q. It says that. And accordingly, and because you are on the board, you have authority and responsibility for

this risk management programme.
A. Chairman, I think we have to make a clear distinction between the standards and accountabilities that the chief executive and the board of directors operated under prior to 1993 and opportunities that officers of the board were attempting to make to begin to worm their way into the area of clinical safety and quality. But it did not have the responsibility for that prior to 2003. Again, you know, I think what this illustrates was that we were trying to stay ahead of the game, trying to integrate reporting, for example, so that we reported clinical incidents alongside non-clinical incidents, and my memory serves me badly, but I think other witnesses to the inquiry have either made written statements explaining that or have given evidence to explain that.
Q. We've established the compass of risk management functions, perhaps we go back to page 229 again, where under the large heading "Accountability and authority":
"The authority and responsibility for the establishment, maintenance, support and evaluation of the risk management programme is vested in the board of directors."
I would suggest to you that that expressly renders the board of directors responsible for the establishment

of an effective incident reporting and investigating system, for the safe and professional care of patients, et cetera, et cetera.
A. Well, I think it depends how you define a risk management programme; okay?
Q. We've just been through that.
A. If we have been in advance of policy or responsibilities and tried to begin to integrate this paradigm where it's individual professional self-regulation and a situation where we did not yet have the duty of quality and any responsibilities or accountabilities for it, if we were trying to integrate the two, then we should be praised rather than trying to catch us out, chairman.
Q. I seek to understand why it is that the Trust should have been publishing policies setting out its responsibilities in these areas and indeed setting out your responsibilities in these areas and now you seek to suggest that there was no such responsibility whatsoever.
MR SIMPSON: Well, with the greatest of respect, that's a comment on my learned friend's interpretation of the document and it entirely is contrary to what the witness interprets the document to say. That's a matter for you to resolve, Mr Chairman.
THE CHAIRMAN: I think the issue, Mr McKee, might be

summarised as this: it's difficult for an outsider -- and particularly, as you'll understand, the families who are here -- to understand how it is that the board of a hospital, and in this instance your hospital, is not responsible for patient care.
A. At the time of these sad and regrettable deaths, yes.
THE CHAIRMAN: Because the natural instinct, I think, of most people is that if you're responsible for running the Trust, you with your board of directors are responsible for running the Trust, its primary service is constituted by the various services provided by doctors, nurses and ancillary professionals working in the Royal, how if something goes wrong clinically that isn't then the responsibility of the hospital.
A. I agree, chairman. But the prime focus that was given to the board of directors was to balance the books, act legally, show prudence, et cetera, around certain financial and administrative issues. I agree, with hindsight, it's difficult to understand, but I think it is important that the families understand this context -- sorry, it's only bizarre with the benefit of hindsight, some 17 or 16 years later.
THE CHAIRMAN: But then let's go back. Pre-1993, who was responsible for clinical care? For instance, under the Eastern Board regime in which the Royal was a unit;

is that right?
A. That's correct.
THE CHAIRMAN: Was the Eastern Board responsible for clinical care? No?
A. Not to my knowledge, chairman. In fact, I could be pretty sure that professional self-regulation was even more deeply embedded the further back in time we go.
THE CHAIRMAN: But then if something went wrong and a patient suffered an injury or died, then the basis for the Eastern Board and then the Royal Trust being responsible for medical negligence is because it was the employer of the relevant doctor?
A. Exactly.
THE CHAIRMAN: Not because the Trust itself was responsible for the duty of care to the patients?
A. Yes, chairman.
THE CHAIRMAN: Okay.
MR STEWART: May I ask you some questions arising from the first report of the Trust, the annual report from 1993 to 1994, which appears at WS061/2, page 25? That's the cover. Over the page to 26. This is the mission statement of the Trust. Did you have a hand in formulating the mission statement?
A. I think, chairman, this mission statement is lifted from the vision of success document, the strategic direction

document, which was published contemporaneously with the annual report. And if that's the case, then I certainly did the first draft.

Q. "It is a fundamental purpose in the Royal Hospitals to provide the highest quality cost-effective healthcare as an outstanding acute general hospital ..."

Further on down:

"Aims. To achieve our purpose, to live up to our mission statement and to play our full part in the National Health Service. We aim to provide the highest quality healthcare in the best possible environment to all our patients."

It seems to be pretty clear.

A. Indeed. I was very careful in writing it, chairman. We can talk about the purpose of a mission statement and the vision of success as a way of driving improvement, changing the culture of an organisation, describing a picture of what we want the Royal Hospitals to be like some years ahead. And the aspirational nature of the document and the fact that we are trying to speak directly to the medical staff in this particular regard, and that doesn't lead then to say: aha, I'm wrong about this legislation in 2003, the board of directors have taken upon themselves these wider responsibilities.

Q. Leave aside what that legislation in 2003 might have

said. That may be --

A. Could we refer to the legislation in 2003? If that had been adopted [OVERSPEAKING]. Forgive me. I have assumed that everyone is familiar with this particular piece of legislation because it is so central to the story of the Royal's progress in trying to improve clinical safety and quality.

Q. Yes, but it post-dates the events with which this inquiry is concerned. And accordingly, it is the documentation from that time in which is set forth the responsibilities of the board and you, as chief executive, that we must look at, not something which came later.

THE CHAIRMAN: I think Mr McKee's point is -- and we will come to the 2003 order -- is that we can better understand the situation in the mid-1990s by looking at the contemporaneous documents from the mid-1990s, but also by taking into account that the 2003 order changed responsibilities. So we will come to the 2003 order to illustrate that, but for the moment let's stick with the mid-1990s documentation.

MR STEWART: Go on to page 34. This is your statement for the year. The right-hand column of text, halfway down the paragraph:

"Each member of the hospital council is responsible

through the chief executive for the management of a clinical service or function within the hospitals. More than half are consultant medical staff."

What does that mean?

A. Well, it means precisely what it says.

Q. I have difficulty understanding what it means.

A. Chairman, is it worth me pausing and explaining something about "Doctors in management" as it was called? When I came to the Royal in 1988, this whole business of doctors in management, copying managerial structures in Johns Hopkins Hospital Baltimore, was being addressed in England as a way forward of bridging this gap between a clinical world governed by professional self-regulation and a managerial world with new -- with an ambition that we should be more managerial in hospitals. This was being championed in 1998 when I was appointed general manager through competition. In 1989, I adopted this and several clinical champions and I introduced it across the Royal Hospitals, a unit of management of the Eastern Board. And crudely, it had been described in the literature as: you get doctors involved, persuade them how to count and manage your budgets. And they in turn can have a role in the corporate direction of the organisation.

So I had no authority to hold clinical directors to

account for patient safety and quality. And it doesn't say that in the document. It talks about the management of these services.

Q. It says:

"Each member of the hospital council is responsible through the chief executive for the management of a service or function."

A. Yes.

Q. In other words, they carry them out for you.

A. Yes.

Q. And they're responsible through you. In other words, you have overall responsibility and they perform, on a delegated basis, to functions for which responsibility flows back to you. It seems to be exactly what it says.

A. Well, forgive me for quoting Lewis Carroll, chairman, but I mean management to mean precisely what I mean. It did not mean clinical quality and safety because I had no authority or responsibility for that. And I could not hold anyone else to account for things that I didn't have responsibility for.

Q. I'm sure, Mr Chairman, you will determine what, on a proper construction, those words ought to mean.

A. And forgive me, chairman, but I find it a bit irksome that I'm being criticised about the individual wording of documentation that shows that we were in advance.

This doctors in management project that we stuck with throughout the whole history of the Royal Hospitals was designated by the department because of lobbying before I arrived as equivalent to one of the six pilot sites in England. The denominator here is probably 250 or 300. So it was a measure of our appetite for this in the Royal and probably the need to particularly bridge this managerial paradigm and the clinical paradigm dictated entirely by professional self-regulation.

Q. You describe your ambition for the Trust. Would it have accorded with Sir George Quigley's ambition of:

"A patient-centred institution driven by the imperative of clinical excellence and supported by an organisational structure and systems"?

A. Yes.

Q. That was your object as chief executive, to achieve those aims?

A. Yes. In the vision of success document, I go further, or it's written -- I would have done the first draft -- that there are essentially two sorts of healthcare organisations: those who work hard to put the patient at the centre and therefore survive and prosper and those that only pay lip service to service excellence and they tend to stumble and fall. It's as clear-cut as that.

Q. So the question comes down to: if you fail in those

ambitions, if you fail in your mission statement, do you say that no responsibility adheres to you?

A. Well, chairman, again, this vision of success document was extremely innovative, greatly admired by other hospitals, cited in literature.

THE CHAIRMAN: I think it also depends on what you mean by "failure". Because I'm not sure that a hospital fails in its mission because every single patient is not treated perfectly. By that definition, every hospital will always fail.

A. I absolutely agree.

THE CHAIRMAN: That doesn't make it any easier for the families of the children who die as a result of failures, but it is a fact that a ... And one interpretation, in one sense, the death of a child in a hospital is a failure.

A. Yes.

THE CHAIRMAN: But whether that means that the hospital is failing to achieve its mission is more open to question. It means the hospital is imperfect, but only in another world could a hospital be perfect.

A. Yes. And I suppose I shouldn't labour the point, but there was no requirement for the Royal Hospitals to have a mission statement, to have a vision of success, to have a five-year strategy of what it wanted to be, to

describe this to staff so that they would know what's expected of them. And I could go on for hours about the importance of a strategic direction document written in this particular way and it's reinforced in the literature and in turn the success of the document is reported in literature.

There was no encouragement requirement to do this sort of thing, but the literature is clear. Unless you do this sort of -- unless you set a clear direction for the organisation, then you won't change it.

MR STEWART: Yes. Good leadership requires good direction?

A. Yes.

Q. But leadership is also judged on delivery.

A. Yes.

Q. Quite. Can you describe for us, in the round of terms, the role of the directors, the executive directors and non-executive directors, how much you relied upon Dr Carson as the medical director and the role of the hospital council at that time?

A. Well, of course, the hospital council, if my memory serves me right, pre-dates a little the establishment of the Trust and again was a way of creating a hinge, a valve, within the hospital that allowed us to get access to the clinical world that wouldn't ordinarily be available to a chief executive and its senior team at

that time. So again, it was a more collective pact, if you like, between senior clinicians, who were often described by their colleagues as having crossed to the dark side, and the executive directors and other directors. The hospital council will be involved in setting -- in the business of the whole organisation corporately and in setting a direction and in turn you will manage your particular group of services as best you can. So the hospital council was the way we do it corporately.

Q. Did it have any decision-making responsibilities?

A. Decision-making ... I suppose the short answer is, to a limited extent, yes, but it was quite an influential body in that we listened to what people were saying and then we formulated a decision or advice that we gave to the board of directors, based on their expert knowledge or opinion.

Q. Were there any non-executive or outside people on the hospital council?

A. No, because the hospital council had no legal status. It was simply a device to allow me and other executive directors to better fulfil their duties. And it wasn't in any guidance. There was no compunction or encouragement about this.

THE CHAIRMAN: In effect, it's a committee.

A. Yes.
THE CHAIRMAN: The term "council" sounds as if it has some status, and although it's important, I think on your evidence, if I understand it correctly, it's important as a link between the hospital managers and the senior doctors. It is effectively a committee, which debates and discusses things and then they're taken from there to the board; is that correct?
A. Exactly, chairman. If I could add, at a more personal level, it was quite a bold and courageous thing to do because I was not aware of my colleagues facing in committee structure the most senior and -- among the most senior and respected clinicians in the organisation.
MR STEWART: Because being a non-clinician yourself, you were reliant upon --
A. In pure, raw power terms, the consultant body was by far the most powerful power group in a hospital and had extreme influence, not only within the hospital, but externally to the hospital.
Q. Extreme influence?
A. Yes. Out of all proportion to their numbers, for example.
THE CHAIRMAN: But that strength comes from the fact that they're the people who are providing the healthcare.

A. Precisely.
THE CHAIRMAN: So you have them providing --
A. -- wider societal views about the status of doctors.
THE CHAIRMAN: Absolutely.
A. Their influence at a national level with governments, but yes, primarily from their particular and unique role in delivering medical care.
MR STEWART: And you also relied on the medical director, Dr Carson, and Miss Duffin, as director of nursing, to bring the clinical information and expertise to the board.
A. Yes indeed, chairman.
THE CHAIRMAN: Let me ask it in this way: our understanding is that neither Adam's death nor Claire's death went to the board; is that correct?
A. Not until after the death of Claire Roberts had been identified to us or the circumstances of the death of Claire Roberts had been brought to our attention by the family, who, to put it very briefly, had said, "Is there any similarity between the death of Adam Strain and the death of our daughter?".
THE CHAIRMAN: Okay.
A. And then that triggered a whole series of points that I think have -- will either be dealt with in detail by Dr Michael McBride, who was at the time the medical

director --
THE CHAIRMAN: Let me take Adam's death first of all. It's 1995. It's immediately made the subject of a coroner's inquest in 1996 and there's certainly some publicity around Adam's inquest in 1996. Did that come to the board?
A. No, chairman. It hadn't been reported to the medical director or the chief executive at that time.
THE CHAIRMAN: The medical director, Dr Carson, did know about it just before the inquest, and knew about the inquest and we heard yesterday what information he received from Dr Murnaghan. Even then, I'm trying to work out what then happens. If you have a death which is as a result of the standard of care provided within the hospital, does that then come to the board as an issue for the board to consider and to make any decision on or to probe any further? Or if it's not Adam's death, can you give me an example, without naming the individual, of another person's death, which did come to the board and what the consequence of that death being referred to the board was?
A. Not in a clinical context. I reported under health and safety.
THE CHAIRMAN: I'm talking about the --
A. No, I can't recall that happening before 2003 or

thereabouts.
THE CHAIRMAN: And do you say that that illustrates the point that the board wasn't responsible?
A. Among other things, yes, it does.
MR STEWART: Would it have been legitimate to bring the death of some patients to the attention of the board?
A. Well, we brought to the attention of the board through committee reports, as I understand it, the death of this elderly male patient, who fell from the balcony. But that was under our requirements of general health and safety legislation.
Q. I think it was a lady who fell.
A. Okay.
Q. What I'm asking about is: in relation to a hospital, whose core, primary, fundamental and paramount purpose is to look after patients, are you saying that there was no mechanism and no occasion for the death of a patient to be brought to the board charged with those fundamental purposes?
A. Chairman, I'm reluctant to keep repeating myself, but the board of directors, the chief executive, and others had no corporate responsibility, had been given no corporate responsibility for patient safety and quality matters. Now, the medical director has a personal, professional responsibility as a qualified medical

practitioner on the register, but that's not part of his corporate role.

THE CHAIRMAN: But that's only for his personal, clinical care?

A. Yes.

THE CHAIRMAN: Then --

A. Well, I think if any medical practitioner had concerns about a colleague, if it had been reported to him and then reported again, there might be an argument for saying that any medical practitioner could. But that would be -- I can't think of circumstances. The GMC and professional self-regulation relied on the immediate clinical team to make a judgment about whether there should be a referral to the GMC.

THE CHAIRMAN: Of course, what this does, Mr McKee, is it emphasises how much more important on this analysis the roles of Dr Murnaghan and Dr Carson were, because if the clinical care of patients isn't a board responsibility, it makes their roles as director of medical administration and medical director even more important because, on your analysis, they're the people who are going to be alerted to adverse clinical incidents, to use that awful term, and to do something about it; isn't that right?

A. The role of director of medical administration, even in

1995, was already anachronistic, because it reflected earlier mores -- which were beginning to be chipped away at -- that the medical world was quite separate from the administration of the hospital. So you appointed a senior qualified doctor to act as a valve between this medical world, relying on professional self-regulation, and the organisation. And he, for example, was responsible for medical personnel. It was not deemed appropriate that personnel matters for doctors should be mixed in with the personnel matters of the other 5,000 or 6,000 staff in the Royal. And he was also responsible for what now would be called professions in support of -- clinical professions: physio, OT, et cetera. Because that was seen as very much in a medical world. And he was the point at which the Trust's legal responsibilities to refer deaths to a coroner would have happened, but the convention would be, within the medical profession, that that's as far as it goes; you don't have to go and tell the administrator or the general manager or the chief executive. And certainly, you know, there was a gradual shift in culture, in behaviour, and the key milestone in that was the formal duty of quality that was given to chief executives and boards of directors some time later, 2003.

MR STEWART: Let's just go back and work through quite a lot of that.

First of all, Dr Murnaghan and others had been confused about his precise reporting, accountability, position in the structures. Did he report to you?

A. I don't think so. I think he reported to the medical director.

Q. Was he accountable to you?

A. In the sense that everyone is accountable to me, yes.

Q. It seems that unexpected deaths, adverse clinical incidents and so forth were reported internally to Dr Murnaghan.

A. Yes.

Q. He was also charged with conducting the defence of the Trust to medical negligence claims.

A. Yes.

Q. And therefore, it appears that he could have been conflicted in his roles as between bringing adverse clinical incidents to the attention of, for example, the medical director, and not doing so because such a reference could reveal vulnerabilities which would be uncomfortable for his defence role. Can I ask who constructed that paradigm?

A. Well, the Trust inherited this structure. I can rather pointedly say that when Dr Murnaghan chose to retire,

I did not replace his post and we restructured. I've used the word "anachronistic". But perhaps, more importantly, in this apparent conflict of interest, I was able to obtain a copy -- I'm not sure if it is a formal piece of evidence available to the inquiry -- which gave very detailed guidance. Can I refer to my note just to get the title, please?

THE CHAIRMAN: Yes.

A. Very detailed guidance on handling claims, "Handling clinical and social care negligence and personal injury claims. HSC (SQSD510)". I only saw it fairly recently. It may not be part of the evidence body. But in advance of having sight of it, I've searched the document and it says that it might be convenient that the same person who is responsible for investigating these incidents is also the same person that handles the claims. So there is no acknowledgment as late as 2010 --

MR STEWART: That's a completely different thing.

A. Forgive me then if I've misunderstood you.

Q. Because if somebody dealing with claims management is also specifically charged with the investigating the circumstances around the claim. That's one thing. There's no conflict there. But there's a clear conflict between the person charged with defending the Trust also being the person charged with referring adverse clinical

incidents to the medical director, and furthermore, being the person to disseminate vulnerabilities determined after a claim or after an inquest.

A. I'm not sure if I understand fully the point that's being made to me, chairman. I will leave it there.

Q. You said that Dr Murnaghan, the position was inherited by the Trust. But surely, the management, the clinical-based management structure, was the invention of the Trust; it came into being with the creation of the Trust.

A. Chairman, I'm sorry: which clinical-based management structure?

Q. The structure that was in place for the Trust with the chairman, the chief executive, the various directors and the lines of accountability and reporting.

A. Chairman, it would be my contention that in the Royal and in every other trust that attained trust status between 1993 and 1997 and elsewhere in the United Kingdom, by and large, the creation of self-governing trust status did not prompt a wholesale review of management structures.

THE CHAIRMAN: Just to clarify this issue, I am just looking at Professor Mullan's report. The section I'm looking at is paragraph 2.42. He refers to the Bristol report, the Bristol report came out in 2001.

A. Yes.

THE CHAIRMAN: He says on page 15 of his report, or he's quoting a number of lessons from Bristol, and one of them is -- the last bullet point on page 15:

"Until well into the 1990s, the notion that there should be explicit standards of care which all healthcare professionals should seek to meet and which would apply to patients simply did not exist. It is now widely accepted that this state of affairs has to change. Patients are entitled to expect that their care will be of such quality as is constant with good practice [et cetera]. Recent developments give cause for optimism. These include statutory responsibility of trusts for the quality of healthcare."

That's your point, that that's reflected in Bristol?

A. Precisely, yes.

MR FORTUNE: Sir, you might like to go over the page to the first bullet on page 16.

THE CHAIRMAN: "There remains insufficient coordination in setting standards, guidelines appear from a variety of bodies giving rise to confusion and uncertainty. Moreover, there are weaknesses in monitoring performance in relation to these standards, whether at the level of the trust or nationally. In particular, there is no mechanism for surveillance to ensure that patterns of

poor performance are recognised and addressed."

MR STEWART: Can I bring us to page 38 of Professor Mullan's report and to paragraph 6.1.6(ii) -- it's at page 210-003-038. In 1994, at 6.1.6(ii):

"In 1994, the NHS Executive [in England] published the report of the independent inquiry relating to deaths and injuries on the children's ward at Grantham & Kesteven General Hospital during the period February to April 1991 (known as "the Allitt Inquiry")."

There Professor Mullan draws a quotation from the report:

"There must be a quick route to ensure that serious matters ... are reported in writing to the chief executive of the hospital and, in the case of directly-managed units, to the district health authority. All district health authorities and NHS trust boards should take steps immediately to ensure that such arrangements are in place."

You were aware of this report, I presume, back in 1994?

A. Chairman, I think this gives me an opportunity to make an important set of comments about Professor Aidan Mullan's expert witness statement. I was disappointed by it, I think it's weak. It wasted lots of opportunities to set a wider context for 1995. He

does acknowledge that there wasn't a system of clinical governance in place anywhere in the United Kingdom in 1995, but he makes a rather Anglocentric, fundamental error in using circulars, instructions and guidance issued from London as applicable to Northern Ireland. And that simply was not the case.

Circulars issued from England did not have any authority. We had a separate administration and a separate Department of Health and Social Services, as it would have been in those days, and they issued circulars that bound the Trust to take action.

Q. Yes.

A. If you go to the particular paragraph, chairman, so:

"... chief executive of the hospital and, in the case of directly-managed units, to the district health authority ..."

There were no, have never been any district health authorities in Northern Ireland. All district health authorities and NHS boards -- well, you know, again, there weren't district health authorities. So this Allitt inquiry was known to me through general professional literature, was probably the subject of great anxiety by the director of nursing because who knows where the circumstances might also pertain? But again, I don't believe that down the nursing line there

was specific guidance given in Northern Ireland about the report into the inquiry of deaths in that particular hospital known as the Allitt inquiry.

Q. That inquiry, as we know, dealt with the case of a clinician, who turned killer, and there had to be a direct route for information to go to the chief executive. Whether you cavil about whether or not there were NHS trust boards or district health authorities, we're dealing with hospitals and with patients and with vital information. In the case of Adam Strain, after his death, the consultant anaesthetist charged with the performance of his anaesthetic didn't know why he had died. They looked at the machinery. That didn't seem to have caused it. They were left without a good clue. If a death is unexpected, if a death is unexplained, it could be the worst possible scenario. There has to be a method of getting the information to the highest possible level, just as in this inquiry and in the recommendations of the report, there had to be that channel of communication. Did you read this --

A. Chairman, I'm not sure there's a question there in that statement. But let me be quite clear. I'm not cavilling about this, I'm stating authoritatively that circulars issued from London did not have authority in

Northern Ireland. It's a straightforward issue to ask the Department of Health if this was the case.

THE CHAIRMAN: I suppose --

A. So while we were aware of this through our professional lives, no such similar guidance was issued to my knowledge in Northern Ireland, and this did not have any writ authority in Northern Ireland.

THE CHAIRMAN: Your other point is, I presume, that there's a difference between having a doctor or nurse who's actually murdering patients on the one hand and a doctor or nurse who, on a particular day or days, provides inadequate medical care.

A. Thank you for that clarification, chairman.

THE CHAIRMAN: That's a difference in circumstances. What Professor Mullan quotes in this report is from the recommendation from the Allitt inquiry. I think it's a recommendation that ... And this comes -- I think the footnote which he has at 6.1.6 at 30, that then refers to a 1995 publication -- although it says 1994 there, it turns out in footnote to refer to 1995. What is coming from this is that:

"... trust boards should take steps immediately to ensure such arrangements are in place."

Serious matters are reported in writing to the chief executive. From 2003 -- you were still in the

trust until 2010.

A. 2006.

THE CHAIRMAN: Okay. After 2003, when things did change, were deaths with issues about clinical care brought to the attention of the board?

A. I can't answer --

THE CHAIRMAN: Sorry, not even necessarily deaths; serious incidents, even short of death.

A. Well, chairman, this is a much more granulated question. For example, by 2006 we were reporting well ahead of the game. I think only half a dozen hospitals were doing the same across the United Kingdom. We were reporting clinical indicators, including mortality figures, both for institutions and individual specialties, in public to the board. Those clinical indicators could be brought down to individual clinician level and they were used in newly introduced systems of appraisal. But the story from 1999 -- well, 1998, when one summer when things were quieter I took all the literature, a bit like women's magazines about how to do a diet. We had the formal English guidance and then there was a lot of discourse in professional magazines about how you'd actually do clinical governance on the ground. I sketched out something as to how it might apply to the Royal. Ian Carson came back from holiday and he took

that and developed it, and within six months or so, we were tabling for approval by the board of directors a detailed framework for how we would introduce clinical governance, and I think Dr Carson may have reported on this yesterday. Certainly Michael McBride --

THE CHAIRMAN: The picture I have is that he, as medical director -- and working presumably in conjunction with the board -- started to develop clinical governance. He got it so far and when he had left, Dr McBride took it further.

A. Yes.

THE CHAIRMAN: What I'm asking for is this: the point you're making, which I think is maybe difficult for outsiders to understand, is how it is that you, as chief executive in the Royal board, didn't have responsibility for clinical care, but you're saying, simply as a matter of fact and as a matter of law, we didn't have responsibility until 2003. So what I'm asking you to do in a way is this: Adam's death did not come to you in 1995 or 1996, and in essence that's because, harsh as it may sound, you're not responsible for clinical care.

A. Harsh as it sounds, yes.

THE CHAIRMAN: After you became responsible for clinical care in 2003, unfortunately there would still be the occasional death in the Royal, which does arise from

substandard care.
A. Yes.
THE CHAIRMAN: Can you, again without naming the individual, give some evidence about such a death coming to the board of the Royal Trust after 2003, after you assumed this responsibility?
A. Well, certainly I think we finally found a minute of a board meeting -- I think it was the first board meeting after the UTV programme, where after my introduction, Dr McBride gave a report to the board surrounding the death of Claire Roberts. So there's that. I don't have a memory of others.
THE CHAIRMAN: Is that because -- I'm just being careful about that because that might be because there's a very damning, very high-profile documentary.
A. Yes.
THE CHAIRMAN: Does that necessarily have anything to do with the new responsibility for clinical care or is that as a reaction to a very difficult programme from the Royal's perspective?
A. Who can say? Probably both, chairman.
THE CHAIRMAN: Okay.
A. But I think I want to get across that sufficient information was being given, by 2006, to the board of directors that they could have zoned down to

a particular specialty, say one of 28 or 30 specialties across the Royal, and said, "Is there something going awry there with these clinical indicators?", or, "These clinical indicators, are they indicating that something's going wrong in this particular sub-specialty?", and we would have the information to identify it down to an individual consultant.

There were occasions when I can recall conversations with medical directors after 2006 where we would have been saying, "Well, is this doctor's clinical performance going off sufficiently for us to intervene?" And I don't want to get too technical, but we had control charts that gave you a sort of running average and there were trigger points above or below this, so you could reasonably rely on those trigger points. So the answer often would have been, "We haven't reached the upper trigger point yet, let's wait for another month's figures before saying it, but in the meantime, I, medical director, will have an informal chat with this individual". So that was the level of interference, if you like, the board was making into the individual clinical practice and performance of consultants by 2006 because we had rapidly developed a whole system of clinical governance.

THE CHAIRMAN: But your point is that you would never have

done that in the 1990s?
A. Certainly not.
THE CHAIRMAN: Okay.
MR FORTUNE: Sir, could we come back to the mid-1990s, around the time of Adam's inquest? Even if Mr McKee asserts that any guidance from England would have no legal effect here in the Province, if Mr McKee extrapolates from that quotation in Professor Mullan's report at page 38, would he not agree or would he not consider it prudent that there be a route for serious matters to come to the board in any event, irrespective of whether it appears in guidance, and if so, what's a serious matter?
A. Well, chairman, I take offence at simply saying I assert. I think it has to be accepted that until 2003 there was not guidance, responsibility, authority given to boards to take responsibility for clinical safety and quality. But I think elsewhere in the report, Professor Mullan acknowledges that there was not guidance generally accepted as to how adverse incidents should be reported up the line.
MR STEWART: Perhaps you could answer the question: did you think it appropriate to ignore this advice in 1994/1995? If you had read it, did you think it appropriate to --
A. Chairman, again, this is based on a false premise. This

guidance did not apply to Northern Ireland. End of story.
THE CHAIRMAN: Let me put it in a different way: the inquest verdict in 1995 in Adam's case is, in terms, that Adam died because of substandard medical treatment.
A. Yes.
THE CHAIRMAN: That would be a serious matter.
A. Yes.
THE CHAIRMAN: Would it have been of any interest for the board to know that?
A. It might have been of interest to the board, but they had no authority to take action. At that time, we relied on the wider clinical team to ascertain whether there should be a referral to the GMC.
THE CHAIRMAN: Yes. The purpose of this, I think -- maybe another line here is: accepting that you didn't have that legal responsibility until 2003, if it is the case that there was a serious incident and this has happened, is it not relevant for the board to seek some information, to get reassurance that if there is something to report to the GMC, that it is being done? What you're doing is you need some reassurance that -- in essence you're saying, "Our responsibility here is to provide the facilities and to provide the services. It's then up to the doctors, nurses and others to take

advantage of the systems and services that we have in place to look after the health of the people of Northern Ireland".

But here we have an incident where a child has died because the care was not good enough. Now, we're worried about that because, against all restrictions and funding and so on and against difficulties partly arising of the location of the Royal over the years and the controversies that that gave rise to, we have here an example of somebody who's died as a result of inadequate care. Can we get some reassurance from the medical director that this has been investigated and, if appropriate, has been referred to the GMC?

A. Well, with hindsight, that certainly would be the case. At the time, I think it's rather more mooted. The medical director, if he had been aware of it, might have expected colleagues to come forward and give a report to him and say whether there was sufficient failure to warrant triggering a number of issues. The Trust could have taken formal disciplinary action, but it's acknowledged later on in a consultation document from the department that the disciplinary procedure for doctors was so cumbersome, so expensive, so long-winded, that it was rarely used in these circumstances. It was normally only used for issues of health, for example,

abuse of alcohol or drugs that might be interfering with a doctor's practice, and was not used for these matters because it was a sledgehammer to crack a nut. It was far too cumbersome.

THE CHAIRMAN: I'm not sure that the sledgehammer-and-nut is the right analogy because a nut is a small insignificant thing, whereas a doctor who doesn't perform to a high standard is not a small insignificant thing. Perhaps your better analogy is: if he's not being reported to the GMC and the GMC isn't doing something about him because he's not a good enough doctor, it's a bit hard for the board of the Trust to do something about him?

A. Yes. I suppose it's reasonable to say that the developments and progress of the GMC over the last 20 years have been to provide a whole series of gradations from "no action is required on this particular doctor", we wouldn't have expected to have heard about it, to a formal referral. In between that, there are a whole series of instruments and devices that were presented as being available to trusts, to medical directors particularly, where performance fell short of disciplinary matters or referral to the GMC, but where a period of training a period of supervision might be appropriate in these circumstances. Now, they weren't available to health organisations across the UK at this

time, and if they were available, it might have been more appropriate to use one of those in these circumstances.

THE CHAIRMAN: I think the problem is this, Mr McKee: we've heard evidence or been given information that the culture in the mid-1990s did not provide for doctors to report each other to the GMC. That's just the way it was. If their employers didn't report them, in essence, they weren't reported by each other. I understand that culture has changed, things have moved on. But if you have doctors not reporting each other, if you have a trust board not being responsible for clinical care, if you have a medical director who's not adequately informed of what has gone wrong -- which is Dr Carson's position -- in essence this means there is no barrier, there's no protection for the public. I know we're looking back on the position which is almost historic already, but that just wasn't good enough, was it?

A. By today's standards, it's shameful. But by the standards of 1995 it was the way it was, chairman.

THE CHAIRMAN: It was the way it was, but even by the standards of the time, it just wasn't good enough. It was the way it was, but it meant that, in reality, nothing was likely to happen to a doctor who, through his actions, brought about a child's death. Even at the

time, was that not recognised as not being good enough? I don't even want to focus necessarily on Dr Taylor here, but just generally in the mid-1990s.

A. This is quite a difficult issue because, you know, I feel very uncomfortable about this. Some writers, I think, by 1995, were beginning, against all the -- were being quite iconoclastic and saying: look, we do have a problem here. If you like, in England this was encapsulated in the article in the BMJ, I think it was, by Gabriel Scally, a Northern Ireland man, and Liam Donaldson then, a regional medical director, who first, I think in English literature, anyway, used the words "clinical governance", and said: what we need is to have the same standards that organisations measure themselves to in corporate governance as for clinical issues.

And some people would have not received that well and have said the situation is fine, it's a matter of professional self-regulation, and other people would have said, "Bring it on, you know, we want to play our part in pushing the boundaries between governance, including clinical governance and professional self-regulation". I suppose I can't fail to come to the view that you have said, that this was unacceptable. But that's the way it was.

THE CHAIRMAN: Thank you. Shall we take a short break for the stenographer? We'll resume in 10 minutes. Thank you.

(11.44 am)

(A short break)

(12.15 pm)

THE CHAIRMAN: Mr McKee, during that break we've copied what I think is the provision in the 2003 order to which you were referring earlier. Have you been given a copy?

A. No, I wasn't referring -- I have been given a copy and, no, chairman, that's not what I was referring to, that order.

THE CHAIRMAN: That's not what you are referring to? Is it a separate statutory provision that you've been referring to?

A. No, I've been referring to a circular, which first instructs boards and their chief executives to take on this statutory duty of quality and clinical care. This document that we have before us is really the order establishing the regulation and quality improvement authority.

THE CHAIRMAN: It is, but if you look -- what I've done is two things. I think this has been distributed pretty much around. The first three pages set out the contents of the order, article by article. But if you then look

on the fourth page, which I have handed out, it is headed "Duty of quality 34".

A. Yes.

THE CHAIRMAN: What it says is:

"Each Health and Social Services board and each trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them."

A. Mm-hm.

THE CHAIRMAN: Is that the new duty to which you've been referring?

A. Well, I was referring to a circular from the Department of Health that slightly pre-dates that and is the one that would have triggered action on the part of trusts and other bodies. It is governance in the HPSS January 2003, that circular. And I can be pretty sure it's available electronically.

THE CHAIRMAN: Right.

A. If we're going to go into detail around this area, I would wish to have the document available to everyone.

THE CHAIRMAN: I agree. So what we'll do is we'll continue and then at -- I wonder is the quickest way to do this to do it now? I think it might narrow the questioning

if we can do it. Let me take five minutes and see if we can find it because it might actually tie down the questioning.

MR QUINN: Mr Chairman, can I raise one issue and I think they may be looking for this at the moment. The witness raised an issue in relation to a presentation by Dr McBride in 2004, after the UTV programme, when he said that Dr McBride, to his recollection, presented Claire's case at the board and that there was a memo or a minute of that. I certainly don't have that, and if there is a minute that has been recently discovered, could we perhaps have access to it?

THE CHAIRMAN: Yes.

A. Chairman, could I just report what I think I did say? I said that Dr McBride made a report to the board, it was a verbal report to the board. So the only written piece would be the minutes of the board.

THE CHAIRMAN: If the programme was broadcast in October 2003 and Mr Roberts --

MR STEWART: 2004.

THE CHAIRMAN: Sorry, 2004. And Mr Roberts contacted the Trust the next day, then that would have developed -- that may be in the November or December minutes?

A. I simply have this memory of seeing a minute of the board that said that I introduced the topic and

Dr McBride gave a report to the board.

MR SIMPSON: Those have been furnished to the inquiry, but have not been circulated.

MR QUINN: It appears at [draft] page 48, line 16, when the witness says:

"Certainly, I think we finally found a minute of a board meeting. I think it was the first board meeting after the UTV programme where, after my introduction, Dr McBride gave a report to the board."

I was just asking, if there is a report, it may well be verbal, I accept that. If there is a written report, I would like access to the written report.

THE CHAIRMAN: He has clarified that it's an oral report and we'll check about the board minutes. So what we're looking for, Mr McKee, if we can find it in the next few minutes, is a circular from the department, you think in January 2003, about governance?

A. Yes, and it introduces the duty of quality of care.

THE CHAIRMAN: Okay, thank you.

(12.20 pm)

(A short break)

(12.34 pm)

THE CHAIRMAN: We're a bit better informed now, are we?

A. I think so. But, chairman, I'm sorry to be a burden, but I don't have a copy of this.

THE CHAIRMAN: Was it shown to you and then whisked away?
MR STEWART: We have, sir, a copy of the 13 January 2003 circular 10, 2002, addressed to you and other chief executives, and also alongside it, a copy of the 2003 Health and Personal Social Services Quality Improvement and Regulation Order.
THE CHAIRMAN: We'll get these paginated and put on the website in due course. When we get a copy for Mr McKee, we can pick up where we were before the break.
MR SIMPSON: Perhaps we can give him this one. (Handed).
THE CHAIRMAN: Thank you very much, that helps.
Do you want to take a minute or two, Mr McKee, just to flick through that?
A. Well, chairman, I've read it many times.
THE CHAIRMAN: Okay.
MR STEWART: It begins with a summary that:
"The guidance is intended to enable you to formally begin a process of developing clinical and social care governance arrangements."
And:
"It should be read in conjunction with guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls and assurance standards as for financial and organisational aspects of governance."

By way of background, it refers to the "Best practice, best care" document, which:
"... set out proposals for a framework to improve the quality of services delivered and decisions on the way forward of implementing these proposals were announced July 2002 focusing on three main areas: 1, arrangements for setting clearer standards for service; 2, mechanisms for promoting the clear delivery of high-quality healthcare services through clinical and social care governance arrangements, reinforced by a statutory duty of quality [and so on]."
So that's the first mention there as a reinforcement of the delivery aims. Paragraph 3:
"Effective systems for regulating the services and monitoring the delivery of the services."
And it goes on to set out the sort of action needed.
THE CHAIRMAN: I think if we go to page 5, the paragraphs that caught my eye, looking at it, were really on pages 5 and 6. I'm sure there's more to it than that. The introduction on paragraph 1 on page 5:
"The purpose of the circular is to provide guidance specific to clinical and social care governance."
And the last few lines of that paragraph:
"This guidance must be read in the context of guidance already issued on the implementation of

a common system of risk management across the HPSS and the development of controls and assurance standards for financial and organisational aspects of governance.
"It's important therefore that while much good work has already been done in relation to the development of clinical and social care governance, from now on all organisations must apply the principles set out in this guidance."
At paragraph 4, they have the key policy objectives, of which there are three. They are "arrangements", "mechanisms" and "effective systems". Then paragraph 5:
"Clinical and social care governance arrangements within organisations which provide or commission services will be underpinned by a statutory duty of quality."
Right? I think that that must refer to article 34, which we distributed a few minutes ago, because article 34 says -- this is article 34 of the Health and Personal Social Services Quality Improvement and Regulation (Northern Ireland) Order 2003. It says:
"Each health board and each trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them."

So that is a statutory obligation to put in place arrangements for monitoring and improving the quality of services which are provided. And that is what is referred to at paragraph 5 in the circular.
A. That's the only paragraph I wish to refer to really, chairman, in this.
THE CHAIRMAN: When you were giving your evidence this morning before we had these documents in front of us, you were saying that this is the combination of the statutory document and the circular, which imposed on trusts for the first time a duty for the clinical care which is provided.
The point I wanted to query with you is whether that's quite so because the statutory obligation, as it's then described in paragraph 5, is about putting in place arrangements for monitoring and improving the quality of services. But the arrangements for monitoring and improving the quality of services are a bit different from responsibility for the service itself.
MR FORTUNE: Sir, if you look at page 9, paragraph 23 --
THE CHAIRMAN: Say that again, Mr Fortune.
MR FORTUNE: Page 9, paragraph 23.
A. Of which document?
THE CHAIRMAN: Of the circular. Yes, thank you. I think

this helps your point, Mr McKee. If you can find it:

"The chief executive of each organisation will be accountable to his board for the delivery of quality treatment and care by the organisation in the same way as he is already responsible for financial and organisational matters."

That's your point, isn't it?

A. Yes, and paragraph 5 says the same, really. Paragraph 5 on page 5 says the same.

THE CHAIRMAN: Right.

A. I think, chairman, this is why I'm saying that this circular is really quite central, seminal, because it says you've had this duty for financial matters and for organisational matters, and now we want you to pay the same attention we required you to do for those two to quality. And in this context, they mean health and social care quality.

THE CHAIRMAN: On this interpretation, the way that is done is by requiring you to put in place governance arrangements --

A. Exactly.

THE CHAIRMAN: -- which will allow you to monitor that quality.

A. Exactly.

THE CHAIRMAN: Right. Well, let me turn, I think, to

an issue, as a way of illustrating this, to see how it fits. Yesterday, we looked at a circular which came out from the local department in October 1994, which was in effect a direction to introduce new consent forms for patients.

UNKNOWN SPEAKER: 1995.

THE CHAIRMAN: It was issued in October 1995.

MR STEWART: 306-058-002.

THE CHAIRMAN: Okay. Can you give us 003 also, please? This was a circular -- I'm not sure if you remember much about this, Mr McKee. It was issued and, as you'll see from the date on the first page, it's 6 October 1995, and it is the action which is required of each trust -- this is paragraph 4. You are asked to:

"Ensure that procedures are put in place to assure that consent is obtained along the lines set out in the handbook and to introduced revised documentation, preferably based on the new model consent forms, with adequate monitoring arrangements."

And then the bit that was discussed with Dr Carson, paragraph 5:

"Trusts are asked to confirm by 31 December 1995 that this has been done."

Where does this fit into the demarcation between financial and organisational issues on the one hand and

the provision of clinical care on the other?

A. Well, I think it straddles it, chairman, so I think it's reasonable of the Department of Health in Belfast to ask trusts to implement this particular up-to-date guidance. But in a way, trusts can only implement it with the agreement, consent, co-operation of the medical staff. So I think we can only produce evidence that we had implemented this in 2005, and if that's the case then ...

THE CHAIRMAN: No, not 2005.

A. Maybe I'm anticipating an area of criticism. We were given some time to Christmas to report back, but great emphasis was made on tailoring it to your circumstances on, you know, taking local advice on these matters. It was rather milk-and-water-ish, really, but it set this target of when we had to report back. I think it's not reasonable for us to try to explain away why -- we can only produce evidence, as I understand it, that this new consent was in place as late as 2002.

THE CHAIRMAN: I'm sorry, that's not the point I'm concerned about.

A. I beg your pardon.

THE CHAIRMAN: The point I'm interested in exploring through this document, by way of example, is: if it is right that the board of the Trust is accountable to the

department for financial and organisational issues, but not for patient care issues, then this is an instruction from the department to introduce new consent procedures and not only to do that, but also to monitor them because the end of paragraph 4 is to:

"... introduce the revised documentation with adequate monitoring arrangements."

Is that really a financial or organisational issue, or is that not a patient-care issue?

A. I suppose the cop-out way to say -- it's in this grey area between the two. There is not a cliff between clinical safety and quality issues and then financial and organisational issues. The two do interact and there's a rubbing point where you have to negotiate this and deal with it.

THE CHAIRMAN: Okay. I'm exploring what you've described as, with hindsight, the unacceptable position in the mid-1990s, and I'm exploring if it's as stark, I have to say now, as this issue has emerged and developed -- we'll pick it up with the department when departmental witnesses come to give evidence in the spring to see what their take on it is. But it does seem at least arguable that the department here is giving a direction to a trust on what is predominantly a patient-care issue because the circumstances in which patients consent to

treatment and the basis on which they consent to treatment and the advice and information they're given before they consent to treatment seem to me to be closer to clinical and care issues than they are to financial and organisational issues; does that seem right to you?

A. Yes.

THE CHAIRMAN: You're suggesting they're in a grey area, but if they're in a grey area, they're closer to care and clinical issues than to -- okay, thank you.

MR McALINDEN: Mr Chairman, just in relation to that point, perhaps the issue could also be seen in light of legal responsibilities in terms of the actual consent mechanism and in terms of whether healthcare providers were acting lawfully by ensuring that treatment was provided in accordance with informed consent. So it may well be an issue not only of patient care but more particularly to ensure that organisations within Northern Ireland were acting within a legal framework.

THE CHAIRMAN: Thank you very much. That's a fair point.

MR STEWART: To add to this debate, can I call up our old friend PEL(93)36 at 210-003-1132. This is July 1994 and it's addressed to you as chief executive of the Trust. It's about the reporting of adverse incidents and reactions to medical equipment, products and drugs. You'll see the executive summary, second paragraph:

"General managers and chief executives are responsible for ensuring prompt reporting of adverse incidents and reactions and defective products relating to medical and non-medical equipment and supplies, food, buildings and plant."

If we go to page 1134, the purpose of this reporting system is described as being:

"An adverse incident is an event which gives rise to or has the potential to produce unexpected or unwanted effects involving the safety of patients [amongst others]."

Why would that come to you unless you were responsible for those issues concerning patients?

A. Well, chairman, I think the first thing I would say is: if the Department of Health were trying to emphasise some aspect of patient safety, I think it's bizarre that they would use their chief engineer -- described here as "divisional director" -- qualified in and experienced in engineering, to promulgate that advice. If we could return to the first page?

Q. Yes, page 1132.

A. You see, you have to read the whole circular. So the executive summary, first paragraph:

"This letter updates the hazard reporting procedure to take into account the EC medical devices directives

and the establishment of a UK competent authority."

Okay? I don't think the European Union, as it is now, has still not intervened in national sovereignty around issues of patient safety. This is health and safety and it's made clear, it's about medical devices, it's about medicines management, it's about broader health and safety, and it's about the physical safety of patients outwith clinical safety. So this circular has nothing to do with clinical safety.

Q. Surely drugs, monitoring machines, all are inextricably bound up with patient safety and care?

A. No, chairman, "drugs" really means was the wrong drug delivered, was an incident regarding a drug reported, and there's clear guidance about when you report on medicines management, not on the clinical aspect of medicines. So this is about medicines management among other things.

THE CHAIRMAN: The difference between whether Dr A gave the wrong drug as opposed to whether that drug, in its normal use, produces an adverse action?

A. Precisely, chairman.

THE CHAIRMAN: In essence, it's a product liability issue?

A. Precisely, chairman.

THE CHAIRMAN: And your point is that when the chief engineer from the estate and property division sends out

a circular, that's a very strong pointer to it not being a clinical care issue?

A. Precisely, chairman.

THE CHAIRMAN: And notwithstanding the very general wording of the penultimate or concluding paragraphs?

A. Yes.

MR STEWART: May we return to the issue of the reporting of deaths to you and ask for page 271/1, page 3, of your statement to be shown? Paragraph 9. The question is posed to you:

"Would you have expected the death of Claire Roberts [this is in 1996] to have been brought to your attention? If so how? If not, how do you explain this."

And you answer:

"At the time, I would not have expected the death of an individual patient to be reported to the chief executive unless the medical director was concerned about the care management provided by the service area, including the performance of a doctor with a potential for referral to GMC or if an independent external clinical review of the case was required or if there was a potential for reputational damage to the organisation."

What would you deem the case of a death, which might

have had a potential for reputational damage?
A. Well, I don't think, chairman, it's possible to give a sort of a priori definition of what that would be. It certainly took the Department of Health in their guidance -- the Department of Health Northern Ireland in their guidance to trusts a long time together before they could cobble together a definition. I think you have to treat each case on its merits and it depends what is happening externally through the media or through criticism from other bodies of the trust for a particular death.
THE CHAIRMAN: Sorry, but apart from that, that answer seems to indicate that if the medical director was concerned about the care management provided by Dr X, then you would have expected that to have been brought to your attention?
A. No, chairman.
THE CHAIRMAN: I'm sorry, is that not what you say?
Question 9:
"Would you have expected the death of Claire Roberts to have been brought to your attention?"
You say:
"At that time, I wouldn't have expected [say Claire's] death to be reported, unless Dr Carson was concerned about the care management provided by the

service area, including the performance of a doctor with potential for referral."
Does that not mean that if Dr Carson had been aware of Claire's death and if he thought that this raises issues about the service area, including the performance of, let's say, Dr Steen, then you would have expected that to be brought to your attention?
A. Yes, is the answer, because the medical director is discharging his medical leadership responsibility by reporting, in exceptional circumstances, this case to the chief executive. So for example, it might have led on to a discussion between him and me about: is there a prima facie case for instigating disciplinary action? In that case, because it's so cumbersome, we would have had to advise the chairman of the board and he would have had a role, and subsequently -- I can't remember the detail of disciplinary guidance at that stage, but I think a non-executive director was meant to nursemaid this particular case, for example, or any particular case. So it would have been -- there may have been circumstances when, if he had reported a case to me, it would have to be escalated into a wider governance zone. It would have left a particular clinical governance zone and gone into a wider governance paradigm for the Trust.
MR STEWART: Would your response have been solely targeted

at disciplinary proceedings or would you have been interested in whether or not the systems were working and the healthcare services were being provided appropriately?
A. I think we've also agreed that in that stage of the development of Health and Social Care in Northern Ireland there was no agreed protocol/guidance/acceptance about when you would trigger an investigation or when you would report it up. So there may or may not. This is a hypothetical situation. There may or may not have been a discussion about: should we do an investigation, is the coroner ... You know, what stage is the coroner's court case at, et cetera, et cetera.
THE CHAIRMAN: Can you give me an example of -- looking at the next line -- a case where you considered instigating an independent external clinical review?
A. I am afraid my memory fails me. I don't know if I went away and hunted through what information I have or could be given to me or whether I could recall one.
THE CHAIRMAN: I presume they would be few and far between, wouldn't they?
A. Probably in 1995, not, or in 1996, not.
MR STEWART: Can I ask you again: if you had received such a report, would you have taken any steps to see if the

operations of the hospital were effective and delivering the services appropriately?
A. Well, I think again, chairman, I would have to rely on professional advice for those matters. If the advice I got from the medical director or even clinical director was that we might have a problem with, then I think that would have triggered actions.
THE CHAIRMAN: Well, the renal transplant service had been developed in the preceding years.
A. Yes.
THE CHAIRMAN: Can I take it that the development of that -- that service moving to the Royal for the paediatric end of it, that the fact that they were brought within the Royal, that is something -- did that go to the board?
A. No, I can't recall even informal discussions with Professor Savage or other clinicians about this initiative. I don't believe it did come even to the medical director. I think it was a clinical initiative.
THE CHAIRMAN: Is that the degree of independence which the doctors had to start providing a paediatric transplant service without the Trust board knowing about it, even as a mention?
A. Yes, chairman, I think some doctors felt they had that level of independence.
THE CHAIRMAN: I'm not for a moment complaining about the

service starting; I'm just looking at structurally how this comes around.

A. And certainly in our discussions with commissioners, particularly the Eastern Health and Social Services Board, those discussions were bedevilled by the corporate part of the Trust not playing by the rules because they had already introduced this service and it would be politically awkward for the Eastern Health and Social Services Board to say, "Then we're not funding it and we'll have to close down". Almost always these services were introduced on the initiative of an individual or a group of doctors, and one of the great issues through this key 12-year period was to try to tell doctors that it was in their interests to tell us about their ambitions for service developments so that we could signal to the Eastern Board and play fair rather than them going ahead and doing it, and then us trying to scrabble around to justify why it had been introduced without approval or funding.

MR FORTUNE: Sir, there must have been some discussion about funding because Professor Savage couldn't magic out of thin air a paediatric dialysis and renal transplant service. He must have been talking to people over the years and there must have been some formal approval.

MR STEWART: Indeed, Professor Savage gave evidence that

a number of multidisciplinary staff were funded and that must have come from board level. There must have been a business plan.

A. I know of no such business plan or no such corporate discussions or approval from the Royal Hospitals to the development of a renal transplant service in the Trust.

THE CHAIRMAN: I'm not sure, but we heard yesterday from Dr Carson that after the introduction of the Trust in 1993, there were budgets devolved to different directorates; is that right?

A. Yes. Oh yes.

THE CHAIRMAN: So the paediatric directorate and various other directorates had an amount of money and it was up to them to use it wisely.

A. Well, yes, and --

THE CHAIRMAN: Is that --

A. Sorry?

THE CHAIRMAN: Is that why you say that they then had the independence because they had the money available to them for them to decide how to spend it, and contrary to Mr Fortune's point, then they can spend it by saying: we're going to use some of this money for a paediatric transplant service. And that can be done without reference to the board.

A. I believe it was done without reference to the board.

I think you can overstate how much ring-fenced resources were needed to begin renal transplantation on the Royal site, provided you have co-operation with a range of other multidisciplinary staff to do so.

THE CHAIRMAN: Because the staff are already there, you mean?

A. Yes.

THE CHAIRMAN: So if the staff are already there, the budget implications may not be significant?

A. They're at the margin, and then, thirdly, I think in many cases the clinical director was saying, "I didn't know about this service development either, I would have wished to know because I have budgetary responsibility". This is not a phenomenon confined to the Royal; this was an issue for all organisations at the time in question. And every delivery organisation was desperately trying to get control over service development so that they could have a fair discussion with their funders, called commissioners at that stage.

MR STEWART: You were particularly charged with achieving cost-effective services?

A. Yes.

Q. Where does cost-effectiveness merge with effective from a patient sense?

A. Of course, if we knew the answer to that, we wouldn't

need chief executives and their senior teams. This is something that organisations have had to wrestle with for the last 20 years and continue to wrestle with.

Q. So if you wrestled with it, you considered it?

A. Oh yes.

Q. Therefore, the considerations of effectiveness of patient services will have been part of your agenda.

A. Well, I think in those days you were concerned about the volume and category of services rather than their effectiveness. So for example, you kindly called up my foreword or introduction in the very first annual report, and I think I was quite proud to report -- I can't remember -- a 7 per cent productivity improvement because we had reduced our costs by 3 per cent and increased our activity by 4 per cent. And we believed collectively that showed a substantial productivity improvement. That was the sort of thing my political masters and my funders wanted to hear from me.

Q. But what you also write in your introductions is a narrative of patient services, of clinical excellence. It's something you return to time and time again in your writing.

A. I have to say again, that was in the context of a mission statement, an aspirational document, a picture of where we would want the Royal to be in three or five

years' time. It was not a statement of fact at the time; it was a statement of where we wanted to be. It was to be an encouragement and a guidance to staff, and to inculcate the idea that we were driven by putting the patient at the centre of all we do and driving improvements in clinical safety and patient quality.

Q. When would the Trust have reported the death of a patient to the department? Under what circumstances at that time, 1995/1996?

A. I'm sorry, I didn't hear a question in your comment. Maybe I misheard you.

THE CHAIRMAN: You did mishear. In 1995/1996, when would the Trust have reported the death of a patient to the department?

MR STEWART: What circumstances.

A. I can't describe the circumstances because there was no clear guidance as to in what circumstances and when we should report such an incident. I think that's accepted by Professor Mullan in his report and I think many other witnesses have said the same.

MR STEWART: WS061/2, page 170. This is the final page of your letter of 26 July 2005 to the solicitor for this inquiry. I just ask you to go down this final paragraph to the line beginning:

"Although in circumstances where we felt there were

lessons to be learnt with wider implication for the Health Service for Northern Ireland or the United Kingdom, from inquests or incident reporting, it would have been our practice to do so."

THE CHAIRMAN: If you just stop there. That's the position prior to July 2004.

MR STEWART: Yes.

THE CHAIRMAN: The rest of the paragraph is from July 2004.

MR STEWART: Yes.

THE CHAIRMAN: Okay.

MR STEWART: I ought to put it in this context because you say:

"Similarly, there was no mandatory requirement or formal mechanism for trusts to report the death of patients to the DHSSPS, unless there was concern that clinical practice or performance was impaired and likely to result in disciplinary action or referral to the GMC."

First of all, were there any mechanisms requiring you to report deaths of patients to the department if there was a concern that clinical practice/performance was impaired and likely to result in disciplinary action?

A. Chairman, again, I'm not sure I understand the point. The first half of that paragraph, a long paragraph,

clearly, says:

"Prior to July 2004, there was no formal mechanism or requirement to report clinical incidents".

Q. "Unless." That's the question I'm asking:

"Unless there was concern ..."

A. Similarly, there was no mandatory requirement or formal mechanism for us to report deaths of patients to the department unless there was concern.

Q. Two questions arise. First, there's:

"... no mandatory requirement or formal mechanism unless there's concern that clinical practice or performance was impaired and likely to result in disciplinary action."

So if you had identified a death where performance was impaired, what was the requirement for you to report it to the department?

A. I don't know. But, chairman, I think the wider point I'm making is that these things were rarely, if ever, reported to the chief executive.

THE CHAIRMAN: Sorry, I think the question comes from a construction of your sentence, which you may not have intended. The sentence starts:

"Similarly, there was no mandatory requirement or formal mechanism, unless there was concern ..."

One interpretation of that is that there was some

sort of requirement or mechanism if there was a concern, or did you write it in the sense that there was no mandatory requirement or formal mechanism, but we had a discretion or we had a freedom to report if we thought it was necessary?

A. I think the latter, chairman.

THE CHAIRMAN: Okay.

MR STEWART: So when did you think it necessary?

A. I would have relied on the advice of the medical director or the nursing director as appropriate, chairman.

THE CHAIRMAN: Can you remember, again without names, any incidents which were reported to the department prior to July 2004?

A. No, chairman, I can't. That doesn't mean there weren't any, it's just that my memory does not allow me to remember.

MR STEWART: What you said here is:

"Although, in circumstances, it would have been our practice to do so."

Why did you write that if you can't remember any circumstances or any instances?

A. I don't think you have to have a direct memory. And maybe I had a memory in 2004 that I've now lost in 2013. But I don't think it follows that I would have to have

had a direct memory of incidents when it happened as compared with taking the advice of the medical director to write that letter.

Q. Okay. So the practice you referred to is something which you remember, but not being a practice that was actually in place; is that what you're saying?

A. No. To say I can't remember -- and it's not unreasonable that I can't remember individual clinical cases so far back -- does not mean that it wasn't in practice or in place. Forgive me, chairman, but I don't see --

THE CHAIRMAN: I think you say you can't remember an example of the practice.

A. Yes, exactly.

MR STEWART: Can I ask you to go to WS061/1, page 2? This is your witness statement to the inquiry. If we might go six lines from the bottom, a sentence commencing:

"Prior to and since that time [the time being 2004], the Trust has reported on a number of serious adverse events to the department where, in our view, there was information on lessons learned which were of wider significance."

So you seem to have, at a slightly later time, a much clearer recollection.

MR SIMPSON: That's just comment left in the air and it's

unnecessary and unworthy of my learned friend to allow questions [inaudible] with sarcasm and incredulity. It's not acceptable in this situation.

MR STEWART: I'm sorry if sarcasm came through; I didn't mean it to be such. I asked you to respond [OVERSPEAKING].

THE CHAIRMAN: Mr Stewart, it's a June 2005 statement, isn't it, this witness statement?

MR STEWART: Yes.

THE CHAIRMAN: And Mr McKee's point is that the letter which he has just been referred to was also written in 2005. I think he's saying: look, it may be that I can't remember individual examples now, but it may be that there were examples prior to 2004 which I just don't remember nine years later because the inquiry's taken so long to get here.

A. And I think, chairman, you can assume that, in 2005 or 2006, I had the full panoply of an organisation to provide background information for me to allow me to make this witness statement. Whereas I've been retired for several years now and don't have access to that and my memory, not unreasonably, has failed since then.

MR STEWART: Can I ask about Adam Strain? The inquest took place, we've heard evidence about Dr Murnaghan's attendance, the attendance of the other clinicians at

it. Is it your evidence that you didn't receive any information about that at the time?

A. Yes.

Q. You have a press relations, public relations, corporate relations department in the hospital.

A. Yes.

Q. And presumably they keep you informed of what the press report on references to the hospital.

A. I can only restate my position that I have no memory of being advised through the press or through the communications office of the Royal of the death of Adam Strain, either contemporaneous with the sad death or contemporaneous with the inquest.

Q. Was a press cuttings officer retained by the public relations department?

A. I have no idea. Chairman, I can only repeat that I'm quite clear that I have no memory and I'm pretty certain that I was not told in any vehicle of the death of Adam Strain.

THE CHAIRMAN: Is that either at the time of his death or at the time of the inquest?

A. Yes, chairman.

MR STEWART: And you weren't, at that time, interested in what the press might have been saying about you personally or the performance of the Trust? Normally

people like chief executives are very interested indeed in what the press might be saying about their organisation. And you had a department dedicated to press matters. It didn't bring press cuttings to your attention?

A. Chairman, I can only repeat that I was not aware and it was not brought to my attention the death of Adam Strain contemporaneous with his sad death or contemporaneous with the inquest.

Q. What awareness did you have of the UTV's intention to broadcast their documentary programme?

A. Of their intention to broadcast it?

Q. Yes. Prior to broadcast, were you aware of that?

A. I did not deal with UTV directly.

Q. I know that.

A. We had decided that the medical director would formulate and gather the response to the programme. They had been asking us a whole series of questions and so I was briefed at a pretty high level by the head of communications and by the medical director, but I had no direct involvement in the lead-up to the broadcast of the programme.

Q. Because you know the Trust solicitors were writing letters and so forth to the producers of the programme.

A. Chairman, forgive me for being facetious, but there is

an implication in these questions that I'm not just omniscient, but omnipresent, and it denies the proper role of a chief executive to expect him to know everything that's going on. You know, really.

THE CHAIRMAN: I think that's a bit oversensitive, if I may say so. It's quite clear that even before this programme was broadcast, people were -- some people in the Trust were very exercised about what the anticipated contents of the programme were going to be. Mr Brangam was writing in advance of the programme, I think issuing threats at one point of legal action or writing in very, very strong terms to Ulster Television. That's almost certainly because there was some intimation that this programme was going to be very critical.

A. Yes.

THE CHAIRMAN: And I think what Mr Stewart is asking you in terms was, even without all the details necessarily being known to you, were you not advised between the medical director, who at the time was Dr McBride, I think --

MR STEWART: Yes.

THE CHAIRMAN: -- and the press office and the head of communications that this was something which was about to explode on you?

A. Oh yes. I'm sorry if I've not given that impression.

I was being briefed about it; I simply took no direct role in the process. For example, that is when I was advised about the death of Adam Strain because it was the central part of the programme.

MR STEWART: Thank you. But you said in response, but prior to the broadcast of the programme. When you heard that the programme was about hyponatraemia, this presumably unknown illness to you, and you heard that there may be assertions of some form of cover-up to be included in the broadcast, did you think to yourself, "Gosh, perhaps we had better see how many other cases of hyponatraemia we had in our Children's Hospital about that time", and perhaps suggest that the clinical coding be retrieved and this vital information brought forward?

A. I relied on the advice I was being given by the then medical director.

Q. Did it cross your mind?

A. No, it didn't, chairman.

Q. Because that's information that would have been readily obtainable for you.

A. Chairman, I can only say I relied on the advice that was given to me by the medical director. I'm aware of his statement and the detailed actions he took leading up to and immediately after the broadcast of the programme.

Q. Can I suggest to you in your position as chief executive

you're giving leadership, giving direction, and with something like a toxic broadcast about to go out on this question of hyponatraemia and the deaths of children, I would suggest to you it would be almost inevitable that you would say, "Let's find out the extent to which this is a problem".

A. Chairman, I relied on the advice that was given to me by the senior professional, the medical director.

Q. The answer to the question is "yes" or "no", not, "I relied upon the advice of somebody else".

A. Well, that advice was not to, and therefore I accepted that advice.

Q. You asked for advice or you were given the advice?

A. I'm not sure I can make a fair distinction. The relationship between me and my directors was familiar and conversational, so I'm not sure it's appropriate to make a distinction between whether I asked for it or I received it. It would have been part of a conversation, a dialogue.

Q. The advice that you received was not to seek further information upon the number of cases of hyponatraemia in the Children's Hospital?

A. I'm not even sure the issue arose. The medical director was briefing me on the actions he proposed to take or was taking and they did not include the actions that

you're referring to at the moment.

Q. Mr and Mrs Roberts have expressed great disquiet that, notwithstanding this television programme, they had to bring the contribution of hyponatraemia to their daughter's death to the attention of the hospital.

A. Yes.

Q. That's a matter of hurt to them.

A. Chairman, I accept that. It simply is the case that we did not link the two cases until Mr and Mrs Roberts enquired of us whether the circumstances, the sad circumstances, of their child's death had anything to do with hyponatraemia and the circumstances of Adam Strain's death.

Q. But the point of the question is that you didn't attempt to make any link.

THE CHAIRMAN: When Mr Roberts rang the hospital on the day after the broadcast, he was told that the hospital was expecting calls; isn't that right? He was told that the hospital was expecting calls as a result of the programme. It's not their most serious grievance, but it's a factor for them that the hospital knew the broadcast was coming, the hospital knew it was about hyponatraemia, and if they hadn't made any contact with the hospital, what we've now uncovered about Claire's death would remain entirely unknown because nobody

within the Royal was carrying out any investigation or any analysis to see whether there was any other linked death or any other associated death. I think that's their point. Without over-dramatising it, if Mr and Mrs Roberts hadn't made contact about Claire, we wouldn't know what we now know about Claire and are there other cases we don't know about because another parent didn't see the broadcast? So their issue really is: why wasn't the Royal proactive? Once this concern about hyponatraemia had been raised with it and you had Adam's case featuring prominently, you had Lucy's case, which had to be entirely re-opened, Raychel's case, which was known at the time because of the actions that Altnagelvin have taken, and they are saying, in a sort of general way, but particularly with reference to the trust: can our Health Service not be proactive when some issue arises? Why can't people in your position or people who you rely on for advice and a steer on clinical issues, why can't they be proactive?

A. I think I accept the argument you're making, chairman. I think it ends whether, by the standards of 1995, we acted adequately or not.

THE CHAIRMAN: I'm now talking about and you're now being asked about 2004. There's a particular context in 2004 with the broadcast coming up. You know generally it's

about hyponatraemia. In fact, you know more than that: you know it's about raising issues about why Adam died and Lucy's death not being examined in the way that it should have been, if I put it at its most neutral, and then Raychel dying and the concern about this as a connected series. And they're saying, even in 2004/2005, why wasn't the Royal proactive instead of relying on people like Mr and Mrs Roberts to contact them to see if there's a connection?

A. I think regrettably we didn't see any connection clinically between Adam Strain's death and Claire's death or any other death.

THE CHAIRMAN: Mr Stewart's last question to you was that you're not going to see a connection if you don't look for a connection, if you don't look to see, or even if you ask within the hospital to the various consultants: without looking back over the records of every child who has been treated here in the last 10 years, this is what's coming up from UTV, whatever our view of the tenor of the UTV programme, it is raising a serious issue, so can you think about children who you've treated and are there any other cases which we may have missed along the same lines? And I think that's what Mr and Mrs Roberts are suggesting might have been a better reaction from the Royal rather than to

wait for phone calls.

A. I accept that, chairman.

MR STEWART: Another thing you could have done was report it to the department.

A. I beg your pardon?

Q. Another thing you could have done, when Mr and Mrs Roberts brought the case of their daughter to your attention, was to report it to the department?

A. Yes.

Q. And can I ask that the 2004 circular, WS061/2, page 422, be shown? This is a circular from 2004, and you will see that it comes to you for action:

"For action: chief executives."

It sets out the requirement to report to the department, indeed within 72 hours, cases such as Claire's. If you like, we'll go through the criteria, but the purpose being, at paragraph 17 on page 426:

"Action by the department: the department will collate information on incidents reported to it through this mechanism and provide relevant analysis."

In other words, one way of finding out whether Claire's case was linked to others was to report it, as you were obligated to do, under the 2004 circular. Can I ask why that was not done?

A. Chairman, forgive me, but it would help if the date of

the UTV programme --

THE CHAIRMAN: October 2004.

MR STEWART: Late October 2004.

A. I cannot give an adequate explanation as to why, except that, again, professional judgment was that this did not fall under the purview of the --

Q. Whose judgment was that?

A. That would have been the medical director or, because this had received so much publicity, the department were well aware of it through other channels and therefore it would be unnecessary duplication to report it under the aegis of this circular.

Q. Unfortunately, Dr McBride has given his evidence to the inquiry on that point, saying he did report it in 2006 and he accepts it was an error on his part in not reporting it earlier, pursuant to the circular. Do you accept that you would have been responsible in 2004 for this omission?

A. Well, I am accountable for errors such as this, particularly given the date.

Q. Yes.

A. I would make a distinction between my accountability for it and my direct responsibility for it.

Q. Okay. There was, however, one piece of information which was fed to the department at that time in relation

to Adam Strain's case, and that appears at 023-045-105. This is from your press and public relations officer, who on 20 September -- that's one month prior to the date of broadcast -- sends it to somebody in the department saying:

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

Have you seen that before?

A. I don't recall seeing it before.

Q. Can you think why such information would have been given in relation to Adam Strain's case to the department?

A. Well, I'm only speculating, chairman, but given the date of the letter, this may have been in the lead-up to the broadcast of the story. So this was communications managers touching base with each other, different hierarchies in the wider health system, as a matter of courtesy or responsibility.

THE CHAIRMAN: The problem about this, I'm afraid, is that when Christine Stewart sought advice on this the person who she took advice from and provided information to the

department is the person who, regrettably, made a major error in Adam's treatment.

A. Yes.

THE CHAIRMAN: It's curious and unfortunate that it appears on this extract that she did not speak to Dr Murnaghan, who was at the inquest and who knew that the inquest finding was, in effect, critical of Dr Taylor, or to Professor Savage or Mr Keane, who might have been over in the City rather than the Royal, but contactable in any event. The information just isn't correct, I'm afraid.

A. I accept that.

THE CHAIRMAN: It's perhaps because she spoke to a person who, at that time, was not facing up to his mistake.

MR STEWART: Immediately after the broadcast, the permanent secretary of the department, Clive Gowdy, sent a letter on 28 October 2004. It appears at 137-002-001. It's addressed to Anne Balmer, chair of the trust. It says:

"The UTV insight programme of last Thursday evening made a number of allegations associated with the tragic death of Lucy Crawford. The department is currently considering how it should respond to these allegations. Without prejudice to the outcome of these deliberations, there is a need to ensure that all relevant records and documents are secured so that, if necessary, they can be

made available for independent examination. To that end, I am writing to you that the department now requires you, as chair, to take whatever steps are necessary to secure and keep safe all documentation which is within the custody or control of the trust, or its employees, servants or agents, including draft documentation and information in electronic format pertaining to the deaths of Lucy, Raychel and Adam."

This was after Claire's death had been brought to the attention of the Trust and Mr Walby has told us that he made no effort to secure or even search for clinical coding records or computer records or audit records or any of the others from a number of category of records that we can think of. Can I ask you why a proper attempt to comply with this letter was not made?

A. I don't know, chairman.

Q. If the page could be turned over to 002 -- or perhaps 002 could be shown beside it -- the letter concludes with a further requirement:

"Confirmation in writing being given that the organisation has taken the necessary action and secured all relevant information by Friday 5 November."

Seemingly, that also went without compliance and I see that, in fact, Mr Gowdy copies this letter to yourself. Did you see the letter at the time?

A. I believe so.

Q. Did you not therefore make it your business to ensure it was complied with and the confirmation was given?

A. Well, I hope I made an attempt to make it my business, but my memory does not recall why we did not make a response by 5 November, some week after the letter was sent.

Q. I'm not sure that any response was given.

A. I'm sorry, chairman, I missed that.

Q. I'm not sure that any response or confirmation was given, at any date, whether a week later or at all.

A. I can't recall the detail of whether there was or was not a response, chairman.

Q. It is right to say, is it, that you had a particular responsibility for the complaints procedure within the Trust?

A. Yes.

Q. And I want to ask you whether or not it occurred to you to initiate an investigation, a full and thorough investigation into the death of Claire Roberts.

A. No, it didn't, chairman. I think at the time the advice I was given was that referral to the coroner and the investigation through Professor Ian Young, et cetera, was sufficient. I'm aware of the contradictions that exist in the legal definition of a complaint that would

have included, in effect, Mr and Mrs Roberts approaching the Royal and saying, "Was there a connection?", even though they weren't making a formal complaint. But I think we held back from treating it down the complaints route in case that complicated issues. But I understand -- well, I simply assert that this is a grey area where the formal definition of a complaint would have meant it should have been treated down the complaints route, but in practice it was felt that this would deflect the Trust from dealing with the enquiries that Mr and Mrs Roberts had made.

Q. And you didn't write to them?

A. I didn't write to them, no. At the time I didn't. The correspondence was between the medical director because he was dealing directly with it and the family.

Q. I think the correspondence was from Professor Rooney and the family. I think you are charged with writing to them at 314-016-019. It's the part of the complaints procedure dealing with the role of the chief executive. It says at paragraph 6.10:

"All complaints, oral or written, should receive a positive and full response."

Paragraph 6.11:

"All written complaints must receive a response in writing from the chief executive."

I can understand that you were a very busy man. Did you, as 6.11 proceeds to say:

"The reply might take the form of a full personally-signed response or a shorter letter covering a fuller report from another member of staff, which the chief executive has reviewed and is content with."

That's exactly what happened here: Professor Rooney put together a full response letter. Did you have anything to do with that?

A. I've already acknowledged that while the strict legal definition of a complaint -- and I think you have some past knowledge of this -- is any enquiry, in practice I think organisations didn't convert every enquiry into a complaint and that we chose not to confuse the issue by going down the complaints route, and therefore the guidance here within the complaints procedure doesn't stand because, for better or worse, we decided not to treat it as a complaint.

THE CHAIRMAN: Mr Quinn, can I ask you this? There is an argument that the Royal should have investigated, but Mr Roberts had made it clear at the time that he wanted Claire's death to come to this inquiry and there was also to be an inquest. In terms of the Royal's decision not to investigate Claire's death internally at that time, would I be right in thinking that's one of

their --

MR QUINN: That's one of the issues they want to raise. In fact, they have already instructed me to raise it today at the end with Mr Stewart to ask questions on it. They also want to raise the issue as to why, after the inquest, when questions were asked at the inquest, that the Royal Victoria Hospital didn't carry out a full investigation after the inquest because the difference is in Adam's case the coroner actually made some recommendations in relation to steps that should be taken by the Royal. In Claire's case he didn't, and therefore the Roberts would have expected the Royal Victoria Hospital to take up, as it were, where the coroner left off and carry out some sort of internal investigation in relation to the issues that were raised by the coroner.

THE CHAIRMAN: And that's notwithstanding the fact that there had already been some preliminary contact with the inquiry from Mr and Mrs Roberts about the inquiry doing the investigation.

MR QUINN: Exactly because there are issues that were never dealt with, as we know from the letters that passed between Professor Rooney and the Roberts.

THE CHAIRMAN: Yes.

MR STEWART: Mr and Mrs Roberts gave evidence that they were

not told that hyponatraemia had played any part in the death of their daughter until 2004, and indeed it was left to them to read the medical notes and records and discover that a potentially catastrophic drug overdose may have occurred. So naturally, they're not very happy with the level of investigation or review conducted by the Trust. In the light of that, I wonder why there were claims made in various documents -- and here's one: this is the annual report of 2004/2005 at 302-096-002. We can go over the page to 004, "A framework for learning".

This is above the strapline about "providing the highest quality healthcare" and so forth. It is written in 2004/2005:

"In line with good governance and our commitment to openness and transparency, the Royal Hospital acknowledges to patients and the public when things go wrong and systematically ascertains what happened, how it happened and why so that we can do all that is possible to ensure lessons are learned to prevent a recurrence."

And so on. Why are the annual reports full of statements like this, which don't seem to accord with what we have learned from the evidence?

A. Well, chairman, I think I have to make several points.

First of all, I accept that the quality of communication between the Roberts family and the clinical team at the time of the death of Claire was not adequate and we failed the family. I have to say that the view was taken that the establishment of the inquiry would trump and supersede any further investigations we would make and, in fact, on the contrary, us carrying out further investigations might have been seen as trying to tidy things up after the event.

Thirdly, this is a statement of how we believe the organisation is behaving as a corporate body, and of course I readily acknowledge that, from time to time, we fail the standards we set ourselves.

THE CHAIRMAN: I think the point of the question is slightly different. As a result of the documentary, of Mr and Mrs Roberts seeing it, of them contacting the hospital, it then emerged that there were more serious issues about Claire's case than had previously been revealed -- at least revealed to the family. That led on to the involvement of Professor Young and Professor Rooney, it led to Claire's death being referred to the coroner for an inquest, and it also led to Claire's death being taken on by this inquiry. But in all of this, the Roberts were left -- and it wasn't until, I think, they were here that they heard Mr Walby say that as a result

of the inquest he would have advised the trust to settle any claim for medical negligence on the basis alone of the fact that there wasn't a repeat on the Tuesday morning of tests which had been previously carried out on Monday night. And he was accepting, in terms, that the Trust was significantly at fault in Claire's death. But Mr and Mrs Roberts heard that here, too many years later, but let's suppose they had heard that in 2006 or 2007 at the inquiry, rather than 2012. The fact that they wait until they're here to hear that statement and hear those words isn't really in keeping with what is contained in the annual report about acknowledging to patients and the public when things go wrong. Their concern is they didn't get that acknowledgment.

A. I accept that, chairman.

THE CHAIRMAN: And the contrast that Mr Stewart is asking you to respond to is between what is being asserted in the annual reports, which is reassuring and is positive, and what happened at least in this case. Because even if you weren't aware in 1995 or 1996 of what had gone wrong in Claire's case and even if that wasn't more generally recognised by those who were involved in her care -- let's make that assumption -- it was recognised between 2004 and 2006 how badly things had gone wrong in Claire's case. But I think the

Roberts' concern is they never got that acknowledgment from the Trust. But your annual report is saying, "This is what we do". So how can you say in your annual report, "This is what we do", when, in this case, it wasn't done? That's the problem.

A. I accept that, chairman. But in mitigation, if you like, I'm saying that this was a general statement of what we believed we were doing, notwithstanding that we clearly failed Mr and Mrs Roberts on a number of engagements throughout the time from the death of Claire to their raising it with us after the programme to subsequent discussions with Mr and Mrs Roberts.

I accept that.

THE CHAIRMAN: I want to break shortly, Mr Stewart. Is this a convenient point or not?

MR STEWART: I won't be much longer, really.

THE CHAIRMAN: Then if you can sit on, Mr McKee.

MR STEWART: I can short circuit many of the questions by coming to the central question.

Do you accept that there have been failings in both these cases?

A. Yes, chairman.

Q. And who ultimately is responsible?

A. Chairman, clearly I've thought about this question many times. May I take a little time to get to my answer --

THE CHAIRMAN: Yes.

A. -- because it's so central to the inquiry. If these incidents had happened closer to the present day or even the present day, then any criticism levied on me would have been interpreted through the quality of the clinical governance system that was in place at the time: did it comply with the basic requirements, was it well understood across the organisation, did the chief executive set a clear example in his engagements with staff that this was important, et cetera? So notwithstanding the need for a scapegoat, I think any responsibility that would fall to the chief executive would depend on whether this was an isolated incident with clear clinical components to it or whether it was an indication of systemic failure.

If I was being held to account in 2004, I think you would have to acknowledge that we were only beginning to introduce a proper system of clinical governance. You would have to tease out the relationship and responsibilities between the medical director and other clinical staff and me and you would have to come to a judgment. Now, the standards that obtained, particularly in 1994 and 2004, were pitifully poor by today's standards and having thought long and hard about it, I think that -- though it is a judgment for others

to make rather than me -- I don't think that the responsibility for this falls to me. Whether there are wider accountabilities that I would have to accept is a different matter altogether.

THE CHAIRMAN: I presume when you said that you're not diminishing in any way your regret or your sympathy for the family, so the fact that these failings occurred, but you are distinguishing between your personal responsibility and the collective responsibility of everyone involved in the Royal for what happened?

A. I don't want to appear that I'm sort of whitewashing. It's a very sensitive issue.

THE CHAIRMAN: I understand. I'm not looking for a scapegoat.

A. But my political masters often were.

THE CHAIRMAN: It's not my role in any way to look for a scapegoat. It's my role to establish and report on what went wrong. In fact, what went wrong is reasonably clear.

A. Yes.

THE CHAIRMAN: And there are different levels of involvement of certain individuals and different levels of responsibility for them. But this is not a scapegoating exercise; okay? I think you wanted to say something further, did you?

A. No, I simply wanted to say that it's clear that we failed Adam Strain and his family in the care management of his fluids. It's clear that we failed Claire Roberts in the treatment she received. And we failed in communication, both before Claire's death and afterwards, because, for example, we led Mr and Mrs Roberts to believe that they could safely go home, that there was not going to be a crisis that evening, et cetera. And then subsequently, I think we failed the Roberts family when they drew to our attention the question: is there a link between the two deaths? So we could have handled -- we should have handled our communication with Mr and Mrs Roberts much better.

THE CHAIRMAN: Thank you. Mr Stewart, have you anything further?

MR STEWART: No. Mr Simpson gave me --

MR SIMPSON: I gave my learned friend a crib sheet of things. Perhaps if we rose for a period of time to tidy those up rather than keep everybody waiting.

THE CHAIRMAN: As you may know, if there are any further questions which need to be asked, Mr Simpson, you get the last word with Mr McKee because he's your witness.

(1.50 pm)

(A short break)

(1.58 pm)

MR STEWART: One or two further issues have arisen.

Can I ask you, Mr McKee, about workload issues, staffing levels and resource issues in 1995 and 1996? We have a copy of a document called "Getting it together" which sets out some of the staffing problems experienced by the Children's Hospital. It appears at WS266/1, page 28. That's the cover, just to remind you. If we could go to page 54 of the document. Under the heading "Funding", it describes the funding of paediatric services and goes on to state:

"The Royal Hospitals have recently reviewed staffing levels and cost pressures within the Children's Hospital on the basis of current activity levels."

And it reaches a number of conclusions in relation to there essentially not being enough money. Can you describe for us some of the background to the staffing problems that did arise at about that time?

A. The background to it? Well, chairman, this was a document written by the Royal Hospitals Corporate in conjunction with the paediatric directorate in response to their voluble concerns about staffing levels. We, as a corporate body, had concerns about other staffing levels, particularly for small specialties. I think Northern Ireland, with a population of 1.5 million at the time, had chosen, as a policy, to be as

independent and self-sufficient in specialties, perhaps because of its political and geographic isolation, as any English region might be with a population of 5 or 10 million, and this placed great strains on the delivery of these specialist services. So notwithstanding our concerns about paediatrics, we had concerns about many other small specialties that were struggling to survive. So we used it as a negotiating document with the department and the four boards as a lobbying document. The funding for services for the Children's Hospital, the paediatric directorate, was given out on a capitation basis to the four area boards, which we thought was wholly inappropriate, and they got together a body that might have been called a regional commissioning consortium, where representatives of each of the four boards negotiated how much of their capitation share of the money would be allocated back to the Trust, the Children's Hospital, the paediatric directorate.

And of course, there was a natural reluctance on the part of the public health doctor who was representing, for example, the Western Health and Social Services board, to bypass the pressures in his local DGH, Altnagelvin, and allocate money to some distant whingeing specialist hospital in Belfast. So we thought

this was a very unfair mechanism that we struggled against. Is that an adequate answer?

THE CHAIRMAN: I take it that the argument for trying to provide as many specialties as you can is because people want a local health service and we don't want to get on to the plane to Birmingham or Manchester or Edinburgh or somewhere else for our treatment --

A. Yes, chairman.

THE CHAIRMAN: -- or even to go down to Dublin?

A. Yes. Well, I talked about the political and geographic isolation of Northern Ireland.

THE CHAIRMAN: Yes. The problem was within the budget/resources, could you actually provide the specialist services for a small population?

A. We struggled to do so. I may be riding a personal hobby horse, but certainly at the time this document was written in 1996, I think, Northern Ireland had an over-reliance on small market town hospitals and subsequent policy guidance said that the number of fully acute hospitals should be reduced to six, and it has taken some time, even up to the present day, to align patterns of delivery of care to those policy documents. But the money was spent on sustaining local hospitals, trying to provide emergency services, et cetera, and not on the regional specialties. At least that would be my

contention.

THE CHAIRMAN: And we see that issue continuing with at least two recent reports. One specifically about paediatric transplants, about whether some of these services can be continued only within Northern Ireland, or whether we need to look at an all-Ireland basis for them. And cardiology is another one, isn't it?

A. Interventional cardiology.

THE CHAIRMAN: Yes. Thank you.

A. I suppose I would add that the evidence currently is quite clear that the paediatric cardiac surgery service and interventional cardiology has outcomes as good as other centres, but even so in England, they have rationalised, I think, down to five or ten centres for a population of 55 million, and we are still trying to sustain a fully-fledged service. So it's anticipating some future deterioration in staffing or quality, but I think we were able, from 2006, to report clinical indicators that said there were no concerns about the quality of care as judged through a range of clinical indicators in the Children's Hospital. That's a testament to the quality of individual clinicians, doctors and nurses, et cetera, rather than to adequate staffing levels.

THE CHAIRMAN: But a side issue on this is that it means

that you are more dependent than you would like to be on individual clinicians --

A. Yes.

THE CHAIRMAN: -- because there's no fallback. If you have got a very small team and there's a problem with one of them or one of them is off ill, to take a more neutral example, you can have a service which is in jeopardy for so long as that problem exists.

A. Well, chairman, let me say two things in support of what you're saying. First of all, because of the reputation and prestige of the Royal Group of Hospitals -- save for very small specialties where we couldn't recruit from Great Britain because of people's perception of political violence in Northern Ireland -- we were able to recruit consultants, for example, to an arguably much higher standard than most other hospitals would be able to do and we relied heavily on their commitment, their dedication. So notwithstanding the fact that the Royal has made mistakes and will continue to make some mistakes -- you know, these are not perfect institutions -- we were able to -- when I was there and now -- demonstrate that the level of mistakes we make is considerably lower than the average compared with similar institutions. But you're right, we did rely -- we abused the commitment and dedication of medical

staff, senior clinical staff, to achieve that.

THE CHAIRMAN: Thank you. Mr Fortune?

MR FORTUNE: Sir, I'm accepting that many patients wish to be treated locally and not talking about sending patients to Birmingham, Manchester or Edinburgh. Given also that we've heard that the Royal, particularly the Children's Hospital, was the regional centre, did that not have any predominance in the obtaining of funds or was it at the mercy of the four boards and what came back to the Royal?

THE CHAIRMAN: I suspect if you ask Mr McKee that question, we'll be here for the rest of the afternoon.

A. Very little of the Department of Health's budget was allocated directly to individual organisations. So for example, the money to support clinical audit was allocated directly -- no, even it wasn't, it was given to area boards. Area boards tended either to use a weighted capitation formula, which disadvantaged regional services, or else they used a sort of apparent fairness rather than equity. In other words, the Royal in those days was as big as the next two biggest trusts, but it tended to get -- you know, if there were 13 trusts, the money would be divvied out 13 equal ways as apparent fairness, even though we were much bigger.

But it's this key point that the four area boards

received their budget on a capitation basis and that capitation basis didn't account of the regional component and then we had to argue to get it back. It's quite understandable, if not fair, that the Western Board or the Southern Board would look after their own local paediatric unit before sending money to this avaricious central, regional service.

THE CHAIRMAN: If I ask the same question of someone coming down from Altnagelvin in Raychel's case, will we get a different slant on it?

A. Perhaps.

MR STEWART: Just for the sake of completeness, can I ask you to look at document 306-096-001? This is a copy of the April 1994 code of conduct, code of accountability. Would that have been one to which you'd have subscribed at that time? We can go through page 003, which is the first page of text:

"Public service values. Accountability, probity, openness. General principles."

A. I suspect, chairman, from the cover of the document that this was issued from London as guidance or a code of conduct for English health bodies or health boards. I can't remember it, I can't recall it. If you wanted to give me a sort of balanced judgment as to whether I thought it was fair, I would have to read it. But

it wouldn't have been a code of conduct that applied to Northern Ireland or probably, for that matter, Scotland. They would have had to choose whether to promulgate their own code of conduct.

THE CHAIRMAN: In a general way, were there -- I'm not sure it's necessary to go into detail on this, but were there differences of significance between the DoH code from London and the local code?

A. Probably not, but I can't recall the local code.

THE CHAIRMAN: I understand, okay.

MR STEWART: And the same observations apply to the code of accountability?

A. Yes.

MR STEWART: I think Mr Quinn has an issue, unless there's anything else you wish to say in relation to staffing or related issues.

A. No, chairman.

THE CHAIRMAN: Mr Quinn.

Questions from MR QUINN

MR QUINN: I just want to ask some questions in relation to 1996 concerning the standard of care and the review of the process that would have applied when Claire died.

In 1996, we've heard from Dr Carson that the standard would have been that there would be a consultant clinician-led investigation at probably

ward level involving junior doctors and nurses. I'm quoting from the transcript of Dr Carson. We've also heard that there seems to have been no internal investigation, consultant-led or otherwise. Who would you have expected to have led such an investigation, if one had been carried out?

A. Chairman, the senior clinician involved in the case.

Q. And who would you feel would have been that senior clinician at that time?

A. I'm not sure I can give a comment on that, chairman, because I would really have to sit down with clinical advice and have it explained to me what the convention and etiquette was as to who would be the senior clinician in --

Q. If a patient is admitted under the care of a consultant, would that not make that patient that consultant's patient?

A. Probably, chairman.

Q. In 1996, what were the duties, if any, on consultants and doctors to report further up the chain in relation to the sudden death, particularly of a child who went in in a healthy state and died within 48 hours?

A. Chairman, I don't know the answer to that question, but I know that my medical director felt in those circumstances he should have been advised and that it

should have gone up the chain as far as the medical director.

Q. We know that it didn't go up the chain at all in this case; would that surprise you?

A. Well, with the wonderful benefit of hindsight, probably not.

Q. Not?

A. Surprise me.

Q. It wouldn't surprise you?

A. Yes.

THE CHAIRMAN: Why not?

A. Because of the predominance of clinical independence, justified through the heavy or almost entire reliance on professional self-regulation. That was the dominant, paramount culture at the time.

MR QUINN: But given in this case that there was no self-regulation in the form of a consultant-led investigation at ward level, does it not surprise you that it wasn't reported further up the chain?

A. I suppose I have to answer "yes" to that question.

Q. And would you also be surprised that there was no clinician or consultant-led investigation at ward level in relation to Claire's case?

A. Well, in this case I think my surprise is based on the advice that I would get from a medical director that in,

these circumstances, he, the medical director, might reasonably have been expected to have been told about it.

THE CHAIRMAN: Thank you. Unless there are any more questions. Over to you, Mr Simpson.

MR SIMPSON: Just one matter, but I think from talking to my learned friend Mr Stewart, it may be completely unnecessary. One of the matters Mr McKee wanted to deal with was Professor Mullan's assertion throughout his report that there was a requirement on Mr McKee to provide statements on internal control, but I understand from talking to Mr Stewart that Professor Mullan now accepts that that is not the case in Northern Ireland at the material time. And if that's so, then I have no further questions.

THE CHAIRMAN: Thank you very much. Okay, Mr McKee, that brings an end to your evidence. I'm very grateful to you for the information you've provided to the inquiry, for your statements and for coming today. You're now free to leave. Thank you very much indeed.

(The witness withdrew)

I would like to hear on a couple of points from Professor Mullan in light of the evidence we've heard this morning. What I'm going to do is take a short break. I think, Mr Quinn, there's an issue which arose

yesterday from the fresh scrutiny by you and your client of Claire's notes. I think you made your points about it; I had interrupted Mr Fortune making his points in reply because we needed to get the evidence finished yesterday, and the issue was beginning to run away a bit in terms of time.

MR QUINN: Mr Fortune and I discussed this and I don't think Mr Fortune is making any points after I assured him that this wasn't an attack on Dr Steen. If anything, it was actually pointing out that Dr Steen probably didn't see the 4 pm on the notes.

THE CHAIRMAN: But you're left with a query about who then wrote in 4 pm? And this feeds into your general concern: were the notes tidied up, to put it neutrally, at some point, either immediately after Claire's death, or perhaps more worryingly, some years later.

MR QUINN: And I'm coming down, in support of my client, of the eight years later because it would seem that Dr Steen did not see the 4 pm, so therefore it would seem that eight years later, the notes might have been tidied up.

THE CHAIRMAN: Mr Fortune, have you anything you need to say?

MR FORTUNE: Given that there is no allegation being made against Dr Steen and, having listened to my learned

friend carefully, there is very much, as I'm sure he'll agree, an element of speculation as to when and by whom any entry was made. In the circumstances, there is nothing I need say by way of submission to you.

THE CHAIRMAN: Okay. Mr McAlinden?

MR McALINDEN: I think there are two interpretations that could be placed on the timeline that has been prepared by Dr Steen.

THE CHAIRMAN: The 2004 document?

MR McALINDEN: Yes. She uses the word "approximately" because the "4 pm" wasn't there and she has to try and construct the time. The second interpretation that could be placed on it is that the entry of 4 pm was there, but she knew it couldn't be right, and therefore she had to construct an approximate time on the basis of other information. So I think it would be important if Dr Steen could be asked which of those two explanations is the correct explanation in this case.

THE CHAIRMAN: I think there are two points. One is I think we will ask Dr Webb formally to confirm in a statement that the 4 pm entry in black pen is not his entry or, if it is, how come it's in a different pen and so on. We'll ask a few questions around that.

MR McALINDEN: Yes.

THE CHAIRMAN: And your suggestion is we also ask Dr Steen

to be asked about the points which you've just raised?

MR McALINDEN: Yes, because my learned friend seems to be putting a case forward that the use of the word "approximately" after the time she has stated to be the time of Dr Webb's first intervention must be used because "4 pm" wasn't written in the notes at that time. The other explanation for the use of the time with brackets, approximately, is that she did see that but she knew it couldn't be right, therefore she has to construct the approximate time of Dr Webb's first intervention from other information.

THE CHAIRMAN: Okay. Does anybody resist this information being sought?

MR FORTUNE: Sir, you had me yesterday, albeit without instructions, try to relate how the word "approximately" could be interpreted by reference to notes within the medical records, in particular the time of the administration of the diazepam and also the anticonvulsant medication later. I'm not sure where this additional line of taking statements is going to take us, but if you want to start with Dr Webb, let's see what he says and, thereafter, if you pursue the matter with Dr Steen, we'll see what she has to say. But at this stage, I'm saying nothing more.

THE CHAIRMAN: We'll do it in sequence with Dr Webb first

and then see what his response is about the 4 pm, and then, if appropriate, ask follow-up questions to Dr Steen.

MR QUINN: That would seem the logical approach.

THE CHAIRMAN: Okay. We'll do that.

I'm not going to take a long enough break for you to go into town to get lunch, but I want to take a short break for 20 minutes and I'll hear from Professor Mullan. I want to hear what Professor Mullan in particular says about the issue of accountability and responsibility of the chief executive for clinical issues, just to clarify the extent to which there's any difference between his position and the position explained by Mr McKee this morning. So we'll do that at 2.40 and then we'll do whatever tidy-up and housekeeping is required before we adjourn.

(2.20 pm)

(A short break)

(2.40 pm)

(Delay in proceedings)

(2.56 pm)

THE CHAIRMAN: I'm sorry I kept everybody waiting. That was my fault.

MR McCREA: Mr Chairman, just before the doctor is sworn, if I could come back just to those points that were made.

We're wearing our hat almost as assisting the inquiry in this respect. If you turn, Mr Chairman, to Dr Webb's deposition statement, and that is at 139-156-015. It doesn't need to be brought up because it's simply points that you might like to put to Dr Webb. He said:

"The next medical note entry is dated October 26, 1996."

THE CHAIRMAN: Sorry, Mr McCrea, I don't have it in front of me. Give me the reference again, please.

MR McCREA: 139-156-015. That's the exact page. It's page 4 of Dr Webb's statement, deposition to the coroner. And what the doctor writes is:

"The next medical note entry is dated October 22, 1996 at 4 pm and is written by myself."

Unfortunately, Dr Webb's statement is undated, but he nonetheless has put down 4 pm. I am not sure whether the 4 pm entry that he refers to is an entry which is written by himself or the time, it's ambiguous, but he has written it down, in fairness.

THE CHAIRMAN: He says the entry is written by himself.

MR McCREA: Yes. And then if you go to the depositions both of Dr Steen and also Professor Young -- I'll give you the references, 139-156-005, which is Heather Steen's and Professor Young's is 139-156-007 -- both actually refer to:

"... a subsequent note in the chart by Dr David Webb, consultant, who saw Claire around about lunchtime."

That's the phrase that both of them use. And finally, and for the sake of completeness, in Dr Steen's draft statement -- the reference is 139-132-007 -- there is actually a prompted correction, I think, in that, by Mr Walby, where she says at paragraph 2, fourth line, really, from the bottom:

"She [that is Claire] was seen some time in and around lunchtime by Dr Webb."

And you can see the correction is:

"Question: just around lunchtime?"

It was just to put those four points for the sake of completeness.

THE CHAIRMAN: Thank you.

MR FORTUNE: My learned friend Mr Quinn did me the courtesy of informing me that his junior was going to raise these matters. I have nothing further to say at this stage.

THE CHAIRMAN: Thank you.

PROFESSOR AIDAN MULLAN (called)

Questions from MR STEWART

MR STEWART: Professor, you are an executive director of the North-East Strategic Health Authority in England, and a visiting professor at Teesside University, and

you have furnished the inquiry with your report dated 29 February 2012 under cover of witness statement 241/1. Are you content that the inquiry should adopt that as your formal evidence --

A. Yes, please.

Q. -- subject to such qualifications as you may wish to make to it?

A. As we have previously -- yes.

Q. You have also kindly supplied a copy of your CV. I would ask that page 306-092-002 be displayed. At the top of the page, you provide a summary of your career within the Health Service from 1980 through to 2007 and on to date. Can you please, quite briefly, take us through the various posts and positions you have held?

A. Probably just one amendment from when this was written in February 2012, then I have since retired from the Strategic Health Authority in March, and now have a part-time professorship -- not a visiting professorship -- at Tees University.

But if you go very briefly, March 1980, at which time I would be 26, for a variety of reasons I applied for a job at Roose Hospital in Barrow-in-Furness, Cumbria, for a ward orderly at that time. In the job description, it was looking for somebody that had previous security experience and I had flirted with the

Liverpool Police as a police cadet and decided not to go.

From there, you'll see I was just over 12 months there. While I was being interviewed for the job, the then nursing officer actually said to me, "We notice you've got two A Levels, eight O Levels, et cetera, had you ever considered being a nurse?", and I did look kind of aghast. I was applying for, at that time, a fairly bloke-ish job -- and that would be very non-politically correct today -- but I hadn't. But as time went on, certainly as I was helping the registered nurses and the auxiliaries specifically to look after male patients, because that was what the job was, I took an interest in what things were like when they were talking about this person's have a CVA, which was a stroke, and I saw things that really inspired me to talk to my wife and say, could we, at that time -- having already a child -- afford for me to ironically reduce my salary, become a student nurse, because I would be very interested in it. I attended the South Cumbria School of Nursing, qualified in August 1984, worked as a staff nurse in intensive care until December 1985.

At that time, I recall that my ambition was to be a clinical tutor, and at that time -- it's not the same today -- you had to have at least two years' experience

as a ward sister or charge nurse before you would be accepted for clinical tutor training.

I applied for and received the job as charge nurse in the high dependency unit in Leigh Infirmary in Lancashire. While I was there, awaiting actually the development of the high dependency unit -- it wasn't quite finished -- I was asked if I would go on what they called then a first-line management programme. I did, I realised at that very early stage that actually if I wanted to continue my ambition of influencing standards of care, improving nursing care as it was then, then it might be a route for me to go into that.

I applied for and actually returned to my old hospital. It had changed, it was then Furness General Hospital, a fairly new hospital, in September 1988 as a senior nursing officer with responsibility at that time for intensive care, paediatrics and orthopaedics.

During that period, between 1988 and 1990, there was quite a move -- and it's relevant to this inquiry -- a move to encourage clinicians, doctors, nurses, allied health professions, to look towards becoming chief executives. So I was on a general management training scheme and was sponsored to do a diploma in management studies and a master's in business administration. On completion of that, then I was

appointed as the first director of business planning and contracts management within Furness General. That's there, 1990 to 1991, and that's relevant in the conversations that I heard today, really. In terms of one of the reasons why I wanted to be in that position was to add a clinical quality angle to the debates that were going on. We've heard today about cost volume, but the third part of the triangle was quality and that's how I saw my job.

I think Dr Carson mentioned the resource management initiative that all hospitals with beds over 300 were able to apply for funding from the Department of Health and it was obvious that that was similar here in Northern Ireland. And that's where I was the project director for the resource management initiative, which looked at introducing the concept of clinical directorates, looking at information technology, et cetera, et cetera, so that's why I did that job.

And then I moved over to the north-east in August 1994, where I took up my very first director of nursing and patient services post at what was then the Hartlepool & Peterlee Hospital, and then most -- the jobs within that, the Trust realigned itself with community and mental health and that is where it became Hartlepool & Peterlee. And that is where I was director

of nursing and therapy services and eventually became deputy chief exec. And once clinical governance was much more established then the post, the title, included nursing and clinical governance.

The period November 2004 to August 2005, unfortunately the chief executive of the Trust had a period of long-term illness, and from that time I was the acting chief executive.

Q. Did you come across many other people acting as chief executives who, like you, had risen from ward orderly through the ranks?

A. Not really. In fact it was rare for, at that time, actually -- there were a few medics that had moved into chief executive jobs, acting chief executives as well, but very few from a nursing or an allied health profession background.

Q. I wonder, can we move over the page to 003? Just if we can to bounce through your career very rapidly to pick out a few things that may be relevant. In the lower section of the page, the seventh bullet point down:

"Reviewed systems of clinical, information and corporate governance in preparation for the development of an integrated governance system designed to provide the Trust board with a more effective controls assurance

framework."
A. Yes, as it says there, within 2004, 2005, so it was responding, as we've heard again today, that actually from 2003 in England, as well as here in Northern Ireland, there was a change to the statutory responsibility accountability, and there was a duty not only for care, but also explicitly a duty of quality, which was part -- at that time, I actually would have signed the chief executive memorandum of accountability.
Q. We'll return to this. This is the main issue we would like to discuss with you. Over the page to 004. Again, the lower part of the page, in the middle of the text:
"Highly commended by the Commission for Health Improvement for excellent systems of clinical governance following their visit in August 2001."
A. Yes. Again, for that period 1999, September 2003, Liam Donaldson -- who we've heard mentioned today -- coined the phrase, you know, and expected trusts to embrace the whole concept of clinical governance and the Commission for Health Improvement, which has now been overtaken by the Care Quality Commission, were charged with assessing the systems of clinical governance, informal visits, and as a board -- not me personally -- had to give assurances through various production of evidence, both in policy documentation form but also by

visits to wards and departments.
Q. And over the page at 005, just further to lay your credentials. The "Achievements in this post", the upper part of the page, third point down:
"Commendation from the King's Fund Organisational Audit for high quality profile of nursing within the Trust."
This was during your career as a nurse, and at the same time as Claire was admitted to the hospital.
A. Yes. Again, as with the trust the inquiry is looking at, we went down the route of seeking King's Fund Organisational accreditation and the process was as has been described previously, and so in their report then they did commend the high-quality profile of nursing within the trust. And I think, again as we see even today, with some of the issues that are surrounding, say, Mid-Staffs, there are still concerns about the profile of directors of nursing within trusts.
Q. And the next section, August 1994 to April 1996. This is a time period which encompasses Adam's death. The second point there:
"Implemented a quality assurance strategy, which included a people-first (customer care) training programme."
What was that about?

A. I was asked by the chief executive to bring together a more formal quality assurance strategy and the people-first concept was something which, I suppose, I should lay claim to. It was the idea -- there were ten principles upon which the board signed up to, which I suppose could have been as meaningful and deep as people -- as meaningless and shallow. We underpinned that with a training programme, actually taking extracts from real patients' complaints measured against the ten people-first values. So it would be things like be "respectful", "listen", "look the part", your professional standards, et cetera. But turning that into a training video with actors, but they acted out the scenarios that I was receiving as the person receiving complaints within the Trust. And we used it as a training model.
Q. Thank you. In relation to the report you submitted, are there any qualifications or additions or further explanations you'd like to provide?
A. I suppose just to repeat the fact that the interim submission on behalf of the Trust and Mr McKee's point that there wasn't a requirement for chief executives to sign a statement of internal control is factually correct. In fact, that would have been in existence in both Northern Ireland and in England. From 1997 to

1998, there was a requirement for chief executives to do a statement of internal control specifically about financial control. It wasn't until later on in 2000 that there was a requirement for wider -- and in 2003 it became even more explicit, as we've seen today.
Q. In relation to the issue that caused considerable discussion this morning of the actual responsibilities and accountabilities of a chief executive for clinical care, can I ask you: first of all, it's quite clear the chief executive was responsible for financial aspects and managerial aspects, but he was asked to sign, as we have seen from the 1995/96 annual report, up to an accountable officer memorandum. Sadly we don't have a copy of this. Is this something with which you're familiar from the contemporaneous English practice?
A. Yes. Again, I can't speak for -- one of the issues when I was trying to fulfil the requirement of the chairman in his terms of reference, I tried to diligently look at what policy was in England, what policies were in Northern Ireland. What I can refer to is on page 7 because there was debate this morning. It isn't around the accountability of the chief executive, it isn't that memorandum, but the document that I quote there at HSS PDD 8 of 1994 was actually published by the Department of Health here in Northern Ireland, which sets out what

a board -- a code of conduct and accountability was.

I think there was a question this morning whether all that we were looking at was the English one. What I would say is that as a chief executive on the accountability agreement then certainly in the English version -- and I am sure the department here in Northern Ireland can produce whatever the Northern Ireland version was -- but certainly there was a section there, 17, which required the chief executive actually to adhere to the code of conduct and accountability.

THE CHAIRMAN: I think the big question, professor, is accountability for what? Okay?

A. Yes.

THE CHAIRMAN: In your report, if I can take you directly to the point I'm primarily focusing on, at page 15, so the reference is 210-003-015. This is a series of bullet points, which is encompassed at paragraph 2.42, which starts on page 14, and it's noting, in this stage of your report, things of significance which came out of the Bristol inquiry.

A. Yes.

THE CHAIRMAN: And in the bottom bullet point on page 15 you quote the inquiry report as saying:

"Until well into the 1990s, the notion that there

should be explicit standards of care which all healthcare professionals should seek to meet and which would apply to patients simply did not exist."

You go in the paragraph:

"Recent developments give cause for optimism. These include statutory responsibility of trusts for the quality of healthcare."

And then you go on to other points. That report was published in 2001; isn't that right?

A. Yes.

THE CHAIRMAN: And we have produced this morning the relevant 2003 Northern Ireland legislation and the January 2003 circular, which I think were put in front of you a few moments ago. Do you have a copy of the circular from this morning?

A. No. I did see it and hear it. (Handed).

THE CHAIRMAN: Thank you, Mr McAlinden.

This morning, our attention was drawn to paragraph 23 on page 9.

MR STEWART: 306-119-009.

THE CHAIRMAN: Thank you.

At paragraph 23 it is stated in this circular in Northern Ireland:

"The chief executive of each organisation will be accountable to his/her board for the delivery of

quality, treatment and care by the organisation in the same way as he/she is already responsible for financial and organisational matters."

You'll have heard Mr McKee say this morning that although this happened a little bit before 2003 in England, and then happened in 2003 in Northern Ireland, the same point applies. That point is that until 2003 here, the chief executive and the board were not responsible for clinical care and the quality of that care, but that this circular, allied with the 2003 legislation, changed that position.

That seems to be supported by the point which you have highlighted in the Bristol report, which I referred to a few moments ago. Do you agree with Mr McKee on that and to what extent do you agree with Mr McKee?

A. I agree inasmuch as this was the first time that either the Department of Health or, in this instance, the Northern Ireland Board made it an explicit requirement and a duty for ensuring provision of high quality and patient safety. That's a fact. But I suppose if I refer back to -- and I think it's similar in this order, in the first-class quality service, which is at the top of page 7, which post-dates the events as well, but what I quote there is:

"These arrangements [clinical governance] should build on and strengthen the existing systems of professional self-regulation and the --

THE CHAIRMAN: Just a moment, what document are you referring to?

A. My report.

THE CHAIRMAN: Page 7?

A. Page 7, which is why, when quoting that, then if when I was listening to Mr McKee ...

MR SIMPSON: Which paragraph?

A. It's paragraph 2.1, it's at the top of the page:

"A first-class service quality in the new NHS HSC 1993/033."

THE CHAIRMAN: And then you say that the White Paper -- this is the English White Paper?

A. Yes.

THE CHAIRMAN: The English White Paper said:

"These arrangements for clinical governance should build on and strengthen the existing systems of professional self-regulation and the principles of corporate governance."

A. Yes.

THE CHAIRMAN: Now, the existing systems of professional self-regulation were self-regulation by the professions?

A. Yes.

THE CHAIRMAN: Right. So that doesn't bind the chief executive of the board?
A. It doesn't, but if I go further down the page, and again --
THE CHAIRMAN: Sorry, your point would be the principles of corporate governance are --
A. The corporate governance, as I understand it, and certainly as a jobbing director of nursing in that period 1994, I suppose you should refer back to -- and I do mention it in the report -- the actual establishment orders for establishing NHS Trusts. I do know that the statutory rules of Northern Ireland 1992, which we do have somewhere -- that's on 2.3. That's where the establishment -- and on that order, to make it very clear, is that one of the functions of that established trust was to own and manage hospital accommodation and services. I'm sure you'll be able to get that from the Department of Health. That was explicit in the function of an establishment moving from a directly-managed unit, then the board were -- one of the main functions was to own and manage hospital accommodation and services. And that wasn't just domestic services, it was patient services.
THE CHAIRMAN: Yes. I suspect that Mr McKee wouldn't argue with that and Mr McKee wouldn't argue that he wasn't --

the board generally and he, as chief executive, weren't responsible for managing hospital accommodation and services. I think if there's a line between you, it is that he says it was our function to have all the facilities in place and, so far as the budget allowed, to have the staff in place for the doctors and nurses then to provide medical care. Now, the quality of that medical care was then a matter, at that time, strange as it may seem, for the doctors and nurses, but not for the hospital chief executive and board.
A. I don't agree -- and I suppose in terms of ...
If we look back to that 2.5, the code of conduct, if we look at the four bullet points there, it is very clear:
"To be collectively responsible for adding value to the organisation. Promoting the success of the organisation by directing and supervising the organisation's affairs. Provide active leadership of the organisation with a framework of prudent and effective controls, which enable risk to be assessed and managed."
It doesn't say "non-clinical risk". It's not explicit:
"Set the organisation's strategic aims. Ensure that the necessary financial and human resources are in place

for the organisation to meet its objectives and review management performance and set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood."
And as far as I was concerned, as a signed-up executive director of nursing then, it was very clear in my job description that I was there with an executive responsibility to ensure patient safety, even though there wasn't a statute until later on in my appointment.
THE CHAIRMAN: Well then, if that interpretation is right, and if I take you back to paragraph 23 of the circular, how is your interpretation consistent with what the department is saying?
A. I just think this is reinforcing it, and I know 1999 -- but one of the reasons why the concept of clinical governance was brought in by the then Chief Medical Officer for England, which was Liam Donaldson, obviously, was to get exactly that message across, which was to be saying: yes, you've been over-concentrating on financial, probity and balance, but you should be looking at clinical issues in the same way as you have been doing around financial.
In 2000, he produced "An Organisation with a Memory", which is actually saying: despite what I said

in 1999, there are still organisations that are failing because the boards are not assuming that responsibility, and I just think -- and you will know better than I, I think -- this document here in 2002 was there to be saying explicitly, not implicitly, that this is the responsibility. And from that time on, the statement of internal control would have included a statement of controls assurance around both financial and clinical.
So I do appreciate what Mr McKee was saying, but then whatever happens, the duty of care placed on the board was a duty of care for both patients and staff. So I don't -- I would never differentiate between being responsible for your services and all that entails. It's not the same as being responsible for developing absolute clinical standards. That would be down to individual specialties, as we've seen mentioned on a number of occasions. But actually, the quality of care provision and what that entails and the safety of those patients, I believe, is explicit in the code of accountability.
THE CHAIRMAN: Okay. You might expect the wording of paragraph 23 to be somewhat different then.
A. Yes, you would. But this was the first time -- up until then, the duty of care, the duty of financial, was very much there as obviously a legal duty. I am repeating

myself, but this is the first time that this became a duty rather than a responsibility.

THE CHAIRMAN: We have to be careful about interpreting a circular as if it's a statute, but if the chief executive was already responsible for clinical quality or clinical care and quality, that paragraph 23 might be phrased: you are reminded that in the same way as you are already responsible for financial and organisational matters, you are also responsible for delivery of quality.

A. I agree with you, chairman. I think it is open to interpretation and that is, as far as I understand, kind of a memo from the department, precising what the actual requirement was. So I understand that you'll be pursuing much more readily what the actual duty was and what that statute was.

THE CHAIRMAN: To what extent do you reflect on what Mr McKee said? Because when I asked him then who was responsible for clinical care in the mid-1990s, he said it was -- he didn't quite use this term, but it was a bit of an unhappy mess, an unacceptable position where there wasn't a culture of doctors reporting each other to the GMC, information didn't necessarily reach the medical director, and the chief executive wasn't responsible. So it almost ends up as if nobody is

responsible.

A. And that's what I find strange. It's certainly back to my own role, but I understand that professional regulation, the General Medical Council and what would have been the UKCC at the time, now the Nursing and Midwifery Council, would not have appointed the medical director or the nurse director. The appointment of a medical or a nurse director to executive board position will have been done by the board. In my case, the chairman of the board and the chief executive appointed me in 1994 to the Hartlepool Trust. The medical director, different inasmuch as they would not have been a full-time position, they would have done so many sessions, but also would have been appointed by the board, not by the General Medical Council.

Similarly, where we've heard about the introduction of the clinical directorates, the clinical directors were appointed on behalf of the board, not on behalf of the General Medical Council, to enable the General Medical Council to be able to fulfil their obligation to regulate medical practice. And I think that's an important difference.

THE CHAIRMAN: Yes, but if I understood what Dr Carson said yesterday and Dr McKee today, in essence those were the early stages of involving doctors in management.

A. It was, and --

THE CHAIRMAN: They used the term that doctors were accused of going to the dark side, which may -- I don't know if that resonates with you, but was there something of a similar attitude in England?

A. Certainly the medical director role was that. The clinical director role -- and I won't be able to quote. I was interested when -- I think it was when Mr Brown was here as a witness -- and he had previously, more towards the late 1980s, had undertaken the role as a clinical director before even the Trust was established. He interestingly said that clinical directorates weren't set up to address quality assurance. And that just to me -- why do you want to involve medics in management, medics in leadership, clinicians in management, clinicians in leadership, unless, even at that time before the statute changed, you were looking to actually redress the imbalance between financial accounting and quality provision?

THE CHAIRMAN: Okay. Mr Stewart?

MR STEWART: What was the purpose of the structure, including clinical director and medical director and the various lines?

A. The purpose was to establish lines of accountability, but also to devolve financial -- and I would argue

clinical -- responsibility further down closer to the patient, so rather than that responsibility and accountability being vested just in the executive team, it would be impossible to be able to deliver that, so the establishment of clinical directorates -- and I do know this for the Royal Belfast -- would have a triumvirate of a clinical director, a nurse manager and a business manager, and they would be attached to the directorate. Now, in the early days of those directorates, certainly my experience in 1992/1993 was that you wanted to be very, very inclusive. So it would establish a clinical directorate almost to represent every "ology", if you will. So you would have one in gynaecology, and you'd have one in medicine just so that you've got people engaged, medics, clinicians involved in the process. And the rationale for that was quite clearly to be able to look at the bedsides, the departments, the operating theatres and say: can we actually learn together to merge in a way the managerial, which was very much dominated by -- and quite rightly so -- making sure that the trusts were in financial balance, but use the experience, the expertise of clinicians of all ilks to actually be better prepared to provide business cases, pathways of care upon which commissioners would purchase.

THE CHAIRMAN: Can I ask you to illustrate this on your CV? If we go to 306-092-005. You were director of nursing in two separate trusts.
A. Yes.
THE CHAIRMAN: From 1994 to 1996 and then 1996 to 1999. Were you a member of the board of the trust?
A. Yes.
THE CHAIRMAN: The comparison might not be perfect, but when your boards met, did they consider clinical issues?
A. They did.
THE CHAIRMAN: What sort of clinical issues?
A. Not with the backing at that time of robust data, but I do recall that on a monthly basis the whole board would have a presentation from one of the clinical divisions, as we call them, so the clinical director, say, of paediatrics would come, do a presentation, supported by their nurse manager, their business manager, about the business that they were dealing with in their division. And that would be a rolling programme to serve two purposes: to particularly target the non-executive directors who would not -- well, wouldn't have had a lot of exposure to clinical matters at that time. And certainly, in 1994 to 1996, that's what would have happened there. But the board implemented a quality assurance strategy that

I presented to the board formally in open meeting and they adopted that strategy and it became the Trust strategy for quality.
THE CHAIRMAN: I'm sorry, I just need to try to clarify this a little bit further with you, professor. If you had a monthly presentation of the business that was being done in each division, and let's say, for instance, it's cardiology, would there be a director of cardiology --
A. Yes.
THE CHAIRMAN: -- who would come to the board?
A. Yes.
THE CHAIRMAN: And that director of cardiology would explain what cardiology services were being provided within each trust?
A. Yes.
THE CHAIRMAN: Right. But that's not the same, is it, as the board being responsible for clinical care? That's explaining to some directors of the trust who are not medical professionals what services are actually provided by the Trust, which they are on the board of. So that can be explanatory or descriptive for them. But in terms of them then accepting responsibility for clinical issues that arise in cardiology or being responsible for those clinical issues, how would clinical issues about cardiology or something like that

be brought to the board?
A. You're right, chairman, in terms of it doesn't describe them having accountability. It was about much more information awareness, but I suppose if I look further up the page to when I was director of nursing and therapy services, which actually inherited mental health and learning disabilities, the board remained the same, but the board, full board, would receive reports from homicides and suicides. They would receive that, at that time, under the line, and so that -- but that was because it was an integrated care provision. That was certainly the case within that role, which was from 1996 to 1999, and it was more common, I think, in mental health provision because of the Mental Health Act, that there was provision for that. The board members were actually Mental Health Act administrators as well.
THE CHAIRMAN: You see, even on that example, I'd like to think that if there was a murder in the Royal, that that might have found its way to the board of the Royal. So when you described that the full board of the Hartlepool & East Durham Trust received reports on homicides and suicides, I would be astonished if the Royal Trust board didn't receive a report of a homicide with the trust. A suicide -- I suppose, strictly speaking, suicide is a crime, isn't it?

A. Again, I don't think the Royal was actually responsible for mental health provision, was it, at that time?
THE CHAIRMAN: It was in the City, I think, wasn't it?
A. I'm trying to use that as an example of whether there'd be more in-depth requirement.
THE CHAIRMAN: What I'm going to get to is looking at this period, this is before the changes which occurred in England and then occurred in Northern Ireland, just before that period. And in the 1990s -- which is the period we're concerned with at this stage of the inquiry -- can you give an example of issues about clinical care or the quality of that care being brought to the board of either of these trusts so that, for instance, a patient death as a result of substandard medical care or concerns about the performance of a consultant or any other doctor?
A. The performance of -- I suppose it's this view that the boards were not responsible for the totality of care. That's the bit I can't quite get around. Certainly, if there had been an incident, an untoward incident, an unexpected death occurring in the hospitals at that time, then the chief executive would have expected to have been informed and either myself or the medical director would have been directed to conduct -- or at least commission -- an internal investigation. That

investigation would find -- the outcomes of that investigation with any action plans would most definitely have found its way on to the board agenda.

THE CHAIRMAN: So if there was an Adam-type incident, you say the procedure was that that did go to the chief executive?

A. Yes.

THE CHAIRMAN: That did lead to a report and the outcome or recommendations of that report went to the trust board?

A. Yes, and would have also gone upwards to, in our terms, the Strategic Health Authority, who -- I know you're going to be looking at the role of the health boards, et cetera, but one of the other issues -- and people have kind of skirted around the contract, but actually the contracts for provision of clinical service, particularly when we get to 1994, 1996, were becoming more explicit about what was expected on quality, not right down to the level of detail of what you would expect the standard of care in a cardiology or a medical directorate to be, but things like expecting. Now, it may be -- I have to qualify this because I think in the Department of Health report the north-east, I suppose by virtue of the fact that Liam Donaldson, prior to his appointment as Chief Medical Officer, was the chief executive of the Northern & Yorkshire Regional

Office, and in 1994 the Northern & Yorkshire Region actually were the first to introduce an electronic incident reporting system. So it wasn't just the trust board thinking it was a good idea, there was direction from, I think, Mr McKee called them "those that must be obeyed" or "the powers above". There was a direction that we should have been looking, as a board, at investing in clinical risk management systems, not just risk management systems.

THE CHAIRMAN: When you talk about the contracts for the provision of clinical services, do you mean the individual contracts of employment between the trusts and the consultants?

A. No, sorry, for clinical services. So the purchasers, the Health Authority contracted on an annual basis for a trust as it did here in Belfast. So in many instances they were block contracts, particularly those that were relating to high volume, low cost provision. But if it was a low volume, high cost specialty service, then there would more likely be a cost-per-case agreement. But underpinning those contracts were identified quality standards, expectations of what the trust, and therefore the trust board, would discharge with regard to ensuring, assuring, a quality of provision to those commissioners of service.

THE CHAIRMAN: And when you say that they were underpinning quality standards, does that mean that they were part of the contract?

A. Yes, there would be a general detail of what was expected. So it could have been something about what information supporting quality would be required. I know certainly in 1994/1996, the Tees Health Authority had a standard auditing system, which was designed to actually monitor the quality provision. Equally, there was probably more robust systems, but the financial monitoring of spend was done in tandem, so we would have joint meetings between myself, the medical director, the chief executive, the director of finance, with our counterparts at the Strategic Health Authority, and would have many a long-night debate about whether or not we actually delivered on those standards, both financially and quality-wise, which again is just why I personally believe -- and I have never not believed the fact that once I became an executive director -- whether it's here or, say, the early days in the trust, or as a Strategic Health Authority executive director -- my role as a nurse was there to support, help, advise, both the chief executive officer, the chair, but the wider board on quality issues. I repeat myself, but I never differentiate between clinical and general

quality issues.

THE CHAIRMAN: Okay. This is an issue which we'll pursue later with the department when their witnesses come in the spring. But Mr Stewart, if you have further questions on that --

MR STEWART: No, but there's one further issue I would like to explore if I may.

You heard Mr McKee this morning say that he did not feel bound or did not feel that English guidelines had any remit here in Northern Ireland. I specifically asked him about the Allitt inquiry. What would you have expected a chief executive or indeed any board member to do upon receipt of that sort of advice in a hospital?

THE CHAIRMAN: Sorry, a chief executive of a board in Northern Ireland to do --

MR STEWART: Yes, in Northern Ireland.

THE CHAIRMAN: -- on foot of the Allitt report recommendations.

MR SIMPSON: [Inaudible: no microphone] you're in the same position as the witness, who has no experience of the board chief executive in Northern Ireland, and in our respectful submission, that is a matter you should answer.

THE CHAIRMAN: Let me start it at this stage. The Allitt report -- I think you mentioned 1995, was it?

MR STEWART: Yes. Paragraph 6.1.6(ii) [inaudible: no microphone] 210-003-038.
THE CHAIRMAN: Okay. Let's start this by asking you, Professor Mullan: when the Allitt report came out in 1995, first of all, these reports, are they automatically circulated to each trust or do you read in the paper that they're published and then you go and get your copy of them?
A. No, the EL 94 16 was directly sent from the Department of Health, from the NHS Executive as it was then.
THE CHAIRMAN: Is that the NHS Executive's way of drawing your attention to the Allitt report by --
A. Yes. But also, there were expectations of actions and, certainly from my role, then I presented the report and actions, and then was, I suppose, directed by the board to return back within a reasonable time frame to assure them that actually the actions had been implemented, and if they hadn't, reasons why they weren't. And one of the obvious ones there was to make sure there was a quick route to ensure that serious matters are reported to the chief -- as it happened in the trust that I was working in, there were already processes to do that, but that wasn't the case in all trusts in England. And I suppose back to Mr McKee's point --
THE CHAIRMAN: Just before you get to Mr McKee's point.

This isn't just a reference to the Allitt report, it is sent to each trust along with the NHS Executive's list of required actions on foot of that report?
A. Yes.
THE CHAIRMAN: And you then have to report back to the NHS Executive to confirm that you have taken actions or that you already have procedures in place which are ahead of it?
A. Yes.
THE CHAIRMAN: So is that in a sense an equivalent to the circular which was sent to the Royal Trust in October 1995 on patient consent to say, "Here are guidelines, the guidelines include a model form. We expect you to have them in place and advise us by 31 December 1995 that they are in place"?
A. Very much so, chairman.
THE CHAIRMAN: But that in effect is a direction then from the NHS Executive to your trust, isn't it?
A. Yes. Because until the establishment of Foundation Trusts in 2005/2006, then all -- even though they were self-governing, all NHS trusts were exactly that: they were accountable through Strategic Health Authorities to the Department of Health, so it was quite fitting that the Department of Health would give directives and that you would adhere to them --

THE CHAIRMAN: I don't think you have any choice, if the department --
A. No.
THE CHAIRMAN: If the department gives direction, you are supposed to adhere to it. You adhere to it because you have a direction from the overall managing body, the NHS Executive.
A. You would -- and also back to the concept of contracting for clinical services: one of the addenda to that quality specification would be adherence to that direction. So it was kind of a belt-and-braces option. You'd have to show your purchasers or commissioners that actually you had action plans to address that with similar -- well, it'd be nearly 10 years ago now with the Mid-Staffs or the Maidstone & Tunbridge Wells. So things like that, where it was of national importance that actually something nationally was addressing it, then there would be that expectation.
THE CHAIRMAN: Right. Isn't that quite different from the chief executive of a Northern Ireland trust who may be aware from the newspapers of the Allitt report, but who doesn't receive from the department in Northern Ireland a copy of the report together with a list of expected actions?
A. If that indeed is the case, I don't know. My

understanding, and I do know it's far more complicated here with devolution, et cetera, but my understanding was that up until 1999, there was very little difference in policy between the English, Scottish, Northern Ireland and Welsh departments.
MR SIMPSON: I wonder before we get off this -- which I respectfully say is speculation, can we identify if the department sent out anything in respect of, for example, the Allitt inquiry to the trusts in Northern Ireland before Mr Mullan goes on with his speculation?
THE CHAIRMAN: It's an issue for us to follow up with the department. I think also, Mr Simpson, I'm not sure that there is -- I think there's a point which Mr McKee made, maybe didn't develop it as well as he might have this morning, when he said about the nomenclature of the National Health Service, where he seemed to be saying at an early stage this morning: there is an NHS, but there are procedures or there are departments in England and Wales, on the one hand, Scotland on the other, and Northern Ireland for a third. So what we know as the National Health Service is not this single homogenous unit.
MR SIMPSON: If something is issued from the Department of Health in England, it is not until it's issued or

something similar to it is issued by the Department of Health and Social Services in Northern Ireland that it becomes something that the Northern Ireland trusts have to deal with. And that's why I'm saying -- if this Allitt point is to have any indication of what went on, then surely one's able to produce a departmental circular or instruction that this must be dealt with. But the fact that it was dealt with in England in a particular way is, if I respectfully say, Mr Chairman, neither here nor there if it's not being dealt with in the same way in Northern Ireland, and Mr Mullan is speculating about whether it might have been dealt with in Northern Ireland [inaudible] does not help, in my respectful submission.

THE CHAIRMAN: I think that's right.

A. I wonder if I could just say: I do know from reading Miss Duffin's statement and her presence here that, within the nursing network within Northern Ireland, because she said herself that, yes, there was a lot of debate around the implications of Allitt. That's very different, I appreciate, from whether there was a directive from above.

But again, back to the duty of care quality, what would any board want to know from their director of nursing if there was a high-profile case like Allitt,

even though it's in England. You would want to learn lessons from it and the lessons were wide in terms of human resource implications, introducing registered sick children's nurses, and Miss Duffin was quite clear about what her and the senior nursing network within Northern Ireland were doing.

So it is not as if the issues and the actions weren't understood, but I take the point that there was no -- they may not have been. You'll have to get that from the department.

THE CHAIRMAN: The specific requirement on English trusts to do anything on foot of the Allitt report comes not from the publication of the report itself, but comes from a direction from the NHS Executive.

A. Yes.

THE CHAIRMAN: It might be very wise and very helpful if chief executives and boards are aware of issues like Allitt, maybe like Shipman, West Staffordshire, I think, is coming at us, Bristol, Alder Hey and so on, and good Health Service management might be that you must be -- part of it must be being alert to issues which are cropping up elsewhere and seeing if you can do something about it in your own area or double-checking that you're not vulnerable on the same point. But that's a bit different from following a direction.

A. It is. I suppose you'd call it good leadership, good management practice, as opposed to being a directive.

THE CHAIRMAN: Yes, thank you. Thank you, Mr Stewart. Does anybody have any specific questions for Professor Mullan? No?

Professor, thank you for your report and for the time you've taken to help us and for coming today. Thank you very much indeed.

(The witness withdrew)

There is no further evidence today, Mr Stewart?

MR STEWART: No.

Housekeeping discussion

THE CHAIRMAN: There are a couple of outstanding issues.

In terms of Raychel, we've a meeting back in Belfast tomorrow, Mr Doherty. We have circulated a report to include reports from Messrs Haynes and Foster, and we've asked them for supplementary reports, which I understand will be available tomorrow. There are Salmon letters to go out, there's the adviser's report to go out, and then there's the opening to be circulated, and I will indicate tomorrow, when I find out exactly the up-to-date position on each those, what the position is for Monday week. Okay? You can take it, for the moment, that that brings an end to this sitting and, unless you're advised to the contrary, we'll resume on

Monday the 28th at 10 o'clock. Thank you very much.

(4.00 pm)

(The hearing adjourned until Monday 28 January at 10.00 am)

I N D E X