Monday, 25 June 2012

(10.00 am)

THE CHAIRMAN: Good morning.

MS ANYADIKE-DANES: Good morning, Mr Chairman. Could I call, please, Dr George Murnaghan.

DR GEORGE MURNAGHAN (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, Dr Murnaghan.

A. Good morning.

Q. You've made two statements for the inquiry. Subject to anything that you may wish to say now in the oral hearing, do you adopt those statements as your evidence?

A. I do.

Q. Thank you very much. Dr Murnaghan, do you have a copy of your curriculum vitae there?

A. Yes.

Q. Thank you. Before we go into it, I wonder if we could locate your position, if I can put it that way, in 1995. Could we please pull up 303-043-510? You see the reporting lines there. Roughly in the middle, the second box down:

"Medical administration. Dr George Murnaghan."

Was that your title in 1995?

A. Chairman, I'm not certain. I started in 1987 as Medical Administrator in the Royal. Then resource management

came and directors were appointed, but I don't know when that happened. I then became director of medical administration. But what year -- I am totally unclear at this stage of my life.

Q. I understand that.

A. And that is not the reporting line.

Q. Ah. Maybe you could help us with that. What was the reporting line?

A. My reporting line was to the medical director and, through him, to the chief executive.

Q. So you didn't --

A. I would be over on the right-hand side of that.

Q. So you'd be with the clinical directorates?

A. Yes. But if I could suggest that there would be a third tail under "medical director".

THE CHAIRMAN: And apart from you, would there be anybody else on the third tail or is it you alone?

A. I'm not certain when the Director of Occupational Health commenced, but he would have been on that table as well, although again his reporting line may have been directly to the chief executive. I'm uncertain.

MS ANYADIKE-DANES: Did you report at all directly to the chief executive on anything?

A. Technically yes, but really no.

Q. Which was the technically yes?

A. Insofar as he was the boss, if I may use that term. We worked together in the same building. I was only separated by a large room between my office and his office. He was on one corridor, I was on the other.
Q. Does that mean you informed him as opposed to, from a institutional point of view, you were reporting to him?
A. Yes, I would have kept him in the loop so to speak.
THE CHAIRMAN: How far away was Dr Carson's office?
A. Next door to the chief executive's, so fairly adjacent.
MS ANYADIKE-DANES: Why I was asking you about your titles is that when you produced your first witness statement for us, which if we can pull up the first page because that has the title there. It's 015/1, page 1. There you see it. If you see under "Present position and institution", it has "Director of Medical Administration, the Royal Hospitals Trust".

That witness statement, without going to the end of it, is signed by you on 30 June 2005. Then if one looks at your CV, if one goes to 306-077-002, if we go under the title "Director of Risk and Litigation Management", we have that as 1987 to 1998. That's why I'm really trying to clarify exactly what your title was because the title that you gave in your first witness statement was in answer to a request for your title as at the time

of the child's death. But your CV seems to suggest that as at the time of the child's death, you were Director of Risk and Litigation Management.

A. Chairman, I'm probably responsible for a little bit of confusion here. And if I may pull back for a second, I started off as Medical Administrator. I then -- and I never had a contract. I never had a job description or a contract when I started in 1987.

THE CHAIRMAN: Okay.

A. I was interviewed for the post, I was the only person interviewed, and I got the job. That job changed as jobs do change over time. And then when resource management came into being, I got this wonderful title of "Director attached to medical administration". Up to that, I was just the Medical Administrator.

MS ANYADIKE-DANES: I understand.

A. Some time later, and after 1995, there was a further change and it was suggested -- or happened, really -- that the post of Director of Risk and Litigation Management turned up, although I was never known as anything other than DMA, Director of Medical Administration, up until the time I resigned from my post in the Royal.

I'm sorry that this CV was created for another purpose and I was a bit lazy insofar as I downloaded it

and sent it off without absolutely checking every word and every line. So I hope that explains where that confusion comes from.

Q. It does. Is there a difference in the role between when you were Director of Medical Administration and when you gained the title Director of Risk and Litigation Management?

A. No.

Q. You were doing the same thing?

A. Absolutely.

Q. But with a different title?

A. Yes, although incrementally -- to assist the chairman of the inquiry, incrementally things happened and things changed and I may have had additional responsibilities. For instance, I know that medical audit and clinical audit is something that I'm going to be asked about later on. That wasn't around when I started the job. That's just as an example. But it became something that I had oversight of --

Q. I understand.

A. -- as time went on.

Q. When you were helping us correct our diagram -- and thank you for that -- you said you really should be under the Medical Director on a third tail, as it were, and that you would be reporting to the medical

directors. It may be there's another confusion for me that you can help with. I want to take you to the Royal's annual report for 1995/1996. If we go first to WS061/2, page 90 just so that you see the title, and then we'll move to the substantive. Right at the bottom right-hand side you'll see it says, "Trust board membership".

Then if we go to page 91 of that document, this is what I want to ask you about. "Trust board membership", if you look at the top left-hand side, it has "clinical", then it has "non-clinical", and you have "Corporate affairs" and then, if you work down, you see "Medical Administration" and your name alongside it.

A. Yes.

Q. Does that mean you were a member of the board?

A. No, but I was in attendance at the board.

Q. Sorry?

A. I was in attendance at the board, chairman.

Q. But it suggests -- sorry, Mr Chairman.

THE CHAIRMAN: I think the Trust was officially or legally formed in 1993, but it had been operating as a shadow Trust for a year or two before that.

A. Yes.

THE CHAIRMAN: So before 1993, the Royal was part of the Eastern Health Board.

A. Correct.

THE CHAIRMAN: In 1987, when you became Medical Administrator, that was Medical Administrator within the Royal and the Royal was part of the Board. So can I ask you, first of all: when the Trust or when the Royal Trust was established in shadow form and then formally with effect from 1993, did that make much difference to the work which you'd been doing as Medical Administrator, which then drifted into Director of Medical Administration or was it effectively the same work that you were doing?

A. The same work, but probably more of the same.

THE CHAIRMAN: Right. And before and after the Trust legally existed, was it Dr Carson or somebody in that position who you were reporting to or answerable to?

A. I can't remember, chairman, when Dr Dennis Coppell terminated and Dr Carson took over from him. As far as my memory goes, Dr Dennis Coppell was certainly the Medical Director in shadow Trust form and possibly -- again my memory fails me -- possibly for the first year of Trust status.

THE CHAIRMAN: That may be 1993, going maybe into 1994?

A. I think so.

THE CHAIRMAN: And then Dr Ian Carson took over.

A. I don't want to land Dr Carson in it insofar as that's

the best I can do from memory.

THE CHAIRMAN: Yes. But essentially, the job that you were doing did not change in a fundamental way from 1987, but there were aspects of it which developed and some other aspects devolved?

A. Exactly.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

So what this page means, although it's got "Trust directors" at the bottom of it, that all these people were actually in attendance at board meetings or at least could be in attendance at board meetings; is that what that means?

A. This is where it gets a little bit difficult again, chairman. I am fairly certain that several of those non-clinical posts and post-holders were full members of the board, but I wasn't. I had right of attendance, but I wasn't -- if one calls me a full member, I didn't have voting rights.

THE CHAIRMAN: Would Mr Bennett of finance have been on the board?

A. Absolutely. He would have to be, wouldn't he?

MS ANYADIKE-DANES: In fact, he was one of the statutory requirements that you had to have that.

A. Yes.

Q. All right. If we then pull up your CV, 306-077-002. If you look under your key responsibilities, I understand that you've told the chairman that these are the responsibilities that span the period 1987 to 1998, but some of them may have developed or had added significance at different points in time.
A. That's correct.
Q. So then if we look at "coordination of medical audit", what did that mean?
A. Well, I know that medical/clinical -- because one developed into the other.
Q. Although they are different, aren't they?
A. They are because one involves medical personnel only and the other involves paramedics, to use shorthand again --
THE CHAIRMAN: Yes.
A. -- not to diminish the professions supplementary to medicine -- and nursing staff and others, as appropriate.
MS ANYADIKE-DANES: So clinical is much broader?
A. Absolutely, yes. And it looks at wherever relevant, all the things that go towards patient care and management.
Q. I understand. So what did it mean that you were a coordinator of medical audit?
A. The department, in its wisdom, when it decreed that clinical audit should develop -- and I have used

"medical audit" here as shorthand for the totality of the process -- allowed a certain small package of money to come down. And we started a service department of clinical audit, which encompassed medical audit as well. My memory is that we were allowed to recruit three staff to start off and, by a process of knocking on doors and attrition and whatever else, we were able to increase the numbers over time.

Three were certainly not sufficient to service all the clinical directorates. And the colleagues who were responsible at directorate level for medical/clinical audit depended on these clerical officers to assist in the process, otherwise the job would not have easily been done at all, particularly if they were pulling charts, getting the information from the charts, providing that information for the clinicians to look at and then for a presentation to be made at the monthly meetings.

Q. So what was the actually process of what you were doing? You were gathering in the information, but from whom?

A. Well, what I was doing was I was the manager of the service end of it.

Q. You personally weren't gathering in, but information was being gathered?

A. That's right.

Q. From whom and in what way?

THE CHAIRMAN: Would it be helpful to take one practical example just to talk us through it, doctor? Allowing for the fact that there are variations in it, if you give us one practical example.

A. If I can go back to my own specialty, it's very easy.

THE CHAIRMAN: Please do that.

A. And there was a tradition in obstetrics and gynaecology for many, many years, prior to it becoming formalised across specialties, of having a monthly meeting where statistics were presented, acquired usually by the Medical Records Officer within the Royal Maternity Hospital, the Jubilee Maternity Hospital and the Ulster Hospital at Dundonald. And staff from the three hospitals came together on a Wednesday night in the Royal Maternity and presented figures on the numbers of Caesarean sections, the numbers of forceps deliveries, the numbers of post-partum haemorrhages, et cetera, et cetera, et cetera, the numbers of babies who died, the numbers of preterm babies below 1.5 kilograms at birth.

And various aspects then of these cases were discussed and there was quite a give and thrust, a very healthy debate, without rancour, which was enjoyed by some and feared by others. But it happened. And the

whole purpose was to review what had happened at the previous month and to improve service where necessary.

MS ANYADIKE-DANES: I understand.

A. Now, there was a medical records officer getting that information. Other directorates didn't have that luxury. The late Mr Reggie McGee, a senior colleague of mine -- I shouldn't say this really, he was a great man and he taught me a lot, but he was in everything but the crib. He was a member of the Eastern Board, he was in the department, he was that, and that the other. Therefore, he had access to soft money or whatever, better than some others, and therefore he was able to ensure that medical records, which was almost a hobby of his because he produced the annual report for the Royal Maternity Hospital, was done and done properly.

THE CHAIRMAN: Then does the development of audit mean that for the other areas like paediatrics and so on, a system similar to the one which had developed in obs and gynae over the years had to be initiated and then developed for those other areas?

A. Yes.

THE CHAIRMAN: And that's what the development of audit meant?

A. That's right. However, if I may, in some of the specialties like anaesthetics, they did have a tradition

of monthly M&M meetings. How far back that went, I don't know. Cardiothoracic surgery had a similar one. I don't know about other specialties up to then because I came to the Royal, from a satellite, the Royal Maternity, and one didn't always know -- I had to learn about what happened in the big Royal.

MS ANYADIKE-DANES: When you were giving the chairman the example from obs and gynae, you were giving examples of the sorts of things that were significant for the obstetricians and gynaecologists to know about, certain key issues that they wanted to know. How did the other directorates deal with that? Did they set their own issues that they wanted to monitor, if I can put it that way, and therefore that was the information that you got? Or was there a more formalised approach whereby they were being invited to monitor certain sorts of things?

A. I'm almost certain that the invitation to monitor came much later. A colleague in a specialty would think up something relevant and ask a registrar or an SHO. Because at this stage, other things were happening as well. Doctors in training were beginning to have to have a portfolio, which was reviewed on an annual basis, and a requirement in the portfolio was that they had a clinical audit project completed satisfactorily. That

included closing the loop, going back and re-auditing, say, three or six months later to see whether any -- if any recommendations had arisen from the presentation.

Q. Yes.

A. To see whether those recommendations had been put in place and whether they had had any effect.

Q. In fact, isn't it right, Dr Murnaghan, that for some of the contracts we've seen of some of the consultant clinicians in 1995, they had a requirement that they participate in clinical audit?

A. I want to be very careful about the use of the word "requirement". My belief is that and my memory is that this was an evolving process, chairman. It didn't happen just like that. As a matter of fact, I'm nearly certain that the circular -- and I'm not positive, but I think -- I'd better not say any more than I think -- I think the circular came out in or around May of 1995. I may be wrong about that, but I think the directive circular, to which counsel is referring, appeared around May of 1995. And it took some time then to filter down and for colleagues to engage. And some of them had, at that time, a very strong view of they being entitled to clinical freedom. And if, as a result of audit, that guidelines, protocols, et cetera, evolved, then that possibly could interfere with their clinical

freedom.

There was a touch of resistance, I'll say no more than that, about it.

THE CHAIRMAN: Part of the purpose of a protocol is to interfere to an extent with clinical freedom, isn't it?

A. It is, yes, but --

THE CHAIRMAN: The protocols don't seem to lay down absolute directions, but they seem, from what I've seen in the inquiry, to set out in writing what is good practice or what should become good practice and then that becomes what the doctors and various others should do from then on.

A. But it also allows for variance in the particular circumstances --

THE CHAIRMAN: Exactly.

A. -- as long as one is prepared to stand up and be counted about that variance. So it's not concrete. In other words, it doesn't say -- it's not like the Ten Commandments, "Thou shalt not". It says: here is --

THE CHAIRMAN: But if you do something different, you may be asked for account for why you did something different?

A. Exactly, yes.

THE CHAIRMAN: And there is a view, which I hope has disappeared, that that somehow interfered with independence.

A. At that time.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I recognise that I'm asking you to recall things over a very long period of time and things that changed and maybe changed gradually without any clear benchmarks to it, so it might be quite difficult to help us with exactly what was going on at any precise period of time. I may be able to help you with some of the documents that we've had that refer to this audit process and its development. If we go back a report to 1993/1994 and I take you to 61/2 at page 58.

That's helpfully titled "Medical audit". And then you will see that just underneath that, it says:

"The Royal Hospital Trust has developed an effective organisational framework for medical audit which supports and encourages changes in clinical practice as a natural part of organisation-wide quality assurance."

Then it goes on to set out what the goals are. And then under "Directorates", to the top right:

"Directorates participate in a rolling programme of audit. Meetings take place monthly and are attended by consultants, junior staff and senior medical students. The meeting format includes sessions on case note review, discussion and presentation of audit projects, discussion of guidelines and protocols, and medical

education."

Just to recall, the period of time we're talking about is 1993 to 1994:

"More recently, there has been a move towards multidisciplinary audit (clinical audit) with a number of directorates having taken the lead with meetings being attended by other interdisciplinary teams. Completed audit projects have involved clinical and nursing staff with planned projects to include the whole care team."

So that's what the Chief Executive is reporting there for 1993/1994. So it would seem at that stage, the Trust has already got the established medical audit that you were talking about and is moving and developing into clinical audit. In fact, some are already there, by all accounts. Just so that we're clear, was that your project? Is that part of what would have fallen within your remit, to shepherd that through from the medical audit into the clinical audit?

A. Chairman, I'm amazed at this wonderful language here. I don't have direct memory of composing all of this, but I must have had some hand in it, because it was under my remit, so to speak. Medical audit, as I've already explained, was in place in several directorates and for quite some time. Clinical audit, which I have explained

as best I can, was beginning to happen. I really stress the word "beginning" to happen and was better observed in some directorates than it was in others.

I can't particularly pick out one from another.

Q. I understand.

A. Nor do I want to.

THE CHAIRMAN: In effect, are you saying about this report that it paints a rather rosy picture of how far things had moved by 1993/94?

A. As one does.

THE CHAIRMAN: In the way that reports do?

A. Yes, in the way one does.

MS ANYADIKE-DANES: Just to round that off, there's the HPSS management plan for 1995/1996 and going forward. The part of that that I would like to pull up is 306-083-017. Then you will see just to the top right-hand side:

"Clinical audit as part of a programme to --"

Sorry, this is all under "Better practice". Just so that we the context in which this is being discussed, under better practice:

"Providers need to continue to focus on the improvement in standards of practice."

Part of that is going to be clinical audit as "part of a programme to improve all aspects of service

quality, not just clinical outcomes".

And then --

THE CHAIRMAN: Sorry, just so that I understand this, this is coming from the department, in effect?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: And it is dictating what the various trusts should be doing or should be improving on or should be building on?

MS ANYADIKE-DANES: It would seem so, yes. [OVERSPEAKING].

A. What year is this?

Q. It's 1995/1996, looking forward to 1997/1998.

A. And the important word here is "should" rather than "must".

Q. Yes. What I'm trying to seek your help on is just where we were in this Trust with auditing matters and what you were doing during that time. I think you have helped us by saying that medical audit was pretty well-established and you were moving towards getting clinical audit throughout the Trust. Some directorates already had a functioning system of that and you were aiming to extend that throughout the Trust and that task fell within your remit.

A. Qualified by, chairman, resource constraints.

Q. Yes.

A. And everybody in the Health Service will always say that

anyway, but it was a real fact in this context.

Q. I understand.

A. We never had enough staff when I was there to do the job as well as my colleagues would have wished, nor that I would have liked to have seen it done. I would have like to have seen more help available and I know my colleagues would have wished to have had the help.

THE CHAIRMAN: Is that, doctor, because clinical audit is really something very valuable and, if you have a properly resourced clinical audit service, then the benefits to the patients are tangible? Whereas if you don't have a properly resourced service, you're always struggling and running behind?

A. Correct. And not only that, but the whole purpose of it is to improve service provision and delivery. In other words, you're looking to improve what you're doing for the patient and to find out if, at times, things are not going right. But there's always a cost to doing these things.

MS ANYADIKE-DANES: Yes.

A. And I can't remember -- I am not an economist and therefore I cannot remember, chairman, when the bad times were in the 1990s, but I know there were bad times in the 90s and, certainly, I was driven on a year-by-year basis to achieve savings on the budget

that I held.

THE CHAIRMAN: At the same time as you were supposed to be developing a better service?

A. Exactly, and robbing Peter to pay Paul and whatever. And one was required to bring in a zero bottom line.

MS ANYADIKE-DANES: Thank you very much, Dr Murnaghan.

I would like to pull two points out of what you've just said there. The first is to pick up on something that the chairman said, which is the benefits to the patient. If one looks down at those three bullets that trusts were being invited to follow for the purposes of better practice, one sees it's not just a matter of support and evaluation of quality improvement programmes -- obviously, you're supposed to have those and evaluate them -- but also to instigate multidisciplinary approaches to the development of best practice in service delivery. So joined-up thinking, joined-up practice, joined-up care for the benefit of the patients. Is that what that was really referring to?

A. Yes, and I'll explain why. When I worked in the Royal, there was very much a family view. And everybody from the domestic cleaners through the works and maintenance department, nurses, laboratory, other professional supplementaries, they were all regarded as part of the

team. And when I walked up and down the long corridor in the Royal, I was acknowledged by various people. It wasn't only my doctor colleagues and it wasn't only junior doctor colleagues who might think that I might be able to do something for them. It was the domestic staff equally because the Royal was a family. And the purpose of clinical audit, both multidisciplinary approaches and audit, was to further develop and strengthen that approach.

Q. So --

A. And I was pleased to be able to work in the Royal because that was the atmosphere that was there.

Q. When one looks at any given situation for a child, one is looking at it in the round, which may involve a number of different clinical disciplines, will involve the nurses, maybe laboratory, radiology, but the whole package was what you were looking at and trying to see how you could audit that and see where one could reinforce certain matters or address others; is that really what the object is?

A. That's correct, but one could always do a project that had the envelope included around everybody at a particular moment.

Q. Yes. But then -- so that was the first point and you have confirmed that, that that was the objective,

that's what you wanted to do and that's why you wanted to do it. The other issue is the resource constraint. You were expected to do that with, as I understand you to say, limited resources. That tension between delivering what the department wishes to have and the other requirement to manage finances in a certain way, I presume there were communications between the Trust Board and the department about that?

A. As there were -- they regarded us as whingeing a lot because we never had enough, we were always doing ... (indicating).

THE CHAIRMAN: And even if you had enough, you were never going to tell them you had enough?

A. Absolutely not because we'd use that for something useful.

MS ANYADIKE-DANES: If we go back to your curriculum vitae at 306-077-002. I think you've helped us with much of what I wanted to ask you about your key responsibilities. There are just a couple of other points. One is the conduct of investigative and disciplinary processes for medical staff. In order to do that, did that mean you were kept appraised of any concerns there were about medical staff and, if you were, what was the process of doing that, or for doing it, I should say?

A. That, Chairman, is a wordy bullet point. It encompasses a whole lot, but there wasn't very much of it.
Q. Right.
A. Investigations and discipline --
Q. Yes.
A. -- arose -- investigations, yes, occasionally. And they could be of various things. If supervising clinician and/or directorates, as they evolved, weren't able to sort things out, they would occasionally come to me or the medical directorate, Dr Carson, and say, "Well, we have a problem here". It could be about timekeeping, it could be about attitude or it could be -- although I don't think it ever happened that somebody exceeded their authority and did something that they weren't competent to do in a clinical sense.
Q. That would be included as well?
A. It would, but I wouldn't have had primacy in all these matters.
Q. Before we get to that, Dr Murnaghan, were there audits of clinical competence that would come to you as part and parcel of this responsibility?
A. Chairman, in a word, I'd have to say no because that was something that developed after I left.
Q. I understand.
THE CHAIRMAN: Sorry, when did you leave, doctor?

A. 1998.
THE CHAIRMAN: Thank you.
A. June or July 1998.
MS ANYADIKE-DANES: Then when you say that if there was an issue with a medical colleague -- well, did you deal with nurses as well?
A. No.
Q. That would be the nursing director?
A. Yes, that was a totally different line. One would never stray.
Q. So if there was an issue, and I think you put it that the senior colleagues, perhaps in that directorate, couldn't resolve themselves, they might come to you or they might come to Dr Carson; I think that is what you were saying. Did you operate a system or were you aware of a system called the "three wise men"?
A. In a nebulous sort of way.
Q. Can you help us with that?
A. That's the best way I can describe it. I never had to involve that process. I know it was there somewhere. It's like cloud computing, I don't understand it. I know it's there, but I don't understand it. I used a bad analogy, but ...
THE CHAIRMAN: Was it an active concept in the Royal?
A. No, no. There were informal contacts, certainly.

MS ANYADIKE-DANES: I was just going to ask you that. Was there an informal "three wise men" mechanism, if I can put it that way, whereby the senior colleagues, maybe including somebody not directly involved in the person at issue, could meet the clinician and see whether that clinician could be brought to see things rather differently in that informal way before having to take a more formal step?

A. Chairman, I have to give you a two-part answer to that. The "three wise men" process: that, I believe, was covered by a document somewhere or other, that I've never read, and was supposed to be an independent process, so it was extraneous to the hospital itself. So these "three wise men" would have been nominees of the Chief Medical Officer at the department, as far as I know.

Q. Yes, you're absolutely right about that. Just to help, we have that document, at least one of them, at 306-091-001. It's actually a circular. So far as we've been able to research it, it really seemed to try to deal with colleagues, where there was some concern about -- you can see it under "General" -- their physical or mental ability. Perhaps there was an addiction problem or something of that sort which was affecting their way. And there's a way -- an

independent way, as you put it -- to have three senior people take them off and see what was happening and be able to report back and see whether any further steps needed to be taken, and whether in fact they did pose a risk to patients. This is a system that you knew as "three wise men"?

A. That I had some knowledge of, but I had never read that circular. I just knew it was out there somewhere.

Q. I understand. I was --

A. And fortunately never had to get involved in it.

Q. I was asking you about it in a slightly different way, which was whether there was some sort of more informal way that senior people could sit down with a colleague and assess in a way what was going on.

A. Chairman, that was to be the second part of my answer. And counsel has used the word "informal". And that's what I was about to talk about. This is part two. If there was a problem that hadn't yet been resolved out there, in the clinical domain, a colleague would knock on my door and come in and talk about it.

And if it was appropriate, I -- and possibly that colleague -- would talk to Dr Carson or the chairman of medical staff, who was a senior elected person of standing, for informal advice and possibly for these new words, that were new in those times, mediation or

dispute resolution. That type of informal need was fulfilled on a few occasions.

Q. What would happen if that didn't resolve it?

A. Chairman, my answer to that is thank God it never happened.

Q. I appreciate that, but what was the next step?

A. I would have had to go and ask somebody wiser than myself and then the circular would have come out.

Q. Well --

A. I believe we'd have worked through the circular.

Q. So in fact you would have instigated a formal system, which might have been the "three wise men"?

A. I'd rather not use the word "would". I might have considered -- I would have considered looking at the circular and seeing if it was appropriate in these circumstances.

Q. Was there any other route if the informal method had not been successful? There was an informal method before you were brought in as an informal method, presumably, because other more senior colleagues would have already tried to see if they could resolve matters in-house, if I can put it that way, before coming to you. So if you, when you are seized of the issue, also can't resolve it, other than invoking the "three wise men", which may or may not have been appropriate, was there any other route

to resolving matters?

A. I think, chairman, that I've already indicated that's what the medical director was for. That was where my line, my next approach, would be. I would go to the medical director and say, "Here's the problem", lay out what the problem was and say," What are we going to do about it now?"

THE CHAIRMAN: Could we just be clear about what sort of problems would come to you on this basis? There's a variety of issues which occur to me, which may overlap or may remain different. You've said, for instance, one example you gave was timekeeping. That should be something that somebody gets a rap on the knuckles for and they improve. The second one is attitude and that may or may not improve. A third one is if some doctor, and particularly during some of the grim times, maybe in the 1980s or 1990s, who's dealing with bomb or shooting victims coming in and then turns, as happened now and again, to drink, that would be a scenario in which you would be intervening to try to resolve that problem.

But does this cover the problem of an underperforming doctor, a doctor who's just not very good?

A. Yes, it does. I don't want to bring you back to it, but

you have identified one of those types in your statement there. That did work, but it worked eventually by consent rather than that the colleague was disciplined formally. The doctor was fortunate enough that they recognised the problem and resigned.

THE CHAIRMAN: Right.

A. And I don't want to go into any more detail. I don't think it would be appropriate.

MS ANYADIKE-DANES: No, no, I entirely see what you mean.

A. But the process did work.

Q. Yes. Had that not happened, though, then does that mean, from the way you put that, you would have to move into disciplinary measures?

A. Of course.

THE CHAIRMAN: And before that resignation came, there had been efforts to improve the performance of the person in question, they had been unsuccessful, it was clear that you were moving on to something more serious and the person jumped before he or she was pushed?

A. I always worry, chairman, about the use of the word "discipline" because it has all sorts of negative connotations. Whereas the process, if used properly, and if it works, is supposed to be positive rather than negative. But if one cannot achieve a satisfactory result, then the disciplinary process comes into play

properly because one has no other choice.

THE CHAIRMAN: We'll come on to this in a bit more detail as the day goes on. On one interpretation of the evidence in Adam's case, what we're looking at here is a situation where there's a good doctor who makes some terrible mistakes, which leads to a child's death. Is that a different scenario again to the ones which we've been discussing about attitude, timekeeping, drink or consistent underperformance? I guess it must be a different scenario.

A. Of course, yes.

THE CHAIRMAN: And I'm not talking about Dr Taylor now, but over your years from 1987 or in other experience that you've had, has that scenario had to be faced up to and dealt with?

A. It has, yes. But not in the particular --

THE CHAIRMAN: No, I want to move away from Adam Strain's case for a moment and I'm moving away from Dr Taylor for a moment. In what sort of way has that type of issue been dealt with? If you could remember a specific example where you can give me an idea. I'm not looking for names, you understand.

A. I can give you a particular example from my own specialty, but it didn't happen on the Royal site.

A colleague was doing a major operative procedure

and there was a record of, I think, six that went wrong. He never had the training and therefore didn't have the skills, although he was a relatively senior consultant, working in a two and, later, a three-man unit, three consultants.

THE CHAIRMAN: Had he strayed into a specific area which he wasn't capable of dealing with?

A. Yes.

THE CHAIRMAN: Okay.

A. And his employer was concerned because claims had arisen, naturally enough. These operations had gone wrong. Fortunately, the patients suffered harm, but they didn't suffer terminal harm, and that was very pleasing. So in that circumstance, I was asked how that could be dealt with. And I convened a meeting of myself and two other colleagues of senior independent status. They didn't work in the area, geographical area, where he worked. We met with him, having discussed and reviewed all the cases, we met with him and after a reasonable discussion -- and he came represented -- it was agreed and formally agreed that he could continue practice, but he would never, without adequate training, which would be arranged for him, do that procedure again. And that worked.

THE CHAIRMAN: Do I understand that this was a doctor who

was generally a good doctor?
A. Yes.
THE CHAIRMAN: Right. So -- it's like me going to do a case in an area of law I know nothing about and going all wrong, except it's rather more serious when things go wrong with a doctor.
A. It's like me going into commercial law, which I know nothing about.
THE CHAIRMAN: So that's a doctor who's ended up, for whatever reason, straying outside his area of competence?
A. Exactly.
THE CHAIRMAN: What about a situation where you have an otherwise good doctor who is working within his area of competence and something goes wrong, which looks like it is his fault? Can you give us an example, outside Adam's case, of how that had been dealt with in the past?
A. Well, you know, chairman, I think, that I was responsible for litigation management on the Royal site --
THE CHAIRMAN: Yes.
A. -- and, therefore, things came regularly to my attention. Yes, I see here that when this CV was composed, there was a £10 million reserve on the claims

that were in place against the Royal at that time. Now, as always, something would come up. Was the claim defensible or was it not? And there would always have been discussions between me and the colleagues involved. It wouldn't only be just looking at the charts and getting statements from them, but there would have been face-to-face discussions about what happened.

THE CHAIRMAN: Mm-hm.

A. And I can remember two -- I don't even like talking about these in public -- but where one opens the wrong side of the chest accidentally, but it happened. And as long as there are two sides and proper processes aren't in place, it is inevitable that some time -- unfortunately, for the patient particularly, but for the clinician who is involved, the surgeon, as well, because it's traumatic for both. Much more for the patient because the patient has suffered an injury. But that's an example. One hears occasionally in the red-top press about colleagues who removed the wrong leg.

THE CHAIRMAN: Yes.

A. Terrible. Terrible, terrible. Those sort of things, the wrong side of the chest, I can aver to. That happened. And other more minor things happened. Another one, yes. Sterilising -- doing a tubule ligation on a patient who was in for investigation of

infertility, and the wrong patients came in in the wrong order on the operating list.

THE CHAIRMAN: And that wasn't picked up?

A. It wasn't picked up at the time until the claim came in.

MS ANYADIKE-DANES: I think what the chairman was asking is: how do you deal with that?

THE CHAIRMAN: I'm not talking about whether the claim is settled or not because, if you open up the wrong side of the chest, that's open and shut litigation. What I'm asking about is what is done with a good doctor who has made that mistake, which clearly should not have been made, and what do you do with that doctor moving forward?

A. You go back ways first and you and others satisfy yourselves -- it's not an independent judgment, it's done with his lead clinician and maybe all of the clinicians with whom he works. His performance is reviewed: has he had other claims of a similar or different nature against him? Have there been complaints against him or whatever? The totality would be looked at and a decision reached whether, chairman -- in your terminology, "a good doctor", known to be a good doctor, good in performance, good in skills, good in attitudes -- has had an unfortunate disaster, but it was unpredictable from previous behaviour. And in those

circumstances, one would decide with one's colleagues how to proceed. Almost certainly, there might have been an element of supervision.

THE CHAIRMAN: In that scenario, doctor, the outcome of that follows a discussion at which these areas are reviewed: have there been other claims, have there been other complaints, are there concerns held by his clinical director? And what about: does he recognise or accept that he made a mistake?

A. Yes, of course.

THE CHAIRMAN: Because if he doesn't recognise or accept that he made a mistake, then the situation becomes more complicated, doesn't it, if he's in denial about making a mistake? That's a far more troubling scenario than it is if he accepts that he made a mistake.

A. I know you're coming to the particular --

THE CHAIRMAN: We'll come on to that.

A. I know we'll get there eventually, but we're talking in principle rather than in practice at the moment.

THE CHAIRMAN: Yes.

A. And the issue then is: what is the type of denial? Is that denial of major, moderate or minor significance? It shouldn't happen at all, of course, but if it is minor or moderate, is there a work-around? And the issues then were clinical freedom as well as everything

else. Audit was coming, but variance from the guideline or the protocol. And --

THE CHAIRMAN: But the fundamental question has to be: is the next patient safe?

A. I agree.

THE CHAIRMAN: And the patient after that and the patient after that.

A. And all subsequently, yes, of course. There's why an element of supervision -- and when one works in an environment where colleagues are close together ... And not only medical colleagues, but nursing colleagues -- and nursing colleagues are fundamental to the team. They are part of the family, really part of the family. I was at a -- to digress just for a second if I may, chairman. I was at a colleague's funeral the other day, an anaesthetist. And the number of nurses who had worked in theatre with that man, I was delighted to see for the family's sake. But it just showed how involved they were. And that is the way that it happens.

THE CHAIRMAN: But that's because the nurses are important because they are often at least as quick, if not quicker, to pick up that somebody isn't really very good or something's going wrong?

A. Exactly, exactly.

THE CHAIRMAN: Sorry, I have taken you off the track.

MS ANYADIKE-DANES: The work-around that you referred to, the example you gave, was of supervision. I suppose it becomes -- keeping this matter hypothetical, asking for you to give us answers in principle becomes harder as we load in more detail because then it becomes more and more the actual circumstances that will dictate what you do, I suppose.

But following on from the chairman, the area I can imagine that you can anticipate we're interested in is: if the clinician really doesn't accept that the approach that he took or whatever it is, the thing that is the subject of concern, was incorrect, in fact considers it was entirely appropriate, then the supervision becomes a little more difficult, does it not?

A. It does.

Q. Because supervision works best when a person has to some extent conceded that that is a appropriate step. Otherwise it's an antagonistic relationship, is it not?

A. Of course.

Q. So if we stuck with the chairman's example to you, how really do you deal with somebody who is an experienced person, to all intents and purposes in the past been entirely competent, but has just, what you might regard, as a blind side about this issue and just cannot accept

that what is being portrayed as errors were actually errors? How really does the Trust deal with that for the safety, as the chairman put it, of the patients who come afterwards?

A. My only answer to that is, other than the particular that we'll come to, I had no personal experience whatsoever.

Q. I understand. Thank you. Can we go back? There's just one last point, and you may nearly have addressed it entirely. One last point that I wish to pull out from your CV. If we go back to it -- thank you very much. You see there in that penultimate bullet under "Key responsibilities", that you had as part of your responsibility:

"The development and implementation of an organisation-wide risk management programme, including the changes to be identified."

Then, as we go on to the second bullet, you were accountable to the Trust board for the administration of complaints, legal services and so forth. If we take the first one: what exactly did that involve, "the development and implementation of an organisation-wide risk management programme"? What sort of things were you looking at and would be part of your risk management programme?

A. Chairman, I know that you have heard about risk management and how it was evolving over recent days.
Q. Yes.
A. And that it was only recently invented, so to speak. And it had arrived in Northern Ireland and trickled down to the Royal. Among other things, I was regarded as the person who was to organise, through clinical audit as much as anything else, how to control risk. Now, there were risks in all sorts of ways identified in various ways. The Control of Substances Hazardous to Health, COSHH, for instance. Medicines administration, for instance. The simple changes required. And they still don't happen of -- the prescriber writing (a) the proper name of the drug, (b) writing it in capital letters, (c) signing his name and then either putting his name in capitals or an identifier such as a bleep number. One looks on a daily basis if one deals with charts, as I sometimes do, at drug kardexes. And there's risk there all the time and one hears about patients getting the wrong drug or the wrong dose of the drug. That's risk management, as I understand it, and how one deals with that and how one has to keep coming back to it and back to it and back to it. And it's a matter of attrition sometimes, unfortunately.
Q. Yes. Doctor, you have actually raised a very

interesting example that you've given us, which is helpful in the sense that it doesn't directly bear on Adam Strain's case, but it's helpful to look at it. So you've identified the significance of accurate, legible record keeping, and certainly when you're dealing with prescription of medication, and how they should be administered, one can see how that is a very important thing and how that leads to risks and vulnerabilities when it's not dealt with properly. But when you're developing your organisational-wide risk management programme, how do that fit into your programme? What is your programme going to do, if I can put it that way?

A. The first thing one has to do is to identify the risks and hazards.

Q. So your starting point would be to draw up a list of risks and hazards across the Trust?

A. Some specialties are better at doing this than others and they would have identified this by the development at super-Trust level, say at Royal Colleges level, of the management of this, that or the other, identifying where risk can happen. And then ensuring that guidelines are drawn up within that specialty to control that risk.

Q. I understand that. Then is part of your --

A. An example, if I may, chairman?

Q. Yes.
A. There are certain types of obstetric forceps that doctors in training should not use, but they're there in the press or they're there in a pack, and there's the possibility of them using -- but they shouldn't use them.
Q. So that would be one of the set of risks that goes with that particular directorate?
A. Correct.
Q. Then is part of what you're doing establishing a system for monitoring the incidence of those risks actually occurring and then how you will address them to reduce that incidence? Is that part of what you would do?
A. Exactly, what the variances were and by whom and for what.
Q. If you might assist us with the particular document I'm going to show you, one of the things I want to ask you is whether that process really started with health and safety, which was pretty well identified as a risk -- slips and trips and sharps and that sort of thing -- and then moved on to the more clinical areas where you're talking about the sort of thing that you've mentioned in your own experience, obs and gynae, somebody straying outside their competence into a procedure that they really didn't have the skills to deal with.

If I pull up this document, you might be able to help us with it. It's 061/2, page 255.

A. Chairman, if I may diverge for a wee second just to do something for myself personally?

Q. Yes. Shall we take a break?

A. No, no, I'll just extract it and take it if I may.

Q. Of course. (Pause).

You can see that this is the Trust Health and Safety policy. It says it was first approved by the Hospital Council on November 1993. And then it was last reviewed on October 1998. In fact, I'm not going to call it up now, but if one goes to the last page, it does have a section which has the review date and it says that:

"The policy will be kept under continuous review by the Trust Health and Safety Committee and changes recommended to the Hospital Council [and so forth]."

So in this way, I presume it becomes a rolling document.

A. Yes.

Q. So at the moment, though, we have this document that spans these five years and what we are not terribly clear on is which bit relates more to the 1993 end, if I can put it that way, and which bit relates more to the 1998 end. If I just turn the next page, which will show you the table of contents so that -- do you recall

seeing this document? That should be my first question.

A. There are so many documents.

Q. I'm sure there are.

A. I probably should have seen it. To say a definite, under-oath "yes", I couldn't.

Q. I understand that.

A. But I am sure, chairman, that I should have seen it.

Q. Right.

A. The only way I could guarantee that I had seen a document such as this, if it came from my department that I worked in and my initials were on it.

Q. I understand that. If we go to 258, there you see:

"The Trust board has the ultimate responsibility to ensure compliance in the Trust's undertakings."

Then:

"The Hospital Council is responsible for the implementation of the Trust board's health and safety policy."

And you can see the various elements that the Hospital Council is to do:

"Ensure that the organisational arrangements contained within this policy are implemented."

Then if one goes down to (f):

"Ensure that the managers within the Trust understand and are competent to undertake their

responsibilities in relation to health and safety legislation."

Because you had risk as your remit, does that mean your part of this process of ensuring that the organisational arrangements are being implemented and that the managers within the Trust understand and are competent to undertake their responsibilities in relation to it?

A. Complicated answer, chairman, because I can't remember exactly when things were in transition.

Q. Okay. Let me pull up the next page.

A. Let me just finish my answer though. I know that I was responsible, in the early 1990s, for health and safety -- slips, trips and all those other things -- and for relationships with the Health and Safety Executive.

Q. Yes.

A. When serious matters happened on the Royal site, like people electrocuting themselves, for instance -- as did happen -- as an example, a contractor, and that department had to be closed as a result. But with the appointment to a new post of Director of Occupational Health and Safety, some, at least, of these matters -- not the litigation end, but the upfront end -- transferred to Dr Stephens, the Director of Occupational Health and Safety.

Q. That's actually why I wanted to pull up the next page because I thought that might help you. If we pull up 259, you will see that there's a Risk Management Standing Committee and the composition of it. We have the Medical Director, then we have you as the Director of Risk and Litigation Management and then you also have the Director of Occupational Health and Environment. A number of others as well, of course, but these are all the people that were thought to be part of this process of instituting some programme to manage these risks for the Trust.

A. And that committee worked very, very well because there were interactions in a major way with reports on a monthly basis, particularly from the facilities directorate, where the majority of problems arose. Not all of them, but a lot of them. And the insurers' representatives were very, very pleased that we had that committee because they saw that we were dealing with the matter in such a way that there was cost containment.

Q. I understand. Can we move on to part of the organisational structure for this? This is why I really pulled it up, for your help, because we know that the medical audit came in first, moving on to the clinical audit. There is a similar sort of shift -- well, a development, it would seem, between pure health and

safety and, as some would know it, into the clinical risk management. If we pull up 262, there you see there's a Clinical Risk Management Group. It's responsible for:

"Clinical risk management within the Trust and its undertakings."

And that's going to report to the Risk Management Steering Group.

If we look down at the second paragraph, it says:

"The responsibilities of the Clinical Risk Management Group involve and affect health and safety and non-clinical risk management."

So we seem to have two branches there in terms of risk. One is clinical risk and the other is health and safety:

"For this reason, there must be close liaison between the Clinical Risk Management Group and the Trust Health and Safety Group. The Director of Risk and Litigation Management will be the link between the two groups."

And it sets out, on behalf of the Clinical Risk Management Group, what is to be done and, in relation to the Clinical Risk Management Group, the specific responsibilities, which include "clinical audit", "research register", but also "untoward incident

reporting (clinical)".

So this has you in quite a pivotal position actually. Not only are you charged with introducing this programme for risk management as at some point between 1993 and 1998, you not only have the direct responsibility, it would seem, in relation to health and safety, but you are also the bridge between that and clinical risk management because the one is thought to impact upon the other.

Can you help us with whether this was the case in 1995, what is described here?

A. Chairman, I wish I knew. "Probably" is the answer, but I can't speculate.

Q. No, I understand.

A. But I do know, but when is the problem, in time terms.

THE CHAIRMAN: Just to make it clear, doctor, my understanding of this documentation is this: that on one view health and safety is about you don't leave wires lying around, you don't leave things for people to trip over or you don't leave a floor slippery and wet so they fall. But this looks as if health and safety is now recognised as extending into something which goes wrong, for instance, in the operating theatre and that's why the bottom line on that page is:

"Untoward incident reporting (clinical)."

So that's not some fluid or liquid on the floor of the operating theatre and a doctor or nurse slips on it and is injured, that is if something goes wrong with a patient; is my understanding correct?

A. You've probably had all this explained to you and I don't want to bore you if you have. Untoward incident reporting -- I received on average 20 to 30 reports a day, almost always exclusively compiled and presented by nursing staff about how Mrs A fell out of bed, Mrs A was an elderly patient, a disturbed elderly patient. And she either climbed over the cot side or they hadn't cot sides in place in the ward. Mr B got the wrong medicine. Child C was discovered to have a pressure sore under a plaster of Paris and it was removed, and so on and so on and so on.

My job then, having received the report, was to either sign it off because they gave an indication at the bottom of the form of what could, might, or should have been done about it and there was some action taken at board/clinical level. If I wasn't satisfied, I went walkabout and I went to the clinical area with the form or forms and I would walk to the nurses' station and the sister, ward manager, would look around at me and would say to me, "What have we done wrong now?"

Now, it wasn't always that, they hadn't done anything wrong, but this is how they viewed it. I mean, I didn't have to get a visa to go into that ward ever, particularly because I wore a white coat. But by the same token, I was always viewed as if I was coming with something that had gone wrong, and occasionally things had gone wrong and I would have a discussion. If there was a doctor involved, I'd talk to the doctor, if there were nurses involved and the nurse was there or whatever, I'd try and find out what happened. And did I need to get more information, particularly if there was likely that a complaint or a claim would arise from that? And therefore, that was source information, identified early and dealt with in the context of a risk that had been identified, if there was a risk, and how to manage it.

Q. Yes. We'll just pull up -- because as you were speaking -- I didn't want to interrupt you, but I would have pulled up this page to assist you. 263, which follows on from what the chairman was saying. You can see, right at the top, (d), part of your duties are also medical negligence and complaints. Presumably, medical negligence can extend from the gamut of falling out of bed because the supports weren't maybe quite put up as they ought to or they weren't monitored quite as closely

as they might have been to really something to something extremely serious at the other end of the spectrum. So what I was trying to have from you is that you are therefore part of this risk: introducing, monitoring, evaluating this risk management programme for the Trust. One of the things that you're charged with doing is ensuring that people know about it. If one goes forward to 276 -- or at least know what they're supposed to be doing. You see under "Training and communication":

"Training of managers and staff to ensure that they competent and able to carry out their duties safely is the responsibility of directorates. The Director of Risk Litigation Management and the Trust Health and Safety Manager will assist directorates in assessing training needs and will coordinate training activities for the Trust."

So, yes, they are going to be making sure that their own clinicians within their particular directorate know what they're doing in relation to managing risk, but ultimately it comes up to you, as the Director of Risk Litigation and Management, and the Trust Health and Safety Manager, to ensure that they are assessing those matters appropriately because the responsibility to make sure that risk is being properly managed is yours and you're going to have to account for that. So you

1 therefore not only have to account up, but I presume
2 you're making sure that what you require is cascading
3 down so that the risks are being managed in that way.
4 A. Chairman, counsel has made the answer for me. I am very
5 pleased to report that this worked very well because
6 there was a Trust health and safety officer,
7 Mr John Orchin and he, while he remained under my
8 management, did a most excellent job and reported to me
9 virtually on a daily basis, but he ensured that training
10 was properly provided.
11 THE CHAIRMAN: Just in very, very general terms, what was
12 his background by way of training? Sorry, was he
13 a medic?
14 A. No, he wasn't. I know that he was appropriate.
15 THE CHAIRMAN: Therefore he could help you a lot on areas,
16 on certain risk areas, but there were other specific
17 medical or clinical areas on which he might be less
18 valuable and you would have to be more hands-on?
19 A. Correct. I think, although I'm not 100 per cent
20 certain, I'd have to look at his file, that he came from
21 an insurance background --
22 THE CHAIRMAN: Right, thank you.
23 A. -- which would have been very appropriate in the
24 circumstances.
25 MS ANYADIKE-DANES: There's actually an organisational

chart, which might help. When you're dealing with the risk management aspect of your responsibilities, I'm interested for you to help us with what the reporting lines in relation to that were. If we look at 279, the Risk Management Group that we've just been looking at, of which you formed a part, that is "5, Clinical Risk Management Group". And you can see that on the second tier there.

Can you talk us through how these reporting lines actually worked? Because I see alongside it are Claims and Medical Negligence -- that's something that you had responsibility for. Then you have one, which was the Risk Management Standing Committee. And that seems to report straight up to the Hospital Council, up to the Trust board and, ultimately, the chief executive.

And then if one looks below that line, literally the first line, that's where you see your directorate, health and safety groups and so forth. So when it came to management of risk, who reported to you personally and did you then report up ahead of the lead clinicians and the directorates and maybe even the medical director?

A. My answer to that is that I reported to myself because I was on virtually every one of these groups.

Q. Yes.

A. And by doing that, I knew exactly what was going on. I won't say I gave direction, but I assured myself that things were happening as they needed to. I wasn't on them all.
Q. I understand that.
A. But the reps H and S group, for instance, I wasn't on.
Q. If we look at it from the level of directorates, part of what you had to do is make sure the clinicians within the directorates were appropriately trained, they were managing their risk and so on and so forth and that you were there to assist with that process, to make sure that that happened?
A. And particularly, if I may interrupt, chairman, through Mr Orchin.
Q. I understand that. So then there is a concern, a matter is flagged, which gives rise to a risk. Does that come from the director of the directorate to you or from the medical director to you? How does that work?
A. Most of these wouldn't have come in that way at all. They'd have come with a knock on my door.
Q. I appreciate that.
A. The informal route, but it was very formal informal.
Q. Yes. Do I understand you to be saying, though, that there is a route, whether it comes from the clinical director or the medical director, they are telling you

about these risk issues?
A. Yes.
Q. Right. So even though your reporting line for other matters may be to the medical director, when one is getting into these risk management points, because of your particular position, those risk issues are coming to you?
A. But I would have always involved the medical director when appropriate. Always.
Q. When appropriate, I understand.
A. We had a very good working relationship. He talked to me about things and I would talk to him. And that would have happened, if either of us were around, on a daily basis.
Q. I'm sure that's so. And when you are now reporting up about risk, who do you report directly to? Do you report directly to the Chief Executive or do you report to the Hospital Council and up it goes and finds its way to the Chief Executive? In practical terms, what happened?
A. In relation to this diagram -- and diagrams are never perfect.
Q. Yes, I understand.
A. There would have been a place on the Hospital Council agenda for a report.

Q. And that's --
A. A short form report. And that was my responsibility.
THE CHAIRMAN: That's a health and safety report to the Hospital Council?
A. Yes.
MS ANYADIKE-DANES: In that way, would the Chief Executive, who chaired that council, learn about that, even if you hadn't told him about it informally, he would formally learn about it?
A. Yes. And very occasionally, he might have required me to report on it to the Trust board.
Q. Yes.
A. I can't remember an example, but I'm sure I did.
Q. Yes. Then just one final point and I'm conscious of the time, in this document, and I ask it because of something you said in one of your witness statements. Can we go to page 277? If you look under the "Defect and investigation centre (adverse reporting)", the first paragraph says:

"The procedural reporting arrangements for dealing with adverse incidents, reactions and defective products relating to medical and non-medical equipment and supplies, food [and so forth] and medical products are described in a document."

Which we have called PEL(93)36. It says:

"The appropriate hazard guidance officers will be responsible for the reporting, on the appropriate prescribed form, all incidents to the Defects and Investigation Centre."

And then there's a reference to the copy of the form being sent to Mr Orchin, who you have mentioned. The reason I pulled this up is because I asked you about this in your witness statement and you said you couldn't remember anything about PEL(93). Is that simply because you didn't have visible to you all the documents and it was just one of many documents that you think about? But given its place in health and safety, you're likely to have known about it, aren't you?

A. I should have known about it.

Q. Forgive me if I get it incorrect, but I think Dr Gaston said he knew about it because it was pretty well publicised.

Mr Chairman, I wonder if this might be a moment.

THE CHAIRMAN: We have to break for the stenographer, so we'll start again at as close to 11.45 as we can.

(11.33 am)

(A short break)

(11.55 am)

THE CHAIRMAN: Just before you resume, Dr Murnaghan, please just sit back for one moment, please.

Mr Simpson, I understand that some issue has arisen about documents which we were told on Friday were going to be provided to the inquiry, but were subject to delay because the office was flooded in the bad weather on Friday afternoon; is that correct?

MR SIMPSON: Yes, there are a couple of issues that I want to deal with before I answer that question directly. The first is there has been some correspondence between the inquiry and the DLS in respect of medical negligence files relating to the Adam Strain case, amongst others.

You were informed, I think by letter, that the DLS does not hold the medical negligence files. When Brangam Bagnall became defunct, their closed files were put, by them, into some form of storage in McConnells, which is a fairly large warehouse storage, which I'm sure you'll are aware of, Mr Chairman. The open files did not got to DLS; they went to MSC Daly who, I think you'll remember, took over their practice for a period of time. The effect of that is that the DLS has no control over the way files were stored. In fact, they were stored haphazardly in boxes. You were told originally that there were about 160 boxes; it turns out that there are several hundred boxes. No box is indexed, no box is properly labelled.

The boxes simply have to be searched through for

anything to be found, which might touch upon this inquiry. The second thing is -- and I want formally to put this on record -- that although, for example, this inquiry was given extra funding for the remainder of the inquiry, the department has refused any funding to any of the trusts for expenditure related to this inquiry. That means that for every pound that's spent on this inquiry by the Trust, it comes out of front line medical care.

THE CHAIRMAN: Or trust management.

MR SIMPSON: Or Trust management.

THE CHAIRMAN: Yes. Not every penny spent by a trust is on front line medical care.

MR SIMPSON: The expenditure on this inquiry comes out of the Trust's existing funding, some of which, as you know, goes into front line medical care.

THE CHAIRMAN: Some of it goes into front line medical care, some of it goes into administration, some of it goes into management. But not every pound which is spent by the Trust on this inquiry comes out of front line medical care.

MR SIMPSON: Not every pound, but there is a very significant expenditure by the Trust in relation to this inquiry, which impinges upon patient care.

The importance of that is that, between DLS staff

and Trust staff, a total of five spent two days searching for the documents that you asked for. That produced the inquest file held by Brangam Bagnall at the time. That, as I understand it, breaks it down into four types of document: first of all, a handwritten transcript of what happened at the inquest; some correspondence back and forward, which is probably neither here nor there, as far as I understand it; a consultation note of a consultation held on 14 June; and a letter addressed to Dr Taylor.

My understanding of my instructions is that, as far as the inquest notes are concerned, those can be disclosed and are in the process of being disclosed, and you know about the flooding last week.

THE CHAIRMAN: Yes.

MR SIMPSON: And there is one issue I want to raise about that. You know about the flooding of last week, but those documents should be able to be produced very quickly. Secondly, the correspondence is capable of being produced very quickly. Insofar as the other documents are concerned, there may be an argument that the privilege or some aspect of the privilege relates to or is owned by Dr Taylor and, accordingly, my learned friend Mr Uberoi may have some remark to make about it. But subject to that, the Trust has no objection and

waives its privilege in respect of all the documentation. Subject to that, therefore, the documents should be available very shortly.

THE CHAIRMAN: That's helpful because a message I was receiving a few minutes ago was that the Trust, contrary to the message which we had received on Friday, had yet to decide whether it had privilege which it was going to waive, but you have confirmed that the Trust is not asserting privilege over these two documents and it's now over to Mr Uberoi on that.

MR SIMPSON: Yes. I want to make one comment about a matter that was said on Friday. Mr Chairman, it was towards the end of a long day. You used the word "conspiracy" in relation to the actions of the Trust. I understand and appreciate that that was meant in a light-hearted way and was not intended as a criticism of the Trust. All of those in this room would have understood that to be the case. But there is a significant number of people who follow the inquiry by way of online transcript and therefore read a word like that, where levity does not come across in the transcript, and I would respectfully ask you, Mr Chairman, please not to use a word like that when it comes to -- even in a light-hearted way -- the actions of the Trust because that type of use of a word sticks to the Trust, and

I would respectfully ask you to indicate here and now that it was meant in a light-hearted way and was not meant as a criticism of the Trust.

THE CHAIRMAN: There was nobody who was here on Friday who could have thought for one millisecond that there was anything -- whether it's because I say something and some people feel inclined to laugh, your junior counsel did laugh. Everyone else here laughed, Mr Simpson.

MR SIMPSON: And probably if I had been here, I would have laughed as well. Do bear in mind, if I may respectfully say so, that not everybody is privy to the way this hearing is conducted.

THE CHAIRMAN: I take the point and you'll know this, but just for the record, it was not meant as anything other than a light joke at the end of a long week.

MR SIMPSON: I certainly accept that, Mr Chairman.

THE CHAIRMAN: Thank you. Mr Uberoi?

MR UBEROI: I'm grateful, sir. I'm grateful for that summary. This is the first I've heard of this issue -- 20, 25 minutes ago -- and up until then I'd been working on the understanding that all the documentation that existed was already, in fact, in the inquiry bundles. So as described, I think there by my learned friend, I'd simply like the opportunity to take instructions on those documents as described.

THE CHAIRMAN: Can I ask, have you seen the documents yet?
MR UBEROI: They've been passed to me in the break.
THE CHAIRMAN: We'll go on with Dr Murnaghan until lunchtime. Is Dr Taylor available to you today or not?
MR UBEROI: I don't know. The suggestion is he should be here at lunchtime and we can make enquiries as to how quickly we can get in contact with our client. I would say, if I may, at an absolute longstop, if we were to notify you of our position by first thing tomorrow morning -- I would hope it would be by the end of today -- but this is the first I've heard of the issue and I would like the opportunity to take proper instructions.
THE CHAIRMAN: Okay.
MR FORTUNE: Sir, putting aside the jokes of leading counsel for the inquiry for the moment, I'm just wondering whether the documents that have been disclosed to my learned friend Mr Uberoi might not have some effect or impact upon Professor Savage? Bearing in mind I was trying to mention or elucidate what appears to be a clear conflict of interest within the Trust as to the representation by the solicitor taking instructions from both Professor Savage and Dr Taylor, knowing that there were two discrete accounts. I don't know how my learned friend Mr Uberoi will be able to deal with that matter

now that the Trust has waived its privilege, but clearly if there's anything in the documents that affects Professor Savage, I would like to be informed.

THE CHAIRMAN: Obviously, you won't have seen documents yet because Mr Uberoi, at the moment, is considering with his solicitor whether there's a basis for any claim for privilege, and if there is, whether they are going to assert it. So if he chooses not to assert a privilege, which his client has, I know that you will want to see the documents, but it's a bit of a stretch to see how it would lead on to a privilege which is vested in your client, isn't it?

MR FORTUNE: Well, I'm not sure, sir, that's the difficulty. And of course, you have the right to see the documents and it may be that you decide that the public interest mandates disclosure. But that may be the longstop at this stage.

THE CHAIRMAN: Okay, thank you very much.

Mr Simpson, can I just come back to one point, because it arose particularly on Friday when Professor Savage was giving evidence. There's a line -- Mr Lavery may have told you about this -- being advanced really by Mr Fortune on behalf of Professor Savage, which is that it was inappropriate for Mr Brangam to represent the Trust and Dr Taylor at the inquest. Has

this has been raised with you?

MR SIMPSON: Yes.

THE CHAIRMAN: And Mr Lavery, who has a lot of experience of doing inquests in Northern Ireland, has said that it has not been, perhaps until more recent years, the practice for doctors to get separate representation in some limited circumstances. The English approach, if I may put it this way, as advanced by Mr Fortune -- who claims the silent acquiescence and support of his English colleagues -- is that that would never happen in England and would certainly not have been happening in 1995. Do you have any observation on this?

MR SIMPSON: Only from my own experience, which is, certainly at that time and before the recent changes in coronial procedure here, I find it very difficult to recall a case in which a doctor was separately represented as an inquisitorial type of hearing such as a coroner's inquest in 1995 and certainly into the 2000s, but I will make enquiries --

THE CHAIRMAN: I can see a proposition that -- the one that Mr Lavery advanced, which is the purpose of the coroner's inquiry and inquest and report is a limited one and it does not include deciding whether somebody was negligent in their treatment of a patient, but what is said during that inquest can then have

repercussions for a medical negligence claim which has already been raised or which is coming down the line.

MR SIMPSON: It can and could have and did have from time to time, but because of the limited nature of the findings of a coroner's inquest in those days, that was not perceived, in my experience, as a problem in those days.

THE CHAIRMAN: Has that position changed more in recent years?

MR SIMPSON: My understanding is that in some recent inquests, doctors have been separately represented but I will have to take specific instructions on whether that's a routine matter or whether it very much depends on the particular circumstances.

THE CHAIRMAN: I'm not sure how far I have to get into this, but it seemed to emerge towards the end of last week as an issue which may, at some point, touch on some of the issues. We'll see how things go. Sorry, I suspect it's going to be an issue which Dr Murnaghan may be asked about later on today.

MR SIMPSON: I suspect so, but it's to be remembered what the procedure was in 1996, which is very much not the case now.

My learned friend is right, the change after the 1998 Act came into force changed the way in which coroners' inquests were carried out in this jurisdiction

considerably and it was fundamentally different in 1996.

THE CHAIRMAN: Okay. Thank you very much.

MR UBEROI: Sir, can I raise a point about legally privileged documents in response to an observation made by my learned friend Mr Fortune. And I hope this is debate or a discussion we end up not needing to have at all, so it may be entirely otiose. I don't know off the top of my head the definitive answer to the question, but there is a question mark in my head about the true position about the inquiry's rights with regard to legally privileged documentation where legal privilege is asserted, given that legal privilege is a protection afforded under the Inquiry Act. I don't know the definitive answer on these documents and it may be an argument we don't end up having or it may end up being a submission I don't end up making as it were.

THE CHAIRMAN: First of all, you'll remember this is not an inquiry under the Inquiry Act, but the statutory powers which I have do not allow me to compel the production of a document which could be withheld on any one of the recognised grounds in ordinary litigation. So if it is a privileged document, I cannot compel the party who enjoys the privilege to produce it.

MR UBEROI: Yes.

THE CHAIRMAN: The question is, (a), is it privileged and,

secondly, who does the privilege attach to? Because it may be -- and this might be an entirely academic debate -- that the privilege is between the Trust and your client. The Trust, if it has privilege, as is indicated, it does not resist disclosing the document. Your client has to make a view on whether you can assert privilege and, if you do, whether you want to assert privilege, but as I've indicated, this seems to me to be something of a stretch from that to say there's a privilege attaching to Professor Savage, but we'll examine that if and when it arises.

MR UBEROI: I'm grateful for that because that's the analysis that would occur anyway under the Inquiry Act, and it may be an academic debate that we don't end up having.

THE CHAIRMAN: Dr Murnaghan, thank you for waiting. Would you come back, please?

MS ANYADIKE-DANES: Thank you very much.

I just want to pick up one or two points before going on to matters that arise more directly out of the Adam Strain case. When you were talking about having these risk management meetings and we looked at the structure in that document that ultimately would lead you to having to make a report ultimately. At the meetings where the risk management is being discussed,

do you have the benefit of any statistics for what has happened in any of the other directorates? Sorry, just to help you, I had referred to you looking at the incidence of things and looking to see what that incidence was, trying to take a view as to why that might be the case, and then perhaps formulate some recommendations as to what might be done to reduce the incidence and therefore reduce the level of risk that was being experienced in any particular area. In order to do that, are you provided with any statistical material at all from those directorates?

A. Chairman, there was a compilation of the clinical incidents, but it was a very simple compilation and it wasn't cross-tabulated.

Q. Right.

A. So one would know how many slips, trips and falls happened in a clinical area or how many wrong doses of medication had been given. But one couldn't bring it back to source in detail. It probably depended at that stage -- again because we were short of staff doing this job -- that the person who did it, among other things, worked part-time, both on a half-day basis and on a number of days in the week. So it wasn't easy to get anything more than that done and it wasn't done in a system on computer, it was done in longhand. So it

depended, to a large extent, on my memory.

Q. Well, yes. I accept you say that except -- and I understood you to say that the documents sometimes make things appear a little more formal than they were. But if we look at just page 266 for example -- sorry, 061/2, page 266. These are the responsibilities. If you look at those ascribed to you as Director of Risk and Litigation Management, you had the responsibility, as we've already discussed, for coordinating and monitoring the health and safety activities throughout the Trust area. You had to report to the Chief Executive, Risk Management Steering Group and the Trust Health and Safety all matters relating to health and safety and report also to these committees on the activities of the Clinical Risk Management as they affect health and safety.

And that's because you're the bridging person between Clinical Risk Management and Health and Safety. And then it goes on with who you're going to work with and so on. So it does, I must say, looking at that document, appear to have a little more structure than people just coming and knocking on your door and then you reporting up the line that somebody knocked on your door. So what I'm trying to get at is, if you're carrying out this function, do you not have some sort of

statistical material, some numbers as to what's happening so that you can look in a relatively systematic way and get a handle on what's going on, basically?

A. My answer to that is that once Mr Orchin came on the establishment, he started to put these matters together, and then very soon after that, I lost him. He was transferred to Occupational Health.

Q. Yes. I appreciate that. But I'm still --

A. And I know this is very prescriptive in the way it is written and this is ideal rather than -- and it's aspirational.

Q. It's not framed in terms of aspirational. If one looks a little bit further down at, say, (f), that's quite significant. You have to advise on priorities. Well, you're only going to be able to advise on priorities surely when you see the incidence of things and then you can see how much a particular sort of thing is taking place and then you can advise on that. Further up, you have to develop guidelines and so forth. So all I'm trying to get at is: did you not, at some stage, have numbers, for example, deaths, paediatric deaths? Are they numbers that would come to you?

A. No.

Q. Even if they arose as a result of something that was

a risk management issue, would you not see that?

A. I don't think I would, no.

Q. Well, let's put it bluntly. Would you see deaths arising out of medical negligence? Medical negligence is fairly and squarely within your area.

A. Of course, if a claim came in, a letter before action came in, then I would know about it because I would then get the file --

Q. Yes.

A. -- and I would find out.

Q. But in those numbers, would you -- I mean, I understand what you're saying, that if a claim came in, you would see the file. But if you're trying to put together some sort of assessment of what's going on, surely that has to be reduced to numbers so that you can report upwards the incidence of certain sorts of things?

A. Chairman, this was developing. I'm sure it happens now, I'm not there any more. I don't know. I'm sure it happens now, but I have to go back to the idea of the aspirational. The headlines are here and this is what was intended to happen, but it happened over time.

THE CHAIRMAN: Okay. We've got it.

MS ANYADIKE-DANES: Well, I'll move on, although I will invite perhaps the chairman that we look at the annual reports. I think there are numbers in the annual

report, otherwise risk management turns into money at some point?

A. It does.

Q. Thank you. I wanted to ask you then about -- I'm not going to go into it overly in detail. I simply want to ask about the structure for it. We have had evidence from Professor Savage that he came to the view, at some point round about the late 1980s -- certainly before 1990 -- that the paediatric renal transplant programme, which was being carried out on the Belfast City Hospital site should be extended to offer renal transplants to younger children and that those younger children should have their transplants carried out in the Children's Hospital because it was inappropriate that their transplants should be carried out in an adult setting, if I can put it that way. So that has been his evidence to the inquiry.

If one looks at the statistics on it, we can see that the first of those happened in 1990, and he confirmed that in his evidence also.

So what I wanted to ask you is: there are, presumably, risk management issues arising out of bringing a new service or a new element of a service over to the Children's Hospital; would that be right?

A. Yes.

Q. Yes. What sort of structures were put in place to monitor the risks that might be associated with that?
A. Simple answer: none. Because I didn't know anything about it.
Q. You didn't know --
A. I didn't know anything about this particular aspect of the service.
Q. When was the first time, Dr Murnaghan, that you appreciated that this service was now being carried out or offered from the Children's Hospital?
A. I think it was -- I'm nearly certain it was when I was told about the regrettable and unfortunate death of Adam.
Q. So you, as the Director of Risk and Litigation Management, charged with implementing a risk management programme and trying to manage that aspect of matters for the Trust, didn't appreciate at all that those procedures were being carried out in the Children's Hospital until that time?
A. That is correct, as far as I can remember.
Q. Had --
A. Let me explain, if I may, chairman. You know yourself the Royal site is a big, big place, and there were several islands on the Royal site and the Royal Belfast Hospital For Sick Children was one of those islands. So

were -- Care of the Elderly was an island. So was the dental hospital an island. So was the maternity. So was the gynaecology separate from the maternity. These were all there within the walls of the site. But one didn't necessarily learn about or hear about anything, as sometimes one hears, until something goes wrong. If things are going all right, it's not that I wasn't interested, but I didn't know. And I did not do captain's rounds in each of those facilities every day or every week. I was in all of those places regularly, I knew my way to them and who was in them and what happened in them, but I went for a particular purpose.

THE CHAIRMAN: Well, can I ask you this? We know that between 1990 and 1995 there were some paediatric renal transplants, but a very small number. And the nature of them was that the numbers would be small. If you had known in 1990 or 1991 that it was Professor Savage's intention, necessarily approved by others, to start doing the paediatric transplants in the Royal in the Children's Hospital as opposed to the children going to the City, would you have said, "No, don't start that until I've had a look at it", or what would you have done?

A. Well, I would have been surprised if it had come to me first because there are all sorts of resource issues in

this.

THE CHAIRMAN: So it would go to paediatrics?

A. The clinical director of paediatrics would have been involved. The clinical director of anaesthesia would have been involved. The clinical director looking after the labs would have been involved. And these, at least, would have had to get together and agree a plan.

I wouldn't necessarily have been involved in that at all at that stage because risk was also devolved to directorates.

MS ANYADIKE-DANES: Yes, but ultimately you were --

A. Ultimately, it would have gone back if it was thought appropriate to report it back to me.

Q. But why wouldn't it? I mean, to start a new service that had never been done before in the Trust, involving young children, major surgery at the Royal Hospital, using surgeons from the Belfast City trust. So it's not the cleanest of arrangements, if I can put it that way, and everybody has accepted that those surgeons were not transplant surgeons. And not many of the procedures were being done. All of that, does it not, have the hallmarks of something that you'd want to look at very carefully and ensure that the safety mechanisms, if I can put it that way, were established to make sure that all this is being done in a safe and appropriate way?

So why isn't that something that you, in charge of risk management, would have been alerted to?

A. Because I would not have been the person at the centre who would have been involved to give it the imprimatur.

Q. Yes, you may not have been involved to give it the imprimatur, but would you not have been involved to know so that you can incorporate that to your risk management programme?

A. If I had known about it --

THE CHAIRMAN: But would you have considered it, doctor?

I just want to get this point. First of all, when this started, the Royal Trust was not a separate trust. When this started in 1990, it was still the Eastern Board; isn't that right?

A. Exactly.

THE CHAIRMAN: So you did not have a separate legal identity, which you had a few years later.

A. Yes.

THE CHAIRMAN: Secondly, if you had been asked to look at it and if it had come to you on the basis that the various implications of it had been discussed between paediatrics, anaesthetists and laboratories and they were content with it --

A. And the medical director, chairman.

THE CHAIRMAN: And they were content with it, looking with

hindsight, how much more do you think you would have required to do or to get involved before you said yes or no? Sorry, would you have been asked to say yes or no to it or would you have been given this as information?

A. I don't think I would, not at that time, because the process wasn't as well developed at that time.

MS ANYADIKE-DANES: Would you have been asked to develop it into your risk management programme?

A. I appreciate that and it's there. I agree. But one and one did not yet make two in this situation. I'm sorry to say, but that's the way it was.

THE CHAIRMAN: Does that also mean in another area, say cardiology, if a new -- if there had been a development of a new technique and a new method of operating on patients with heart problems, that that would not come to you either?

A. I would have been more likely, chairman, to know about that because the numbers were much greater.

THE CHAIRMAN: Right.

A. And therefore, there would have been discussion, whether formal or informal, in regard to that type of proposal.

THE CHAIRMAN: Whatever the system is now, at that time in the early to mid-1990s, the system did not require or did not involve you being told what services were going to be provided on the Royal site before those services

went ahead?

A. No.

MS ANYADIKE-DANES: Can I just pick up one last point before we move away from this? That is, I'm asking you about a very particular issue and the chairman is giving you another particular issue, so all these are discrete incidents of things and we're trying to see to what extent your programme would have required all these discrete things to be reported to you so that you could have, if you had been notified of them, factored them into your risk management programme.

If I help you with this: that there was a concern at around this time of not just paediatric renal transplants, but specialist surgery being undertaken by those who didn't do it very often and there may be a whole raft of reasons why they didn't do this very often. Maybe the demographics were such that they wouldn't see it very often. But in any event, there was concern about that because it was thought that that was a potential risk area in the same was as you talked about your surgeon who was not so familiar with the particular procedure. It's an analogous situation.

So the document that I'm talking about is what's been called the BAPN report, which is "The provision of services in the United Kingdom for children and

adolescents with renal disease", and it was a working party report from the British Association for Paediatric Nephrology. It's dated March 1995. We have referred to it already in these proceedings. The only reason for referring you to it is because it had pointed out that very thing and Professor Savage was alive to it, that what you were having was very small numbers of a highly specialist procedure being carried out, and he recognised that there was a concern about how people maintain their skill set, not to put too fine a point on it.

If you're the person dealing with risk management, do you not need to know about that sort of thing so that you can, at the very least, from your specialism of risk management, offer some guidance? If you're going to do that, jolly good thing because we don't have that service being available in Northern Ireland, but you might want to think about putting in place X, Y and Z -- or whatever it is -- so that this proceeds in a careful way, if I can put it that way, to minimise any risk there might be. Do you not need to know about it from that point of view?

A. If I was answering about it today, I would say yes. In those days, it would not necessarily have come to my attention because (a) Professor Savage was well

recognised as being very caring, very careful, very professional. And I know that he would have discussed with others, both the clinical issues that are involved and the resource issues.

Q. Yes. I was speaking at it from a risk management point of view. I'm quite sure he did that; in fact, he says he did that. But your remit is managing risk for the Trust and this is an area that has been identified, not just renal transplants, but these incidental surgeries, as giving rise potentially to higher risk. And that's the reason I'm asking you would you not have expected to have been involved in that, even just on an information basis?

A. Not necessarily at that time.

Q. Okay.

A. I think that's the fairest answer I can give, chairman.

Q. Can we move to another issue, and that's the issue of consent? One of the things that we're concerned to know about is how guidance, protocols, those sorts of documents that come to the Trust, cascade down, if I can put it that way.

The issue of consent is one that has potentially risk management issues. If it's not given properly or not taken properly, there are risk management issues for the Trust in relation to that, not to mention

potentially for the patient also. So we've been provided with a letter. Let me pull it up for you. 305-002-003. If we can pull up the second page just so that you can see who it's from. That'll be 004. So that's from the chief executive. And what this letter is doing is providing a guide on consent.

It goes through the summary, the background, and then the action point is:

"Health and Social Services boards and trusts 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 introduce revised documentation (preferably based on the new model consent forms) with adequate monitoring arrangements."

If one goes over the page, they're asked to confirm by 31 December 1995 that this has been done and they're told who they have to do that to.

Then you can see, from the CCs, all the undernoted who have received it.

So this would have come into your trust is that right?

A. General manager, chief executive, and I note, chairman, the date on this is 6 October 1995, which is post hoc.

Q. Sorry?

A. Isn't that after the transplant?

THE CHAIRMAN: No, Adam was treated on 27 November.
A. Ah. So it's a month afterwards.
THE CHAIRMAN: Yes. This comes in on 6 October, Adam is treated on 27 November, and the Trust is asked to confirm by 31 December that this had been done. So on that reading, Dr Murnaghan, there's effectively a three-month period for the Trust to implement this directive and to confirm to the management executive that it has done so. But we're looking at it from two perspectives: one is -- and I think you'll be asked about this in a moment or two -- what steps, that you're aware, of were taken within the Royal to implement this -- not just a new patient consent form, but the whole new developed thinking which came with it. And that's one point.

The second point is because, when we look at Conor Mitchell case later on, there's an issue there about how guidelines are disseminated by the department and how they are then communicated to Trust staff. So we're looking at this from two perspectives.

A. Well, chairman, the circular would have arrived, addressed to the chief executive or general manager.
MS ANYADIKE-DANES: Yes.
A. That would have gone to his office.
Q. Mm-hm.

A. And a member or members of his staff would have, at that time -- because clinical directorates had already been established.

Q. Yes.

A. I use the word "cascade". It would have cascaded to all the relevant places where clinical procedures -- well, to the relevant directorates.

Q. Including yours?

A. And it would have come to me for information.

Q. I understand.

A. For information, not for action.

THE CHAIRMAN: Could I just get you to pause? Look at the left-hand page: it goes to the general manager, chief executive; that's Mr McKee, right?

A. Yes.

THE CHAIRMAN: Then it says "Director of Public Health". Who was that in the Royal at that time?

A. Not in the Royal, there was no director of public health. That is an Eastern Board or a department officer.

THE CHAIRMAN: Okay. So it goes to the Director of Public Health and Chief Nursing Officer or Director of Nursing for each board, so those are the areas of the boards. Then within the Trust, it only goes to the chief executive.

A. Yes.
THE CHAIRMAN: Right. And then if you look at the right-hand page below Mr Hunter's signature, it also goes to all GPs, all dentists. What does the third term "unit general managers" mean?
A. Well, departments where -- facilities were divided into units and we didn't have that in the Royal. There were no units. There may have been in other healthcare facilities.
THE CHAIRMAN: Okay.
A. I would be guessing if I suggested one especially rather than another.
THE CHAIRMAN: Okay. Then we'll move on down a bit. It goes to the secretary of the BMA Northern Ireland branch. So that's presumably for the BMA to circulate.
A. For information, yes. And possible discussion at their board meetings or whatever. All the rest there, I would think, is for information.
THE CHAIRMAN: Okay, thank you.
MS ANYADIKE-DANES: So it would have come to you for information?
A. Yes.
Q. Would you have been part of monitoring the extent to which this is being implemented and followed in your role as risk manager?

A. Directly, if I had been given an instruction from the chief executive's office to do it, yes, I would.
Q. Other than that?
A. Other than that, no, not at that time.
Q. At which point would you?
A. Because the cascade would have been the appropriate way to deal with that.
Q. Yes. At which stage would you have started to look at the implementation of this from a risk management point of view?
A. It would have come up for discussion at one of those committee meetings that you showed there and there have would have been encouragement from me to colleagues to act upon it and perhaps to remember that there was a return date.
Q. Yes. And would you be monitoring the extent to which it was being complied with?
A. If I would been required so to do.
Q. But even if you hadn't been required to do, given that it is something that could give rise to risk for the Trust, would you be monitoring it on that basis?
A. Not at that time; I had so many other things going on.
Q. I'm sure that's true. At which point would you start to look at the question of consent from a risk management point of view?

A. When and where it came to my notice. In the context of management of medical negligence claims where consent was a significant issue, I would then have gone to see how the consent was obtained and in what form. And if the forms weren't correct, then that meant that I needed to go walkabout.

Q. I understand. I wonder if I might put this thought to you: you have explained to the chairman how you were being asked to do all these things, but the budget on which you were being expected to deliver them was actually quite restrictive. Is it therefore the case that the best that you could do is respond to the knock on the door or respond to when you actually saw a medical negligence or something of that sort that came to your attention and use that as a way of looking at what the risks associated with that particular incident were and maybe develop some guidance out of that? So reactive?

A. Yes, chairman, it would be so much easier because you had an example and it might be a misfortune that has already arisen and one would hope it was a very minor one, but it happened and now one could go and say, "Look, colleagues, this has happened and in the ideal world it shouldn't have happened. What are you doing about it? What can we do about it? How can you get

this form printed and properly used?"

Q. So the effect of that is if you're -- for whatever reason, constraint of resources and so forth -- are essentially reacting to these things and using them as learning points, that means that your risk management programme is not operating to prevent something because that thing will happen, come to you and you may develop -- if you can do it -- some procedures arising out of it. Would that be a fair characterisation?

A. It would, chairman, but over time things were intended to improve.

THE CHAIRMAN: As I understand it, what you're describing is in this area, at least, your role is reactive. But when people came to knock on your door, surely at some point they might have said to you rather than referring back to an incident which had happened, "Look, doctor, if we don't do this or we don't do that, something might go wrong". So the knock on your door could be proactive rather than reactive, could it not?

A. It could have, chairman, but never did.

THE CHAIRMAN: It never did, okay. So it's reactive --

A. Yes.

THE CHAIRMAN: -- coming to you and coming from you?

A. Yes.

THE CHAIRMAN: Okay.

A. And that was part of the development of the process.
MS ANYADIKE-DANES: I understand. This was dealing, as the chairman has said, with a new way or approach to consent, communications with parents and their families and so forth. Were you aware of the consent regime before this was introduced? Just to help you, if you look at the second page --
THE CHAIRMAN: I think Dr Murnaghan must have been since he was a consultant in obs and gynae for a number of years.
MS ANYADIKE-DANES: Ah. Well, what was that regime?
A. Well, again, it was incremental, it was usually the lowest common denominator.
Q. What does that mean, sorry?
A. It means that a house doctor obtaining consent. And it was signed there and there was a witness signature by the doctor and that was it having filled in the form, but there was no real information imparted. There are various factors of information that needed to be imparted. I'm going back several years when I describe this.
THE CHAIRMAN: Yes.
MS ANYADIKE-DANES: Yes.
A. The medical defence organisations over the years published regularly, giving advice to their members,

recommending that, in the case of surgery, the person who was to do the procedure should provide the information appropriate to obtain informed consent. Now, if the person to do the procedure wasn't, at that time, available, then somebody else competent and with the knowledge, skills and attitude suitable to obtain consent could have that devolved to them. For instance, a senior SHO or a registrar, but not the shiny faced young doctor in on the first day into that unit, who didn't know how to spell the procedure. I beg your pardon.

THE CHAIRMAN: Yes. Somebody fresh, somebody green or wet behind the ears?

A. I've heard a conversation earlier between you and counsel, chairman, and I'd better not go any further.

MS ANYADIKE-DANES: The reason why I ask you whether you were aware, formally, of what was in place before this document was despatched is because if you look under paragraph 7 on the second page, "Cancellation", it says:

"My letter of 31 December 1990, which accompanied the booklet prepared by the Department of Health in England, distributed as an interim measure is now cancelled."

So it appears that formerly that was the guidance, but you weren't particularly aware of that?

A. The only thing I was aware of was a consent booklet.
Q. I understand.
A. And there was a copy kept of the consent in this booklet.
Q. Yes. Were you aware of whether the confirmation to be given to Mr Lunn in the General Hospitals Policy Branch actually happened from the Trust? Were you aware of that?
A. No, I was not.
Q. Were you aware of when the old forms were replaced by the new specimens? I can pull one up in case that helps you remember.
MR FORTUNE: Before my learned friend does that and we leave this document, could we find out from Dr Murnaghan when he first saw this document? And thereafter ask Dr Murnaghan who was supposed to confirm that the document had been cascaded down through the hospital?
MS ANYADIKE-DANES: Yes. Well, the first one is obvious. When did you first see it?
A. Unless I saw the copy that came to my department and I could see my initials on it, I'm afraid I can't tell you.
Q. On the other side, you described it cascading down to the various directorates.
A. Yes.

Q. Was your understanding -- and please say if you can't help -- that it would be for the various heads of directorates to go up the chain to say, "We've received it, this is what we've done in relation to it", or some sort of confirmation that they have addressed the matter; is that how you think it would have worked?
A. One or other of the troika in each directorate would have been charged. I use that word "troika", you understand who I'm talking about, clinical director, nurse manager, business manager. One or other or all of them would have been charged with closing the loop.
Q. And so far as you understand it, would the introduction of something new like this have been associated with a certain amount of training for people at a directorate by directorate level?
A. Yes, but I think most of it was self-evident or should have been.
THE CHAIRMAN: It would be self-evident to people who had good practices and who had received good training. The problem is of course that it would not be self-evident to people who were a bit sloppy around the edges or not very careful or who hadn't had good training. The purpose of this, as I understand it, is to set out in written form what is now regarded as good practice to make sure that it is followed universally; does that all

seem right to you?
A. It does, of course. You're now dealing with 200 consultants and 400 non-consultant, medical staff on the Royal site.
THE CHAIRMAN: Yes.
A. And I am not sure that any -- each or any directorate would have copied that within their own directorate to their own medical staff. It probably would have come up for mention at a directorate meeting, but what happened after that, I would only be speculating.
MS ANYADIKE-DANES: I understand that. When we were looking previously at that document, if you remember, the document that started in 1993 and was revised up to 1998. When we were looking at that document, I took you to a part where part of what you had to do was to ensure that there was sufficient training for people on risk management issues. That was supposed to happen at directorate level, but you were there to assist with devising training. Do I understand you to be saying to the chairman that this is the sort of thing that could receive training at directorate level?
A. Yes, it could, but from whom it would be provided -- maybe a medical records person would have that type of knowledge, if they had one available to them.
Q. Thank you. I was just going to take you to the new

consent form to see if that would assist you as to when you think they came in. If we look at 305-002-018. There we are. If we blow that up a little bit because it's difficult to see.

You can see what the chairman was saying, that this is a far more structured form, involving much more information to be recorded and effectively checking that these sorts of things, which people who had good practices were probably doing anyway, but in formalising it in this way, it provides a prompt and it has to be signed off, so it's easier to see that people are adhering to what people recognise as good practice.

Can you remember when that form came into use?

A. No.

Q. Do you remember it?

A. I do remember it. Now, whether it was that form or a modification of that form which put "The Royal Victoria Hospital" or "The Royal Belfast Hospital for Sick Children" on the title rather than "Appendix A1", I'm not sure. And probably some time in 1996.

Q. Yes.

A. Probably.

Q. So some time before you left, you think it was there?

A. I hope so.

Q. I understand.

THE CHAIRMAN: Doctor, I just want you to be careful because it is tempting to say something like that, but I rather got the impression that you're not at all sure that this was implemented in 1996.

A. I'm not.

THE CHAIRMAN: You'd like to think it would have been implemented in 1996.

A. Yes.

THE CHAIRMAN: But you're not at all sure that it was; is that fair?

A. Correct, and it would not have been within my remit to make sure at point of service delivery that that happened.

THE CHAIRMAN: On your evidence, it would really come to your attention if a medical negligence complaint came in, perhaps one specifically saying, "I didn't consent to this", or, "This wasn't explained to me", and you go on to investigate what was or was not explained or advised.

A. Exactly, chairman. That would be the nub of the thing.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: I understand.

Dr Murnaghan, if I raise an issue and you're not entirely sure whether you do remember it, I know that you are trying very hard to assist the inquiry with the

information, but it may well be that we'll have other evidence that contradicts that and then it just makes it more complicated for us if we have your evidence saying it went one way.

A. I will apologise to --

Q. No, no, everyone's trying to do their best.

A. -- in advance if such an issue should arise.

Q. There's one final issue on these sort of protocols. There were guidelines for the implementation of what's called near-patient testing and if you have read the papers, you'll see there was an issue to do with the blood gas analyser and that's one of those pieces of equipment. Is that a kind of guideline that you would have seen in your role as managing risk? Let me see if I can pull it up.

A. I don't think you need to because the time that it came across my notice was in or about the time of the inquest.

Q. Ah.

A. We can either deal with it now or later. Because near-patient testing wasn't all that well developed in that place at that time and other arrangements to improve the situation were resourced --

Q. I understand.

A. -- as part of the learning exercise.

Q. Yes. Then finally --
A. Is that helpful?
Q. Yes, it is helpful. I wonder if we could pull up 210-003-003. This is a report, part of the report from the inquiry's expert, Mr Ramsden, I believe. The point I want to take you to is clinical pathology accreditation, which I think is in there. It's what I'm looking for at the moment.

I beg your pardon, I may not have got the right page reference. I will come back to that matter later on. My apologies for that, although you may be able to help us in the absence of it. The laboratory service is obviously an important one for surgery and also is an area for risk also, as is radiology. Were you in your role as risk management or dealing with risk management, did you deal with issues to do with accreditation and standards and that sort of thing?
A. No, I didn't, chairman, but I did know when they were happening. It was very, very obvious that if you went near a laboratory or a place that was associated with a laboratory, like the pathology department, that everything was spick and span and ready for an inspection. And I was also pleased that these inspections were happening because it was an external audit of service delivery.

Q. That's really the point that I was getting at.
A. It was external and it was nationwide. I can't remember the acronym.
Q. I understand.
A. But it was a quality assessment exercise and I was always pleased to hear that when it had happened, the majority of the facilities examined got a gold star.
Q. Yes.
A. To use a --
Q. I understand. Can I ask you this: let's take another issue arising out of laboratories, and that's turnaround times. Turnaround times are part of standards in a slightly different way.
A. Yes.
Q. They have an impact on treatment, their delay may be significant. Were you involved in dealing with that aspect of laboratories?
A. Not at all.
Q. Not at all. Who would have been so far as you're aware? You may not be aware, but so far as you're aware.
A. I wasn't aware.
Q. Thank you. Then I wonder if we can come now to the detail of this case, or at least Adam's case. How did you first learn about Adam's case?
A. Chairman, if I may, before I even answer this

question --

Q. Yes.

A. -- just add a personal level. I have remembered this unfortunate death since it happened. And I'm still sorry that it happened. If there are any members of the family here present, I would like them to know that I feel that way about it.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you.

A. Now, to answer your question, I can't be absolutely certain, but I think it was a telephone call from Her Majesty's Coroner.

Q. Yes. And do you know when? Would it have been the day of his death? Do you know when?

A. I don't know, but I have somewhere that it was the next morning.

Q. In addition to Mr Leckey, did anybody else tell you that Adam had died?

A. I don't remember.

Q. Let me pull up --

A. If I had the file, I might be able to help myself, but otherwise --

Q. I understand that. It's very difficult without the file. Let me help you with this document. 059-073-166. This is a letter from Mr Leckey to you, dated

30 November. Adam died on the 28th. And if you see, he's alerting you to the fact that Dr Alexander is going to be preparing an anaesthetic report for him to use at the inquest. He says:

"I should be grateful if you would let me have, as soon as possible, statements from the clinicians involved. Also, it would be useful to have a statement from the technician responsible for the equipment in theatre confirming that it was functioning properly."

So this is the first letter that we have seen in relation to this, but given how it's couched, it would seem that he's had previous communication with you about this; would that be fair?

A. That is absolutely correct and each and every one of these issues was discussed with me, including his choice of Dr John Alexander.

Q. Did you make a note of these conversations that you had with the coroner?

A. If I had the file, I could tell you.

Q. Well, would it have been your practice to have made a note?

A. I made a lot of notes and one or other of them was going to get me into trouble later on.

THE CHAIRMAN: Forget about that. I think you're being asked a more general question, doctor.

A. In the context of it, I made a lot of notes, but I didn't always make a note.

MS ANYADIKE-DANES: But is it your general practice to do so?

A. Yes, but in the context of this, Mr Leckey had discussed with me on the telephone what he wanted done and this letter was coming to confirm that. I would have almost certainly have actioned the matter in the context of -- I would have found out where the chart was because the chart was central to the whole process.

Q. Sorry, which chart?

A. Adam's chart.

Q. You mean Adam's anaesthetic record and his medical --

A. No, the whole -- well, the most recent. I understand now that there were ten volumes. I would have looked for volume 10.

Q. Those that covered his last admission and his surgery?

A. Yes.

THE CHAIRMAN: Let's make it clear. It's all of the most recent notes and records from when he came in for his transplant.

A. All the case records, volume 10.

THE CHAIRMAN: "Chart" is shorthand term for referring to that file 10?

A. Yes.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: This is being written on 30 November. It looks like it's received on 4 December. And that's the coroner letting you know. Given what we've said about reporting lines and so forth, who advises you that this has happened from within the Trust?

A. Various or nobody.

Q. Sorry?

A. Various or nobody.

Q. Well, do you recall whether anybody from within the Trust advised you that Adam had died following his surgery?

A. I don't recall.

THE CHAIRMAN: Can I ask you, would you -- I can entirely understand why you don't recall 17 years ago, but would you expect that if a patient like Adam had died and the circumstances were such that they had to be reported to the coroner, who is likely to order an inquest, would you expect that your first information about that would come from a call from the coroner or would you expect to be notified internally first of all, or would you have any expectation one way or the other?

A. Well, I know that I would have heard from the coroner or the coroner's officer or the police acting on behalf of the coroner. Because there was an office in

Grosvenor Road Police Station and they would have made contact with me.

If I may cut across you, chairman, for a minute, and explain the process that we had developed at the Royal with the agreement of the coroner and with the agreement of the Chief Superintendent in Grosvenor Road Police Station.

That was that I would obtain the necessary information, statements, for the coroner, so that he could then decide whether he was going to order an inquest or not, based upon the statements provided.

MS ANYADIKE-DANES: That was your general practice, was it?

A. That was the general practice and it saved -- and these were difficult times when the police had to have the army supporting them to come on site and so forth. And it was difficult. Therefore, we made this arrangement, which suited everybody, that the police together with their escort going towards, chasing around, looking for doctors, who could be anywhere or nowhere. I had the facility to find them and to obtain the relevant information. I then would go through the file, the case record, and find out who it was relevant to contact, tell them that I knew about this and that I needed a report.

Q. Can I ask you for a bit of clarification right there?

You have described yourself as going to get the most recent medical notes and records, the procedure, if I can put it that way, of his last admission, and that you would go through that and see who'd been involved and that would help you satisfy the obligation that the coroner had given you, or the responsibility, which is to let him have as soon as possible statements from the clinicians involved. So your first attempt to gather those together is only as good as the record is?

A. That's correct.

Q. So if, for example, you've got two anaesthetists involved but the record only shows one anaesthetist, you don't know, subject to somebody telling you when you start to ask them to produce a statement, you don't know that you need a statement from that other anaesthetist?

A. Until I see the primary statement.

Q. Yes. So in what way then do you notify people that you require them to provide statements? What are you telling them?

A. A memorandum goes out to all those involved and I think, on the website, there is the relevant memorandum that you can pull up, counsel. It identifies those that I thought I should obtain statements from in the first instance.

Q. And what do you tell them you want them to provide you

with?

A. I'd love to look at the memo, but essentially what I'm saying is I've been contacted by the coroner, who has asked me to obtain statements from all those involved in the treatment of, as it was in this case, Adam Strain.

Q. Actually, you seem to have had some volunteers before you actually do that.

A. Good.

Q. Because if you look at 059-066-153 -- and we can pull up the second page to that. It's a two-page document, 154. That is a document from Professor Savage to you and you can see the date of it: it's 28 November 1995. So that's before you get your letter from -- or before the letter's even written to you from the coroner, although perhaps not before he has spoken to you. But that's the day of Adam's death. He is providing a one-and-a-half page account, if I can put it that way, "To whom it may concern". So what produced that?

A. Simple answer: I can't remember. But I certainly would give a gold star to Professor Savage for producing that --

Q. I appreciate that.

A. -- as quickly as he did.

Q. That's not quite the point that I'm getting at. The

point I'm getting at is: did he produce this knowing because he has reported the matter or, at least, he's aware that the matter has been reported to the coroner? Did he produce this to assist or did he produce it in response to your memo, circulated to the clinicians, asking them all to provide statements?

A. I can't tell whether or which, but I'm very pleased to have received it as quickly -- it may have been that I made phone calls.

Q. I understand.

A. It may have been that I went over to the Children's Hospital.

Q. Yes.

A. I don't know. It could be any of those. But I do know that contacts were made, whether written or phone or personal.

Q. What I'm trying to ascertain is -- there's any number of things that people can tell you about an incident.

A. Yes.

Q. You presumably have in mind the sorts of things that you think the coroner will be interested in, or, for that matter, you are interested in knowing what happened. So what is it that you have asked the clinicians to provide?

A. The details and circumstances surrounding the death.

And I've got to personalise this, and it makes it difficult. But who was Adam? Why was he there? What had been proposed? What was done? And why did he die? From the clinical perspective.

Q. Yes.

A. And those are the things that the coroner would have wished to have known and I would have gone through that statement then to ensure that I understood almost as a layman because I wouldn't have the specialist knowledge in relation to renal transplants.

Q. Yes, but before we get to what your response to that document would have been, earlier before the mid-morning break, I think, you described a situation when you were dealing with the health and safety matters that you would have -- I think you referred to it as "gone walkabout" or something. You would have gone walkabout and see what exactly was going on. And that was happening for slips and trips and things like that. This is a child's death following surgery, so what's your approach then?

A. It's more than probable that I did that, that I went walkabout, as I've given you one of the three options: phone call, walkabout or write. And I certainly would have done two of those three. It would always have been confirmed by a letter or

memorandum.

THE CHAIRMAN: It's almost 1.10, Ms Anyadike-Danes. I think we'll break. Mr Fortune?

MR FORTUNE: Before we break, can we find out from Dr Murnaghan whether it's more likely than not that Professor Savage picked up the telephone and told him that Adam had died and that was the start of the procedure? I'm not saying definitively that it was, but can he rule it out?

A. I preface my answer by saying that my experience of Professor Savage is that he is a good communicator, therefore it is very likely that he did what Mr Fortune has just suggested.

THE CHAIRMAN: I think I asked you a variation on this a few minutes ago: if you got the call from the coroner, would you normally expect that to be the first information you'd receive from within the hospital? And I'm not sure --

A. Very frequently, is the answer to that, but it came as a surprise to me.

THE CHAIRMAN: Right. But if you have a good communicator who's involved, you might find out earlier?

A. Yes.

THE CHAIRMAN: Thank you. We'll start at 2 o'clock.

(1.10 pm)

(The Short Adjournment)

(2.00 pm)

THE CHAIRMAN: Ladies and gentlemen, just to confirm, before Dr Murnaghan resumes his evidence, that we had a discussion on Friday afternoon, following which there have been two alterations to the witness schedule. One is that Dr McKaigue will not now be giving evidence tomorrow. Tomorrow will be only Ms Duffin. And next Monday and Tuesday, we were scheduled to have Mr Ramsden on Monday and Mr Mullan on Tuesday, the inquiry's governance experts. It didn't seem to us towards the end of last week as if we would need both, and we therefore raised the idea on Friday afternoon that we would keep Mr Mullan for Tuesday, but dispense with Mr Ramsden on Monday. That's on the basis that his report stands subject to any submissions or observations people make on it. There is no further views on that beyond anything that was expressed on Friday? Is everyone content? Okay? Thank you very much.

MS ANYADIKE-DANES: Dr Murnaghan, I had taken you, before the lunchtime break, to a report from Professor Savage. You also received a report, and we'll pull it up, 059-067-155, and there's a second page to that, 156. Dr Murnaghan, that is dated 30 November 1995.

Dr Murnaghan, do you recollect whether you received

this letter from Dr Taylor before you'd received your letter from the coroner?

A. I'm afraid I couldn't tell which came first.

Q. I understand.

A. And particularly, this one is not date stamped. Oh it is, but it doesn't come through on my -- on what I can see.

Q. No, that's all right. You now have these two documents, one from Professor Savage and one from Dr Taylor. What did you understand them to mean in terms of what happened to Adam? What did you take from them?

A. Chairman, I will have to preface my remark by saying that I'm not an expert in either of these fields --

Q. Exactly.

A. -- and therefore I'd only be able to get the gist of what was going on, rather than the detail.

Q. You may not recall what you thought, but can you recollect what impression they made on you at the time as to what had happened?

A. I can't, other than the sadness of the death of a child.

Q. If we go to the very final paragraph from Dr Taylor:

"I remain extremely perplexed and concerned that this happened to Adam and cannot offer a physiological explanation for such severe pulmonary and cerebral oedema in the presence of normal monitoring signs."

What effect did that have on you, to receive a letter like that from the clinician involved?

A. I needed to know more because there were to be other contributors to this.

Q. Yes.

A. The forensic pathologist was certainly going to give more information.

Q. Well, at this stage, you're really trying to gather in the statements for the coroner.

A. Yes.

Q. So you've had these two and, certainly, the one from Professor Savage came before your letter from the coroner, but it may not have come before your conversation with the coroner, if I can put it that way. And you've had this one and you're not sure where this comes in terms of the correspondence from the coroner. Who else do you go and seek a witness statement from?

A. The surgeon, of course. He's the third body involved.

Q. Yes.

A. And, subsequently, from the nurses.

Q. You sought statements from the nurses?

A. Yes.

Q. Can you recall which nurses you sought statements from?

A. I cannot.

Q. But you are absolutely sure about that?

A. I'm almost certain that I would have done that, yes.
Q. The difficulty is that the nurses that were involved don't actually seem to recall them ever being part of the process.
THE CHAIRMAN: And there were no nurses' statements ever forwarded to the coroner.
A. That surprises me in the context of something like this. But if I didn't do it, I didn't do it.
THE CHAIRMAN: Let me ask you then, why would you have asked the nurses?
A. Because they would have had or might have had some information of help because they were involved, they were present. And if there was anything -- there might have been nothing that they noticed untoward whatsoever, or they might have.
THE CHAIRMAN: When you say that you're surprised that we don't have any statements from the nurses and it appears to us that they weren't asked, then in essence are you saying that, however important it is, that is a degree of failure in the investigation that the nurses were not involved?
A. Yes. It comes as a surprise to me now, but I didn't realise that I hadn't.
MS ANYADIKE-DANES: What the coroner had asked for is he wanted to have statements from all the clinicians

involved, and although perhaps not strictly "clinicians", you'd include in that the nurses.

A. In the context of a death, yes.

Q. He also said:

"It would be useful to have a statement from the technician responsible for the equipment in theatre, confirming that it was functioning properly."

There was a medical technical officer in the theatre. Who did you understand that the coroner wanted to have the report from when he uses the expression "the technician responsible for the equipment in theatre"?

A. Well, arising from my telephone conversation with the coroner, I believe that he and I agreed that I would commission as independent a report as I could in the circumstances, and, therefore, request that the chief technical officer and another would -- and I think it was on a Saturday immediately after Adam's death on the 27th -- that they would go over with Dr Fiona Gibson.

Q. In fairness to you, it may be that you haven't entirely recollected the chronology of it. You're quite right: you did have a conversation with the coroner about it. In fact, he refers to it in a note that he makes of 8 December and we'll come to that. But this is his first request to you and all he seems to be asking for here, if you leave aside the "statements from the

clinicians involved", is a statement from the technician responsible for the equipment. So if we just kept it at that reference, what would you understand "the technician responsible for the equipment" meant? Would you have thought that meant the medical technical officer who was in the theatre at the time?

A. (a) I'm not too sure that I would have known that there was an MTO present in the theatre at that time, although I did know that there was an MTO attached to children's theatres.

Q. Yes.

A. But the chronology of involving MTOs in the examination of the equipment, I am not 100 per cent certain about.

THE CHAIRMAN: Could we go back, Ms Anyadike-Danes, and turn this up? It's 059-073-166. It's a letter which was referred to before lunch. This is when the coroner wrote to you, Dr Murnaghan, and you think that that is after you'd spoken. What you were being referred to in the second paragraph is:

"I should be grateful if you would let me have, as soon as possible, statements from the clinicians involved."

And you have said Messrs Savage, Taylor and Keane, and it should have included the nurses. Then you [sic] say:

"Also, it would be useful to have a statement from the technician responsible for the equipment in theatre, confirming that it was functioning properly. That statement should cover the frequency of checks and whether such checks were carried out both before and after surgery in this instance."

Just over a week later, this issue about the equipment extended because there were other deaths and there had to be an issue ruled out or clarified as to whether there was a pattern of failure or a systematic failure which had affected all three deaths. But that wasn't apparently on the agenda at this point. At this point, the coroner is not asking for the test which was done subsequently; at this point the coroner seems to be asking for something more limited. So whether there was an MTO in theatre, you at least knew that there was an MTO attached at that time.

A. I did.

THE CHAIRMAN: Is that the person who you thought the coroner was asking for the statement from?

A. I'm not sure, but if I can take you back to the first line of Mr Leckey's letter:

"I am writing to confirm."

Meaning that he's confirming that we've already discussed the matter.

THE CHAIRMAN: Yes.

A. This is why I say that we've had a conversation rather than -- that's his first letter, but I'd had a telephone conversation from him. And that is -- I'm almost certain, with respect to Professor Savage, that I heard from the coroner first before Professor Savage's detailed and careful report arrived.

MS ANYADIKE-DANES: Okay.

A. But which was first, I'm not 100 per cent certain. But that's the way it came. And at that time, I believe that I discussed with the coroner, even though he puts it in that way, that I would arrange to have ...

THE CHAIRMAN: The inspection?

A. The other two MTOs to do that inspection. And in addition, having discussed it, I believe, with Dr Gaston, that Dr Fiona Gibson should separately --

THE CHAIRMAN: Okay.

A. So that we covered as many aspects of the anaesthetic contribution as was possible so to do.

MS ANYADIKE-DANES: I understand that.

Dr Murnaghan, if you had gone, as you did, to the notes of the transplant procedure to see who are the clinicians directly involved and who should I therefore be seeking a witness statement from, leaving aside the nurses, you would have seen that Dr Montague was the

assisting anaesthetist and you would have seen that is in addition to Professor Savage, Dr O'Connor was also making notes and being in the theatre at various times. We don't have any record of you seeking a statement from either Dr Montague or Dr O'Connor. Why is that?

A. I'm trying to -- I knew this question was about to arrive and I'm trying to puzzle out and ... Life gets more complicated because where were the notes at this time? They weren't in my possession. And this is by way of explanation and nothing else. They were down in the State Pathologist's Department. Dr Armour had them.

Q. But you'd gone to look at them.

A. I must have gone down there to look at them.

Q. If you'd done that, even the anaesthetic record would have told you that Dr Montague was involved. And if you'd looked at the medical notes and records, you'd have seen that Dr O'Connor was involved.

A. Now, in relation to that, I'm not certain, although I knew later on, that Dr Montague wasn't present for all of the anaesthetic.

Q. Yes. But he had been there at some point because his name is there.

A. I appreciate that.

Q. And at that stage, you wouldn't have known how long he'd been there because that's actually not recorded anywhere

in the medical notes and records. So why didn't you seek a statement from Dr Montague?

A. I don't know.

Q. Well --

A. I do not know.

Q. Do you agree that it would have been appropriate to seek a statement from Dr Montague, since all this seems to be, at first blush, coming down to something to do with the way the child was anaesthetised or the way his fluids were managed?

A. I'm sure it would.

Q. Yes. And what about Dr O'Connor? Would it not have been appropriate to have got a statement from Dr O'Connor because she is the only nephrologist who moves in and out of the theatre after some time around 9.00, 9.30?

A. The only answer, chairman, I can give in relation to that is, at that time, I did not know about Dr O'Connor and her presence in theatre.

Q. But it's recorded --

A. It may be recorded, but I personally did not so discover. I missed it.

Q. Well, Professor Savage is going to say that he had a number of conversations with you about this. Did it not crop up in his conversations with you that

Dr O'Connor had been in the operating theatre?
A. How many years ago is that? I can't remember.
THE CHAIRMAN: Sorry --
A. I cannot remember.
THE CHAIRMAN: Dr Savage has told the inquiry that he had a number of conversations with you, not necessarily in the days immediately after 28 November, but over the following weeks.
A. Indeed he did, yes.
THE CHAIRMAN: And he made his position clear to you about what he thought had gone wrong.
A. Indeed, yes.
THE CHAIRMAN: And particularly who he thought had gone wrong.
A. Yes.
THE CHAIRMAN: This inquiry has heard from Dr O'Connor that when she arrived at some point later on during Adam's operation, she noticed and raised an issue with Dr Taylor about the CVP readings. I think the point which is being put to you, just as an example, is that since Dr O'Connor's presence appears on the records that that would have been an issue which was identifiable, if not in the day or two after 28 November, at least reasonably soon after that, to pick up with Dr O'Connor because it's relevant to issues which are to be raised

with Dr Taylor. We're piecing this together years afterwards, but I think to put it bluntly, Dr Murnaghan, the potential criticism of you is that there were elements of this investigation which you did not pick up as you might have done at the time, or as you should have done at the time.

A. And again, by way of explanation and not excuse, I saw Professor Savage as having primacy in this matter and that he was providing relevant information from the nephrological, the kidney side, and therefore in that context I took the view that that was sufficient.

THE CHAIRMAN: Okay.

A. And if I was wrong, I'll accept that I was wrong. And I'm sorry if I was wrong.

MS ANYADIKE-DANES: No, no, I appreciate that. In retrospect, do you accept that given that she was physically there and had conversations with Dr Taylor, it would have been appropriate to have sought a statement from her?

A. I hate that word, chairman, I hate that word "retrospect" because --

Q. But do you accept that?

A. A retrospectoscope is a very dangerous and blunt instrument.

Q. Recognising that she was actually there and that she had

conversations with Dr Taylor, she has recorded elements to do with seeing the perfusion and colour of the kidney and the CVP levels and all that sort of thing, recognising all that detail, which you would have seen when you finally got to look at the medical notes and records, would you not accept that she is somebody from whom you should have taken a statement?

A. Chairman, I've already accepted that.

Q. Thank you.

MR FORTUNE: Sir, I am concerned about the use of the word "primacy" is Dr Murnaghan suggesting by use of that word that Professor Savage was adopting or accepting some responsibility for Dr O'Connor's role in this matter or speaking for her?

THE CHAIRMAN: That's not how I interpreted it, but I will let Dr Murnaghan clarify it.

A. I'm grateful, chairman. I saw Professor Savage as being the senior person and the lead clinician on the kidney side in Adam's care.

THE CHAIRMAN: In the sense that --

A. And that is what I meant by "primacy".

THE CHAIRMAN: In the sense that Dr O'Connor had only arrived at the hospital a few weeks earlier, but Dr Savage had been treating Adam for a number of years?

A. Exactly.

THE CHAIRMAN: And Adam was a patient who had overwhelmingly been under his care rather than Dr O'Connor's?
A. Exactly, and no disrespect to Dr O'Connor at all.
THE CHAIRMAN: I understand.
MS ANYADIKE-DANES: Thank you very much indeed.
I was saying that, in chronological terms, I think that the reports in relation to the equipment may have come before the issue of independence arose, but I understand what you say, that you had a phone conversation. If we go to --
A. Chairman, could I ask for clarification about that use of the term "independence"?
Q. Yes.
A. I was reassured by the coroner orally that what I had done was sufficient for his needs --
THE CHAIRMAN: Right. Sorry --
A. -- in commissioning the reports that I did about the equipment.
THE CHAIRMAN: Right. How did that --
A. And the independence was in relation to they did not work in the Children's Hospital.
THE CHAIRMAN: How did the question of that reassurance arise, doctor?
A. I discussed with him who I was going to get to do it and he gave that a tick.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Firstly, if we pull up 059-069-161. This is the cover letter to you from Dr Gibson for her report. What does the expression "I hope this is suitable for your purposes" mean? What had you told her you wanted it for?

A. I'm afraid that sentence will have to be referred back to Dr Gibson. I know she's not available at the moment. But that's her expression; it's not something that I understand.

Q. I understand. Then if we go to the next page, 162. This is her report. You can see that right at the top she says:

"I visited the operating theatre suite of the Children's Hospital on 2 December 1995 at the request of doctors Murnaghan and Gaston to discuss with Dr Taylor three patients whose post-mortem examinations had been brought to the attention of the coroner."

Pausing there: why were you asking her to discuss three patients with Dr Taylor, only one of whom was his patient?

A. I have no idea at all. The only thing that I know about the three patients who unfortunately died was that there was a common element. And that common element was that they were operated upon in the same theatre, I believe,

from memory.
Q. That's correct. It says so later on at the bottom.
A. That is the only common issue that they had. It wasn't Dr Taylor that was the common issue at all.
Q. I understand. That actually is why I'm asking why were you asking her to discuss the deaths of two other children with Dr Taylor?
A. Again, I think we would have to ask Dr Gibson how she came to construct that sentence in that way.
Q. Well, she says you've asked her.
A. I know she says that, but again I would like to enquire of her how she came to form that view. I don't believe that that was what she was asked to do.
Q. Well, what had you asked her to do?
A. She was asked to see if there was any common issue with the three patients --
Q. And had you --
A. -- and, in addition, to look at the equipment --
Q. Yes. Had you asked her --
A. -- from a professional point of view.
Q. Sorry. Had you asked her to discuss anything with Dr Taylor?
A. I don't think I did. And I think, again, not 100 per cent guaranteed, that the conversations essentially with her were about Dr Gaston. Now, I know

he's not here today and he can't hear what I'm saying, but I'm almost certain it was from one colleague to another.

Q. But so far as you're concerned, you don't recall requiring her to discuss anything with Dr Taylor?

A. Not at all.

THE CHAIRMAN: And would you add to that --

A. As far as I can remember.

THE CHAIRMAN: -- in a way, it would not have made sense to ask her to speak about the two other patients with Dr Taylor because they weren't his patients?

A. Exactly.

MS ANYADIKE-DANES: Well then, when you received this report --

A. And may I come back further, chairman? Dr Taylor was upset enough at that stage.

Q. Yes.

A. And why would I personally attempt to compound any issue when he had not been involved?

Q. Apart from anything other thing, the point you have just made about independence would be slightly undermined by having Dr Taylor there, wouldn't it?

A. Yes, it would.

Q. It would. So as you had gone with pains to make sure that you didn't have any of the MTOs, which is Mr Wilson

or Mr McLaughlin, directly from the Children's Hospital, it wouldn't have made an awful lot of sense to have then involved Dr Taylor, who not only was from the Children's Hospital but actually was the consultant paediatric anaesthetist in one of the cases. That wouldn't have made sense, would it?

A. I can't explain that.

Q. I'm saying, as an observation, it wouldn't have made sense from your independence point of view?

A. Exactly.

Q. So when did you do when you received this report and realised that she appears to have discussed, at least, Adam's case with Dr Taylor, who's the consultant paediatric anaesthetist involved in his case?

A. I didn't believe that Dr Gibson's independence had been prejudiced.

Q. That actually wasn't quite the question that I put to you.

A. That's how I have to answer it.

Q. Well, you had told the chairman that you had identified to the coroner the two technicians who were going to carry out the inspection of the equipment and had satisfied him that they were independent. This is a slightly different report. This is a report dealing with a slightly broader remit. But you'd also indicated

just now to the chairman that it would have been appropriate for Dr Taylor not to have been involved, lest there be any issue about independence. So whether or not she actually would have had her independence compromised, what did you do when you realised, in some way, she had been discussing one of those cases with the person involved in the case?

A. I didn't do anything.

Q. Did you not ask her why or --

A. No.

Q. -- how she had come to be discussing it with Dr Taylor?

A. No.

THE CHAIRMAN: Doctor, can I ask you a slightly variation on that? I understand that there was a separate technical report on the equipment and we've seen that and we'll probably come back to it in a moment or two.

I understand that was obtained at the coroner's direction --

A. Correct.

THE CHAIRMAN: -- to rule out an equipment failure.

What was the purpose of Dr Gibson's report?

A. I think this was superimposed upon it, and I think essentially --

THE CHAIRMAN: By who?

A. Dr Gaston, I believe. I know that I'm tied into this.

THE CHAIRMAN: The only point of looking at the equipment is to see if an equipment failure explains or contributes to an explanation of the three deaths.

A. Indeed.

THE CHAIRMAN: And once it is found, apparently, that the equipment is working fine, then that means you have to look at each of the three deaths: three different children, three different conditions, different surgeons, different anaesthetists; right?

A. Mm. Yes.

THE CHAIRMAN: And you then revert to looking at Adam's death by going to the people who were involved in his treatment. You have the technical report there. What does Dr Gibson's report add other than apparently to give a sweeping acquittal of the doctors who were involved? You see the penultimate paragraph.

A. Yes, I'm just looking at that to remind myself.

THE CHAIRMAN: Three lines down:

"All cases were performed in the same operating room. Each case was performed by a different surgeon. All the cases were extensively monitored. The protocols for monitoring anaesthetic set-up and drug administration are amongst the best on the Royal Hospital site and I can see no reason to link these very sad cases into any pattern."

So is that really Dr Gibson saying: apart from the fact that there's no equipment failure, nor is there any failure in the practices with the anaesthetic practices in the Children's Hospital?

A. In relation to her understanding of these three cases, I believe that's what she's setting out to say. Now, I didn't -- as far as I know, because I wouldn't have known who to ask to do this report, and in ways, I had almost certainly agreed to it happening, but I didn't request Dr Gibson -- select Dr Gibson or ask her to do it.

THE CHAIRMAN: Sorry, my point is slightly different.

A. I see I'm tied into it.

THE CHAIRMAN: My question is not about why was Dr Gibson asked to do it rather than Dr X or Dr Y. My question is: why was anybody asked to do this report?

A. I wish my friend Dr Gaston was here and I had an opportunity to ask him to remind me why it happened.

THE CHAIRMAN: Well, maybe we'll have to come back to it. Okay, thank you.

A. I'm sorry, chairman, that I can't help any more.

MS ANYADIKE-DANES: Thank you very much indeed.

Well, I think the chairman has been raising with you that this actually wasn't a report that the coroner had requested.

A. No, it wasn't.
Q. This is not what the coroner wanted; the coroner wanted something in relation to the equipment.
A. Chairman, this was additionality.
THE CHAIRMAN: Yes.
MS ANYADIKE-DANES: Yes. Well, let's go to the report that you were getting in response to the coroner's request. We see that at 059-068-157. There we are. The report is by Wilson and McLaughlin and they go out on 2 December. Then if you work your way down to the fourth paragraph and, in parentheses, you say:

"The Siemens patient monitor is currently out for repair. A new display screen is being fitted and a loan monitor is in use."

So that meant, didn't it, that they actually hadn't examined the monitor that was in use during Adam's surgery?
A. Chairman, my understanding of this is that a display screen had been fitted into the monitor, but everything else was the same. It was only a --
Q. But the display screen --
A. -- display screen, a TV screen, so to speak, on which various parameters --
Q. And it is those very parameters that are at issue, at least in part, in this case. And how those parameters

may or may not have shown on the display screen is the very thing that they can't check because they don't have available to them the display screen that was involved in Adam's surgery. That's correct, isn't it?

A. It appears so.

Q. Yes. And when you saw that, what did you do about that? Because you're on the point of furnishing the coroner with a report that doesn't, in all respects, look at the equipment that was present in the theatre during Adam's surgery.

A. Chairman, I'm not an expert on these matters. The coroner is pursuing an investigation. My function, primarily, was to obtain and provide information for him.

Q. Yes, but the --

A. And this is the information that was provided and I was the conduit for that information.

Q. I appreciate that. But why did you not take up the point that, actually, they haven't seen this monitor and that was the monitor that was present in the operating theatre during his surgery? Why don't you pick up that point and address it with the MTOs and seek to see if you can find the monitor?

A. If you go to -- if one goes to the very last paragraph:

"A service report for the Siemens monitor is expected this week, but verbal indications are that nothing untoward was discovered during its overhaul."

That refers to it and that gave me sufficient comfort to pass that report to the coroner.

Q. Did you draw to the coroner's attention the bit in the parentheses, regretfully --

A. That wasn't my job.

THE CHAIRMAN: And did he come back to you on it?

A. No. It was a coronial investigation, it wasn't my investigation.

MS ANYADIKE-DANES: I understand that.

A. It wasn't my investigation on behalf of the Royal Trust. The coroner had primacy. I've used this word again, I'm sorry. But he was leading the investigation --

Q. Then if it's --

A. -- and I was a service officer.

Q. I understand that. If it's a coroner's investigation and he has spoken to you on the phone, perhaps some time before 30 November when he sends out his letter to you, as I think you suggest, then as soon as he tells you that he's going to want an investigation or a report on the equipment, what do you do to secure the equipment?

A. I think I asked Mr Jim Wilson to communicate with the medical technical officer in the Children's Hospital to

ensure that the equipment that had been used remained in place. I'm not certain whether it was quarantined or not.

Q. Sorry?

A. I don't know whether it was quarantined or not. I can't tell you that.

Q. That's quite an important point to make sure that the equipment is still there. So is that not something that you would have put in writing to secure that equipment immediately?

A. I didn't.

Q. Why wouldn't you do that?

A. I don't know.

Q. Do you think it would have been appropriate to have done that?

A. It appears now, with retrospection, that it would, if one dots all the i's and crosses all the t's. In the circumstances, I was doing my best.

Q. If we then go to 011-025-125, Dr Murnaghan, I had told you that there was a further conversation between you and the coroner, which the coroner had recorded in relation to the equipment. It really starts, the whole issue about the equipment, if I can put it that way, in that first paragraph but towards the bottom of it. This is a conversation that he has recorded that he

had with Dr Armour. She's spoken to Dr Taylor and she has stated:

"It could either be to do with the anaesthesia or the anaesthetic equipment. She realised that no alarms had sounded and she had looked at the readouts from the anaesthetic equipment and had also discussed the case with the anaesthetist, Dr Bob Taylor. Both she and he were mystified about what had happened."

And then there's another conversation on 1 December that he's recording between himself and Dr Armour:

"Dr Armour has telephoned me and she indicated that she is becoming ever more convinced that there is a question mark against the equipment."

And that she had discussed the case and so forth. So that's the context in which the coroner is concerned about it.

If we come down to where you are recorded:

"From then [which is 1 December] until today, I had a series of telephone calls with both Dr Murnaghan and Dr Armour."

Then he goes on to detail some other matters. If we go almost three lines up from the bottom of the page:

"I spoke to Dr Murnaghan and said that it appeared imperative that the equipment was now independently examined. I said that before making any arrangements,

he might ..."

And that goes on to deal with something else. So it would appear, if one goes to "Today Dr Armour showed slides", today being the date of the note, which 8 December, it would appear that when the coroner records that he spoke to you, he's speaking to you on 8 December and that he is telling you that he now wants the equipment independently examined, which sounds like he hadn't asked for it to be independently examined before.

And if you go over the page to 126 of his note:

"Dr Murnaghan then telephoned me back from Dr O'Hara's office and I spoke to Dr O'Hara. It was agreed that the equipment should be independently examined."

And so on. So it would appear that the agreement about it being independently examined is something that happens on 8 December. Do you remember those conversations with the coroner?

A. I remember that there were multiple conversations.

Q. Yes. I appreciate that.

A. That's the part I remember, that there were quite a number, from different places, including over in Dr O'Hara' office.

Q. And then if we --

THE CHAIRMAN: Sorry, there never was a further report, sure there wasn't.

A. There wasn't.

MS ANYADIKE-DANES: No, that's the only report. Dr Murnaghan perhaps can help. That's the only report we've received.

A. That's correct, and I believe that what I had done satisfied the coroner --

THE CHAIRMAN: Well --

A. -- because he didn't come back to me.

THE CHAIRMAN: I'd just be a bit careful about that heading of 8 December. This is not Dr Murnaghan's note; it's the coroner's note. If it was agreed on 8 December that there was to be an independent examination and one was never sent, then one would have expected that the coroner would have followed up and asked where it was.

MS ANYADIKE-DANES: I don't think that, at that stage, the coroner appreciates that report is under way. If one looks back at 059-071-164, all that has happened is he's asked for one. If one looks at this, which is a memo dated 6 December, this, Dr Murnaghan, you had said that you recollected sending a memo out, asking people for their statements.

Then this memo is dated 6 December and you say:

"The coroner has spoken to me on several occasions about this very unfortunate clinical outcome and has now written requesting that I obtain for him, as soon as possible, statements from the clinicians involved."

So that may well have been his 30 November letter:

"Additionally, he has requested a detailed statement from the anaesthetic technical staff about the equipment used during the surgery and anaesthesia. This has been arranged."

And that, I take to be the report that had been already, actually, carried out or at least the inspection for it, on 2 December, before this goes out. So that's why I think you're saying it's in train. And then you talk about getting the medical notes and records for people.

So that's why I'm suggesting to you, or at least asking you to assist us with -- it seems that the whole issue of independence came later on. You were already part-way through, in fact the inspection had already happened for the preparation of the report and it's after that, it would appear, on 8 December, that the coroner is saying that it's imperative that the equipment is now independently examined as opposed to what he had said previously, which is "I just want to see statement from the technician responsible for the

equipment". So it seems as if the coroner is now talking about a different kind of report.

THE CHAIRMAN: In light of his conversation with Dr Armour?

MR SIMPSON: Sir, this would be a very easy matter to sort out by asking the coroner if he thought there was another report he was waiting for and didn't get rather than asking Dr Murnaghan from a letter which is written on the 8th, but refers to earlier dates. One doesn't know exactly what dates he's referring to, but the coroner could simply be asked.

MS ANYADIKE-DANES: Can I ask it this way: when did you send the report that Mr Wilson and Mr McLaughlin had prepared to the coroner? When did that go?

A. I'd have to see the file.

Q. Okay. If we stay with this document for a moment.

A. But chairman, just for clarification of that: reports for the coroner, as I've already explained, were gathered and provided on the appropriate forms to a police officer acting on behalf of the coroner and then transmitted onwards.

THE CHAIRMAN: So it's a matter then for the police in conjunction with the coroner to come back to you to say, "Thank you for A, B and C, but D isn't quite what we asked for. Please give us another statement or some more information".

A. That would have been very rare, but it could have happened.

THE CHAIRMAN: If the police or the coroner thought there was something significant missing, they could have raised it?

A. Yes.

MS ANYADIKE-DANES: Sorry, Dr Murnaghan, I just asked you when you think you provided this report to the coroner. I may be able to help you by pulling up this document, 011-075-210A. This, so far as we understand it, which is a document from the coroner's file, is a list of those who are going to be witnesses at the inquest. So it would appear to have been generated at some point after that decision was made. Then if you see right at the bottom:

"Technical statement re equipment being obtained by Dr Murnaghan."

So it would seem that at this stage the coroner doesn't yet have it. Is there any reason why you didn't send it on to the coroner as soon as you received it?

A. I don't believe that your interpretation is what I believe in relation to that note. I would regularly, chairman, have had conversations with staff from the coroner's office. And I would interpret as saying for their file that these were the people to whom I had made

requests for reports and, in addition, I had sought a technical statement re the equipment. That's my interpretation of that note. It's not dated, it doesn't say any more than that.

Q. That's why I've asked you for your help on that.

A. That's why I interpret that as identifying that the information I provided to a member of staff in the coroner's office --

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Well, can you recall when you received the report from Mr Wilson and Mr McLaughlin?

A. It's dated and it should be date stamped.

Q. Well, we don't actually have one that is date stamped.

THE CHAIRMAN: It is undated, but it refers to the date upon which they did the inspection, doesn't it?

MS ANYADIKE-DANES: That's correct, the inspection was carried out on 2 December.

A. Saturday.

Q. Yes. So when would you anticipate receiving it?

A. Very soon thereafter. 2nd, 3rd, 4th, 5th.

Q. Yes, and if that happened, then -- and you received it like that, would you not be sending it immediately out to the coroner?

A. I'd put them all together.

Q. Put what all together?

A. The statements, rather than send them piecemeal.
Q. Can we now deal with what you actually asked Mr Wilson and Mr McLaughlin to do, what information you gave them for the purposes of their report?
A. I know that the one thing that I did not tell them is what had -- what was the reason for the examination.
Q. Yes. Is there a reason?
A. Yes. I wanted them to look without any prejudice at the equipment and tell me was it working properly so that they could put a report in to the coroner saying that the equipment was as per spec or it wasn't. Nothing more, nothing less. But certainly not to prejudice anything that they did and just to find out: was the equipment working properly, because that's what the coroner wanted to know.
Q. Yes. What they understood was that they had to look at the equipment that was in situ. They didn't understand, because they didn't know that, for example, Adam's case was a relevant case, so they didn't understand that what they should really be identifying is what was the equipment in situ on 27 November.
A. I'm not certain that your interpretation's correct.
Q. They say that in their witness statements to the inquiry.
THE CHAIRMAN: But the statement goes beyond that, doesn't

it? It doesn't just refer to the equipment in situ; it refers to the other equipment which is out for service and then says, "Verbal reports say, in broad terms, that it's in order".

MS ANYADIKE-DANES: It does say that. The point I'm putting to him is unless they're told what the date of the incidents are that are relevant to the inspection, they won't know what equipment they need to satisfy themselves is there for them to check.

A. Chairman, I'm at a disadvantage here because that operating theatre, from my memory -- and it goes back a wee while -- is that there were three operating theatres and there wasn't a surfeit of equipment in the place. What would have been used in this operation would have been the top level of equipment, so to speak. And how many more of those pieces of equipment there were separately in theatre, I don't know at this stage. I didn't go over and conduct an inventory at that time.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: The point still I'm asking you is: why didn't you tell them that, even if you didn't give the name, but one of the incidents that has given rise to asking them to carry out their check is something that happened on 27 November?

A. I've already answered that question, chairman, by saying

that I did not want to prejudice anything that they did.
Q. Okay. Why did you think they were independent?
A. Because they didn't work in that area.
Q. Well, Mr Wilson, who's the only one who signed it, he was the chief medical technical officer for ATICS, which is the directorate in which Dr Taylor was in.
A. Correct.
Q. So how did that make him independent since that was one of the cases that was at issue and prompting the inspection?
A. He was looking at equipment solely. He wasn't looking at anything else other than equipment. And equipment that he didn't have dealings with on a day-to-day basis.
Q. Yes, but they both refer to the fact that Dr Taylor was there. Dr Taylor was there, they say in their inquiry witness statements, having conversations with Dr Gibson. And you have sought to cover off the issue of independence by having people who weren't connected, but, as it happens, Dr Wilson, who's the only person who signs the report, is actually in the same directorate as Dr Taylor. So how does that ensure independence?
A. Chairman, I'm afraid that counsel and I are somewhat opposed on the understanding of the word "independent", and I can't help any further than that. I've done my best to explain.

Q. Let me pull this up.
A. I really don't understand how we can go on much further in trying to parse the semantic word "independence". I'd love to help.
THE CHAIRMAN: The issue, doctor, is whether actually there is independence. And your position, just to bring an end to this, is that because they didn't work -- let me get your words -- Mr Wilson didn't have dealings on a day-to-day basis with people like Dr Taylor.
A. Yes.
THE CHAIRMAN: And therefore, even if they're under the same heading of ATICS as Dr Taylor is, your position is that he's independent?
A. Yes.
THE CHAIRMAN: Okay.
A. That was my view at that time.
MS ANYADIKE-DANES: Just one further point and then we'll move on. It's a witness statement from Mr McLaughlin. Mr McLaughlin was in the Royal Group of Hospitals and what I had understood Dr Gaston to be saying is, yes, Mr Wilson was in ATICS, if I can call it that, but he'd sent along Mr McLaughlin as well, who was not in ATICS, and it was Mr McLaughlin actually who was providing the degree of independence, if I can put it that way.
But if one sees his witness statement, 109/2,

page 9. He's specifically asked at the top about it being undated. Then (b):

"Why did you not countersign the report?"

His answer to that is:

"I was not asked to submit a report, but agreed with the content. The report was written by Mr Wilson."

It doesn't appear to be exactly a joint report.

And just finally, their report discloses some other matters which, given your risk management remit, might have been appropriate to consider. If we go to 059-068-159. Then you see the first full paragraph, the penultimate sentence:

"The anaesthetist using the machine is also expected to sign the log before commencing the list, but this does not happen on most occasions. A reason for this omission should be requested."

What did you do about that, Dr Murnaghan?

A. Nothing. The first I saw of this was when I read it on the website.

Q. Sorry, the first you saw of this report?

A. That particular issue.

Q. But this is part of the report.

A. I appreciate that. I don't remember reading that part of it.

Q. So you got a report that you'd got for the purposes of

assisting the coroner and this is identifying things in the equipment to be addressed and you can't remember reading that or doing anything about it?

A. Correct.

Q. Okay. If we look at the paragraph immediately underneath that:

"The anaesthetic machine is approximately 10 years old and has been regularly serviced by anaesthetic services. The last visit was on 12 September 1995. It is difficult to believe that five pins have come loose in three yokes in such a short time. This must be considered as a major omission on the part of the service company and requires investigation."

What did you do about that?

A. I didn't because that was within the remit of the medical technical officers. That was their job. It wasn't mine.

Q. But you are part of risk management. This is a risk.

A. And they were dealing with the risk. Having identified it, they were dealing with it.

Q. Yes, but from your risk management point of view, don't you want to know how that could have occurred?

A. They weren't able to tell me how it occurred and they're the experts. I'm not a expert in these machines. I wouldn't even recognise one if you brought me to see

it. I'm a former obstetrician, I'm not an anaesthetist. I don't have training, I don't know what these machines are or what they do.

THE CHAIRMAN: Does this mean that you expected, on the foot of this report, that Mr Wilson and Mr McLaughlin would take the issue up with the service company because they are two of the people within the Royal --

A. Indeed.

THE CHAIRMAN: -- who are responsible for the machines? So if your technical people have picked up the issue, then you trust them to bring it up with the service company?

A. Not only did I expect, but I knew I could trust them to do it. I know these people, I know them well, I know them over the years and I know that those were their standards. Having identified something, they would deal with it straightaway. So that's risk management.

MS ANYADIKE-DANES: I understand. Did you therefore, as part of monitoring, require them to report back to you as to what had happened?

A. What would have happened, and I didn't require --

Q. No, sorry: did you?

A. No. And I didn't require them because it would have gone into the equipment log and would have been brought up again subsequently if required.

Q. Thank you. Then it says:

"Finally, it must be emphasised that the protocols and monitoring procedures set up within the children's theatres for more than two years would have discovered if a reversal of cylinders had occurred. If these procedures had been ignored, the following actions had to occur."

And they list them down.

A. Correct.

Q. As to what they are:

"The MTO did not check the anaesthetic machine. The anaesthetist did not check the anaesthetic machine. Fresh gas supply was not checked. Datex monitor was not used."

There's a whole number of things that he is identifying as potential things to explore. Those are risk management issues as to whether those things were happening and seem to go further than the remit of having a machine fixed. What did you do about the possibility that poor practice may be happening?

A. Mr Wilson's pay grade was the senior MTO on the staff of ATICS. That was his management responsibility, to deal with those issues with the relevant MTO on site, and sort it out.

Q. Yes.

A. That was his responsibility --

Q. I appreciate that, Dr Murnaghan --
A. -- on a distributed and cascaded risk management issue. It wasn't possible for me physically, mentally or otherwise, to go and follow up everything. I appreciate that this was coming particularly to me, but I would not have assumed, I would have known that Mr Wilson would have dealt with that --
Q. I understand.
A. -- with his management hat on.
Q. That I understand and I can quite understand what you say in relation to, say, matters such as number 1 and so on. But if we go to item 2:

"If there was a possibility [and one's not saying that there is, he's just identifying the sort of things that could have gone awry] the anaesthetist did not check the anaesthetic machine."

That's not really a matter within an MTO's remit. That's a clinician, and that you'd have to take up in a different way; isn't that the case?
A. Absolutely.
Q. And did you?
A. And if this refers to Dr Taylor, it is beyond belief that Dr Taylor started any operation without checking his machine thoroughly, because he was a most careful, competent --

Q. Sorry, Dr Murnaghan, that's not my question to you.
A. But it relates to it.
Q. But this has been raised in a report as potential areas of poor practice, so what I'm asking you is: did you take up with his clinical lead or somebody else in ATICS the possibility that anaesthetists were not checking the anaesthetic machine? That's the point.
A. No, I didn't.
Q. Thank you.
THE CHAIRMAN: Is that quite how that reads? Does that not read by saying that: look, the protocols and procedures are there, if a reversal of cylinders had occurred, it meant that the following six items did not happen.
MS ANYADIKE-DANES: No. Sorry, Mr Chairman, it's a matter for you how to interpret that.
THE CHAIRMAN: Yes, let's move on.
MR UBEROI: [Inaudible: no microphone] one observation, simply for clarity. A few questions ago my learned friend referred to Dr Taylor being present in the theatre when Messrs McLaughlin and Wilson --
MS ANYADIKE-DANES: In a separate room with Dr Gibson, definitely not in the theatre.
MR UBEROI: Thank you very much.
MS ANYADIKE-DANES: If there's one thing that the MTOs are clear on, it's that neither Dr Gibson nor Dr Taylor were

in the theatre when they were checking.

If you are just coordinating these reports, statements, if I can put it that way, for the coroner, to what extent was there an internal investigation for the Trust?

A. In what regard?

Q. Sorry? An internal investigation into Adam's death and its circumstances.

THE CHAIRMAN: You see, and this comes back to an answer you gave a few minutes ago. You were asked about the McLaughlin/Wilson report and you said your role was to provide information:

"The coroner didn't come back to me and ask for more."

Then you emphasised:

"This was a coronial investigation, not my investigation for the Royal Trust."

Accepting that, that the coroner's asked for certain information and your responsibility and your agreement is that you will provide that for the coroner because the Trust is legally obliged to provide it for the coroner. So that's the coroner's investigations. What about the Royal's investigation into Adam's death?

A. Well, we're coming downstream now.

THE CHAIRMAN: I'm sorry, I'm not sure what that means.

A. Coming downstream to the inquest, first of all, and then what would have happened after that.

THE CHAIRMAN: Well --

A. You see, I had to wait to see what evidence was provided by the coroner's experts. I saw the written reports. They had to be -- they were to be tested.

THE CHAIRMAN: So that my understanding is clear, does that mean that in the Royal, even if you've got reason to believe that an individual has done something seriously wrong, you have to wait for the inquest to test if that is the position?

A. Here, the nub of this is somebody has done something seriously wrong.

THE CHAIRMAN: Yes.

A. I had not been advised by anaesthetic colleagues that something seriously wrong had been done at that stage. Because if they had advised me orally or in writing, then not only I, but they, would have been through the door to Dr Carson, the medical director.

THE CHAIRMAN: I'm sorry, that leads on to this. This is certainly going to be gone into, so let's go to it now. We've been given as clear as possible understanding from Dr Savage, last week, that he made it clear to you from early on after Adam's death that he thought Dr Taylor had got this wrong. You then did see, as I understand

it, a report from London, from Dr Sumner, in or about January 2006, which effectively points the finger at Dr Taylor. If it's right that you've got Dr Savage pointing the finger at Dr Taylor and, if it's right that you've got Dr Sumner's report, which is effectively critical of Dr Taylor, why isn't somebody in the door to Dr Carson?

A. The professional advice that I had received to that stage did not point the finger at -- the anaesthetic professional advice. And I've heard Dr Gaston's evidence here and I did not hear either that question put to him or a response upon it.

THE CHAIRMAN: Well, does that -- let me ask you this, Dr Murnaghan: you did know what Professor Savage was saying. You did know what Professor Savage was saying.

A. Yes. If I may, in my defence, so to speak, and it's by way of explanation rather than defence. Dilutional hyponatraemia were two words that I did not understand before this came along. It was not something that I had ever come across in all my professional life.

THE CHAIRMAN: I understand. It doesn't feature in the world that you came from.

A. It certainly does not.

THE CHAIRMAN: But if you had Dr Savage saying that this is Dr Taylor's fault, if he expresses it in those terms or

however precisely he expresses it, and if you have Dr Sumner saying something very close to that, perhaps something even stronger, and you don't go to Dr Carson, is that because you're being told something to the contrary by Dr Gaston? When I asked you about why nobody was going to Dr Carson, you said that's not the professional anaesthetic advice I was receiving.

A. I'm trying to get this in order so that I can answer you, chairman.

THE CHAIRMAN: Yes.

A. I'm not reluctant to answer.

THE CHAIRMAN: I understand. But let's just get it clear. I understand this. Let me make clear what my question is.

When I asked you why nobody had gone to Dr Carson -- and that is to raise a competence issue about Dr Taylor, right? -- your answer was that that wasn't the advice that you were getting from the professional anaesthetic service. But you did have advice from Dr Savage and you did have advice from Dr Sumner and they should clearly, I suggest to you, point anybody towards Dr Carson. What I'm asking you is: did you not go to Dr Carson because you were somehow getting a contrary position from Dr Gaston or any of the other paediatric anaesthetists?

A. Let's put this in context if I may. I know that

Dr Savage did talk to me more than once. How many times he did, I don't know, chairman. I also know that I spoke to Dr Gaston almost on a daily basis and I spoke to the other paediatric anaesthetists, Dr McKaigue and Dr Crean, at that time on more than one occasion. I further know that informally, if not formally, I brought the matter up with the medical director, Dr Carson. But in what detail I brought it up with him, I don't know, but I do know I mentioned it because I was talking to him about one of his anaesthetic colleagues. Dr Carson wasn't, at that stage, working full-time and he wasn't working in an area that Dr Taylor was working in, but by the same token, I thought he should know about it as well. How much detail I gave him, I don't know. And I further, again in context, knew and had been reassured that Dr Taylor had never, ever, in all the time he'd been in the Royal, had ever had a problem in his anaesthetic management of any patient whatsoever. And not only that, but he was probably the most diligent of all the anaesthetists in the RBHSC. That's the context in which I was working. And therefore, one could put it that I was between a rock and a hard place about a colleague.

MS ANYADIKE-DANES: Well, which is the rock and which is the hard place?

A. The anaesthetic side and the paediatric nephrology side.
Q. This is about patient care.
A. I appreciate that. And the paediatric anaesthetic colleagues did not give me a steer, so to speak, directly at that time.
Q. Well, did --
THE CHAIRMAN: The paediatric anaesthetic colleagues did not give you a steer directly at that time?
A. Yes, to confirm to me that Dr Taylor had done something seriously wrong.
THE CHAIRMAN: But is Dr Sumner not a consultant paediatric anaesthetist?
A. He is. But I didn't know who he was other than ... I don't even know whether at that stage I had seen his written report.
MS ANYADIKE-DANES: I can help with you that.
A. I may or may not have.
THE CHAIRMAN: It's dated --
A. I know that he had been asked.
THE CHAIRMAN: He's engaged at the specific suggestion of Dr Gaston.
A. No, Dr Crean.
THE CHAIRMAN: Sorry, the idea that an external expert should be engaged comes from Dr Gaston and Dr Lyons.
A. Yes.

THE CHAIRMAN: The specific identity of the --
A. Came from Dr Crean, yes.
THE CHAIRMAN: So the suggestion that you need an external expert paediatric anaesthetist comes from within the Royal?
A. Yes.
THE CHAIRMAN: So when that external expert returns and gives a report which is effectively critical of Dr Taylor, you have -- to go back to Ms Anyadike-Danes' question and the rock and the hard place. The rock, you might say, is Adam's death.
A. Yes.
THE CHAIRMAN: The hard place is the cumulative view of the paediatric anaesthetists who are not steering you to believe that there is a general issue about Dr Taylor. But also, if you look at the hard place side, you've got Dr Sumner, who's saying, "I'm not talking about Dr Taylor generally, but on this instance it looks very problematic for him"; right? Did the paediatric anaesthetists who you spoke to acknowledge that, however good Dr Taylor is generally, on this occasion he had not been good?
A. That is not my memory. They separately and severally, chairman, were all totally supportive of Dr Taylor.
THE CHAIRMAN: Sorry, doctor, I understand that. I'm not

being critical of them, saying to you "Look, bear in mind that Dr Bob Taylor is a good anaesthetist". My concern is whether everybody wanted to put their heads in the sand because he's generally a good anaesthetist, as if to hide from the fact that, on this day, he was not a good anaesthetist. And it seems to me that it would be far more compelling if the doctors had come to you and said, "Look, Dr Taylor made a mess of this. Adam is dead directly or at least in part because of this. But if you're considering doing anything about that, you have to bear in mind that he's a good doctor". But when they come to you and they don't accept that, they don't concede that there was something seriously wrong with his management of Adam's case, does that not make their position rather less persuasive, particularly when you have Dr Sumner?

A. Well, let me put it to you this way. Back in 1995, a year or two ago, performance management -- this wonderful, relatively new term -- hadn't come across the horizon in medical terms. And if it had, and if that was today, well then each and every one of us would have done things completely differently.

THE CHAIRMAN: I understand that.

A. And I wish that we had had performance management then because then we probably wouldn't be in the position

that we're in today. And I regret all of this because of the pain and hurt it's causing so many different people.

THE CHAIRMAN: I'm anxious not to fall into the trap of judging the actions of 1995 by the standards of 2012. But I can judge what happened in 1995 by what were the standards or what should have been the standards at that time; okay?

A. Yes.

THE CHAIRMAN: I don't want to go on about it repeatedly, but my concern here is that I infer from what you said to me that Dr Savage made his position quite clear to you. Dr Sumner's report, which the Royal was instrumental in getting the coroner to obtain, effectively confirms what Dr Savage says, that this is a fluid management problem.

Nobody on the paediatric anaesthetist side seems to accept or concede that Dr Taylor acted imperfectly. So when you're balancing --

A. And, if I may, the clinical directorate didn't either.

THE CHAIRMAN: Yes, okay. But when you're balancing what to do, which might be a difficult question, when you're balancing what you do, how do you weigh in the balance what Dr Savage is saying, which is borne out by Dr Sumner, which somehow seems not to be conceded by the

clinical director in ATICS or the paediatric anaesthetist colleagues?

A. And there was a continuing dialogue with Dr Taylor and he was producing, as you've seen, more documents and more arguments to persuade us about his point of view. My understanding was that the matter had not been resolved, no matter what Dr Sumner said or Dr Savage. That's what I mean by the rock and the hard place.

THE CHAIRMAN: But the trouble about that is that Dr Taylor came to this inquiry and he said that various statements which he has made, which reinforce what he was saying from the start, are irrational and outrageous. So if they are outrageous and irrational now, if they were outrageous and irrational when he started to make statements to the inquiry, if they were outrageous and irrational when he was interviewed by the police, how were they not outrageous or irrational when he was developing his theories or what some might say are his excuses in 1995/1996?

A. I wasn't competent to make a judgment. I'm not an anaesthetist and I didn't understand dilutional hyponatraemia at that time. I do now, but I didn't then.

THE CHAIRMAN: Okay.

A. And, if I may, I wanted the process to continue. I'd

been reassured that his colleagues were looking after him, overseeing his work.

MS ANYADIKE-DANES: I beg your pardon, Dr Murnaghan. What does that mean, "looking after him and overseeing his work"?

A. Looking after Dr Taylor's professional welfare.

Q. In which way?

A. In the anaesthetics that he was providing. I understood that this was happening as well as in the intensive care unit.

THE CHAIRMAN: In effect that they were supervising or monitoring --

A. Mentoring, or whatever the word is.

THE CHAIRMAN: Sorry, there's two different parts to this. One is to support him in an encouraging way. That's one aspect. And the second aspect is for them to be double-checking the actual work that he's doing.

A. Reassuring themselves that he wasn't doing any -- potentially doing any harm or likely to do any harm.

THE CHAIRMAN: Were they doing both of those?

A. Insofar as -- I wasn't checking on them day and daily, but insofar as I understood, this was how it was happening. And then the plan was to go on to the inquest, deal with the matter there, and see what the coroner's finding was.

MS ANYADIKE-DANES: Yes. I'll come to that in a minute. We actually have no documentation at all that that is how matters were being conducted during this period coming up to the inquest. But does that mean that the safety of his patients relied on that oversight that his colleagues were providing for him?

A. Yes.

Q. Because that's how you were going to satisfy yourself that his patients --

A. Not only --

Q. At the moment, you've got the risk management, you've got the -- that's your directorate, to manage that whole area, including leading up to litigation, which is where all this may end up and actually did end up. That's your remit. So are you satisfying yourself that the patients are not at risk by virtue of the fact that you have been assured that his colleagues are providing some sort of oversight?

A. That's a distributive function via the clinical director and his colleagues. I can't supervise his anaesthetics.

Q. No, but you can --

THE CHAIRMAN: Can they, doctor? If Dr Taylor's in theatre number 1 -- and there's a shortage of anaesthetists at this time. He's in number 1, let's say Dr Crean is in number 2 and let's say Dr McKaigue isn't there or he's

going to come in later, he's elsewhere. How can Dr Taylor be supervised?

A. I'm sure it was possible for a general oversight. They walk around. They're not tied because the majority of cases that they would be doing in paediatric surgery would not be so complex or be as complex as Adam's was.

THE CHAIRMAN: Quite short in time and much simpler?

A. Yes.

MS ANYADIKE-DANES: But is that not something you have to be absolutely sure about? Because if you're not sure about it, then patients could be at risk. And there is absolutely nothing written down, no confirmation anywhere that you've instituted some sort of system whereby there would be oversight in relation to Dr Taylor carrying out his professional duties.

A. Chairman, counsel can keep on with this. All I can do is put my hands up and say I did the best I could in the circumstances, based on the advice they gave. And if it wasn't good enough, I'm sorry.

THE CHAIRMAN: Let me ask you a slightly different question. You said you raised this with Dr Ian Carson formally and informally.

A. I beg your pardon, if I said formally, I'm not too sure. Informally, yes, but formally no, because if I raised it with him formally, there would be a file note. I don't

believe that there is a file note.

THE CHAIRMAN: No, well, I don't believe so either. But if it was raised informally with him, and he was, at that time, the person responsible for performance, wasn't he?

A. Insofar as performance management was very much in its infancy.

THE CHAIRMAN: Yes. Well, let's try to simplify it. Whatever the procedures were, however developed or advanced they were compared to now, you would still have had a concern: is it safe for a doctor to operate or be involved in operating on patients? How that is managed or controlled has developed, had developed before 1995 and has developed since 1995; right?

A. Yes; but not very much before 1995.

THE CHAIRMAN: Before 1995, you would still have had occasions when doctors behaved imperfectly, behaved inadequately, and patients suffered as a result or maybe, if you were lucky, sometimes they didn't suffer as a result. What was Dr Carson's input or suggestion about how Dr Taylor might be managed in the months ahead up to the inquest when you spoke to him about it?

A. I cannot remember in detail. And there's two or three things I need to talk about here in this context. I'm almost certain that I would have told him that Dr Gaston was involved and the paediatric anaesthetic colleagues.

I'm almost certain that I would have told him that Dr Taylor had a different view and he was advancing various arguments in his support. How much more I told him of that, I don't know. I would have told him that the coroner was involved and was going to hold an inquest. And I do not know what we agreed after that, I can't remember. But I know that Dr Carson is on the witness list.

THE CHAIRMAN: Yes, he will be here on Wednesday.

A. I'm sure -- I believe he's present at the moment and he's hearing my evidence, and therefore he'll able to deal with this matter himself from his memory.

THE CHAIRMAN: Yes.

A. But I'm not in a position to deal much better than this from memory.

THE CHAIRMAN: Okay. Thank you very much.

A. I regret it, but I can't.

MR FORTUNE: Sir, this is the first mention of any form of supervision of Dr Taylor by his anaesthetic colleagues. Was the concept of supervision -- sir, I'm sure you'll be interested to find out -- known on a wider basis? For instance to Professor Savage or Dr O'Connor, bearing in mind they had patients, potentially, who could be anaesthetised by Dr Taylor thereafter, or indeed to paediatric surgeons? Secondly, insofar as Dr Carson is

now involved, what steps did he take to seek advice, either from a protection body or even, at that time, the General Medical Council? Because we are talking about a serious issue, namely monitoring -- and you have raised the question, sir, how it was to be carried out -- of a senior paediatric consultant anaesthetist.

THE CHAIRMAN: I have to say on your first question, Mr Fortune, my interpretation of the evidence of Dr O'Connor in particular is that the nephrologists instigated their own supervision by changing their practice completely. In fact, Dr O'Connor said that now in the Royal, this is the only part of the United Kingdom in which the nephrologist is ever present during a paediatric renal transplant.

MR FORTUNE: But that's a different issue, sir, because Dr O'Connor said: these are my patients, I looked after them in this way.

THE CHAIRMAN: Yes.

MR FORTUNE: That's independent of a system of monitoring by consultant paediatric anaesthetists.

THE CHAIRMAN: It is, or it's additional to perhaps.

Anyway, do you know, Dr Murnaghan, whether the two consultant nephrologists were made aware of whatever supervisory scheme was developed for Dr Taylor?

A. No, I don't. I think I've given an indication that this

was informal. It wasn't formal.

THE CHAIRMAN: For instance, when you were speaking to Professor Savage, who, I assume, was expressing serious concern to you about Dr Taylor, did you reassure him that there would be some level of supervision of Dr Taylor or there was now some level of supervision of Dr Taylor?

A. I don't know, but I hope I did. And Dr Savage and I have had and have a close relationship. It's not something that I would have kept from him.

THE CHAIRMAN: Right. On the second question, do you have any idea of whether the General Medical Council was advised about --

A. No, they weren't. And it wouldn't have been a routine matter to do it in those days.

THE CHAIRMAN: Okay. It's 3.30. I'm going to take a short break. Sorry, have you a couple of tidy-up questions and we can finish?

MS ANYADIKE-DANES: On this point, yes.

Firstly, is it your understanding that prior to the inquest, the advice you were getting from Dr Taylor's paediatric colleagues was that they did not agree with Dr Sumner's report?

A. Oh, I can't go as far as that. I couldn't.

Q. That's the point, I think, that you've been asked

because you do have Dr Sumner's report. In fact, we know when you got it. You got it in early January. So you've got his report. You, I think were saying, we had on the one hand Professor Savage and Dr Sumner, on the other hand, we had Dr Taylor's paediatric anaesthetic colleagues, who were effectively agreeing with him. And your plan, as I think you used the expression, was to proceed on to the inquest and see what happened after that or as a result of that.

A. If I may challenge one part of what you've said.

Q. Yes.

A. I do not believe that I said -- and I wish to correct it if I did -- that the paediatric anaesthetic colleagues agreed with the specific care that Dr Taylor provided for Adam Strain.

THE CHAIRMAN: I think that's right, doctor. I don't recall you saying that, but let me ask you --

A. It's just the way the question was put.

THE CHAIRMAN: I understand. Let me ask you this as a follow-up to that: when they were expressing their general support for him, did anybody ask them if they agreed that his care of Adam was inadequate?

A. I don't believe that I did.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: There's just one final point, which is

really to follow up --

A. There's an inference there that ... No, I'd have to put it a different way. It's not the inference so much as what he had done before.

THE CHAIRMAN: He was generally a good anaesthetist?

A. Not generally, always.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Just to follow up on one point that Mr Fortune made --

A. He went the extra mile always.

Q. -- which relates to the GMC. I think you'd been asked a question about that. In fact, the GMC Good Medical Practice, which is what would have been in force at that time, talks about -- 210-003-403 -- your duty to protect all patients; not just your own, but all the others:

"You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them."

Over the page, 404:

"Before taking action, you should do your best to find out the facts. Then, if necessary, you must tell someone from the employing authority or from a regulatory body. Your comments about colleagues must be honest. If you're not sure what to do, ask an experienced colleague."

In terms of the concern that Professor Savage --

A. Chairman, it would be helpful if I knew which version of Good Medical Practice this comes from. There are several versions. What date is this?

Q. I'm just going to find that out for you.

THE CHAIRMAN: If you go back six pages from 403. Could we try 396 or 397, please?

A. 1995.

THE CHAIRMAN: Yes.

A. Thank you. It's just I wanted to know which it was.

MR FORTUNE: From recollection, sir, you'll find that the previous guidance was similar.

THE CHAIRMAN: I would hope so, Mr Fortune.

MS ANYADIKE-DANES: The issue here is that Professor Savage has identified a concern in Dr Taylor's fluid management of Adam and he has relayed that concern to you repeatedly, according to his evidence. Dr Sumner has come in with his report, which was an independent report sought by the Trust, and his report identifies --

A. Chairman --

Q. Sought by the coroner?

THE CHAIRMAN: At the Trust's instigation.

MS ANYADIKE-DANES: Sorry, it was a bit of a short cut. Anyway, that was something they wanted to have as well. The result of that report is to refer to shortcomings

and criticisms of Dr Taylor's care on that occasion. Dr Taylor, as you have said, was providing you with numerous documents which made it clear that he did not accept the report of Dr Sumner. Professor Savage did and I think his colleagues did, but they were still supportive. At least Dr Gaston's evidence is that ultimately he did accept Dr Sumner's report, but they were supportive and thought there were, if I can put it that way, mitigating circumstances.

Nonetheless, you have this concern and it's such a concern that people are putting in place informal supervision methods, if I can put it that way, and in fact, the response of one of the nephrologists is to instigate her own supervision methods by being in the theatre all the time. Did you not think that you should -- I think she says she was in the theatre when Dr Taylor was acting as the anaesthetist.

A. For renal transplants?

Q. Yes.

A. Not all the time.

Q. No. All the time for the renal transplants.

A. I just wanted to make sure [OVERSPEAKING].

Q. I'm not seeking to make it larger than it is. Did you not think that you really ought to engage in something a little bit more formal than an understanding that he

would be managed in some way until you got the verdict on inquest?

A. No, not at that time, and I know we're going to come to this again in relation to another matter.

THE CHAIRMAN: Okay. We'll start again at 3.45.

(3.37 pm)

(A short break)

(3.55 pm)

MS ANYADIKE-DANES: Sorry, Mr Chairman. One point I would like to correct from before we rose. I think that I had given the impression -- in fact, I know I had given the impression -- that Dr O'Connor, who was the other nephrologist, was effectively operating her own supervision over Dr Taylor's anaesthetics in relation to renal transplants. That's not the case, Mr Chairman, and the easiest place to see that is Dr O'Connor's evidence in this governance part of the hearing. The date for it is 20 June and if one goes to page 119 of that, starting at line 17.

I will read it. There we are, we can see it there:

"Since Adam has died, I have been to theatre for every single transplant I have been involved with. It was not my practice in Bristol, it is not the general practice in the UK, but it has become our practice in the Children's Hospital because we were just devastated

by Adam's death."

And you ask her:

"So it's because of Adam's death?"

And she responds that yes, it was, and I'm sure she goes on later on. But in any event I wanted to draw that to your attention, Mr Chairman, because it's not correct that she was singling out all of Dr Taylor's cases or all his renal transplant cases. It was her practice --

MR FORTUNE: Would you read line 25 and onwards, please?

MS ANYADIKE-DANES: Yes, of course. Mr Stewart, my junior, asks:

"Question: Were you any more vigilant when Dr Taylor was undertaking performance of the anaesthetic?

"Answer: My behaviour was the same no matter who provided the anaesthetic. My preoperative plan, my discussion with them and my presence in theatre and my discussion about every single bag of fluid that was erected. Sometimes I think maybe they think I'm a nuisance in theatre but they've got used to me being present now for transplants."

That was her evidence and that was a step she took as a result of her experience.

I have been asked to draw your attention to one

particular document, which is a letter that you received from Dr Webb. I'm going to do that. You will recall that when I had the memo up of 6 December, when you were seeking statements, it's 059-071-164. You can see right down at the bottom left-hand side there's a number of people who whom this document is circulated. Those presumably are the people from whom you were seeking statements. And then, on the right-hand side, there are two names. One is Dr Webb and there is "action" against his name. And one is Dr Wilson and there is "action" against his name. I have assumed, but you can correct me if I'm wrong, that the action you were seeking from Mr Wilson was the report or at least a finalised report and get it to you. Maybe I'm wrong about that. What was the action Mr Wilson was to take?

A. Related to number 1.

Q. Ah. So then what was the action that Dr Webb was to take?

A. As far as I remember, chairman, Dr Webb was only involved in relation to brainstem tests.

Q. Yes. So what --

A. I'm trying to be as sympathetic as possible in this context.

Q. I understand.

THE CHAIRMAN: Well, that being so -- and I think that is

right -- he became involved at that very late stage.

A. Yes, and only then.

THE CHAIRMAN: Do you have any recollection of what action it was, which might have been required of him?

A. Purely to provide a report for the coroner that he had conducted the tests and the results thereof. It would have been purely a factual --

MS ANYADIKE-DANES: I understand. If I pull up this document, maybe you can help me if this is the response to the action you were speaking. 059-061-147. There you see it's from Dr Webb to you. It's dictated on 12 December:

"I note your request for a statement from the clinicians involved in the medical care of this child."

Then he deals with that and says how he was contacted by the nephrology service to see the child. He says he examined him and then reviewed his CT scan and then his final statements are:

"I repeated Adam's brainstem assessment 12 hours later and confirmed he fulfilled the criteria for brainstem death. My impression was that he had suffered severe acute cerebral oedema, which was likely to have occurred on the basis of osmotic disequilibrium causing a sudden fluid shift."

So that's what Dr Webb thought it was at that stage,

at least the approximate cause of Adam's cerebral oedema, and therefore death.

How did you see that fitting in with the information that you were receiving from the other clinicians?

A. The only way I can answer that is to refer you back to what I've already said.

Q. Which is?

A. We were attempting -- at least I was attempting -- to put everything together and looking forward to how it would be dealt with at the inquest.

Q. Thank you. I'm going to ask you one further question in relation to this run-up phase to the inquest, if I can put it that way. You were copied into a letter from Dr Armour, who was the pathologist. The reference is 011-023-123. It's dated 8 December. It's a very short letter. It's actually addressed to the State Pathologist, but you are cc'd in along with the coroner. Do you recall seeing this letter?

A. I do.

Q. And she says:

"I have been dealing with the case of Adam Strain. I am willing to attend any meeting about this case, including a meeting with clinicians, administrative staff, HM Coroner and whoever else wishes to attend. As I was the pathologist who carried out the autopsy,

I feel my opinion on the case is relevant to such a meeting and, as such, the case could be discussed in full."

What, so far as you are aware, generated that letter?

A. My memory in relation to this is not precise and I haven't read Dr Armour's evidence. It is probable that this matter came up, but at that time, my belief is that there was an element of disharmony between herself and the State Pathologist.

Q. How is that relevant to the case of Adam Strain?

A. There may have been a challenge within the department.

Q. What do you mean by that?

A. A challenge to Dr Armour by her clinical lead.

Q. You mean a suggestion that she may have got it wrong?

A. I don't know what was going on and I never did determine what was going on. But there is a clue here. I don't think it's relevant to this matter. The clue is the fact that Mr Calvin Spence, her representative at the BMA, is copied into this.

Q. Perhaps we shouldn't speculate.

THE CHAIRMAN: I think Dr Armour gave us her explanation for this letter, which is tangential even to a very broader inquiry than ours, so I think we can move on.

A. I'm semi-correct, I think. Thank you.

MS ANYADIKE-DANES: I don't want to get into that, the element you have just raised. What I want to know is what did you do about it, having --

A. I didn't do anything because it was only confirming to me that about which I had superficial knowledge and it certainly was not something that was within my remit or appropriate for me to do anything about. I don't know why she copied me, other than perhaps for protection.

Q. Before the inquest, there are a number of meetings and we have taken various parties through them. I don't intend to take you through them because you, I think, unless you correct me, have fairly said that you actually didn't regard yourself as carrying out an investigation at all.

A. At that time.

Q. You were simply gathering material for the coroner. And some of it post-dates when you were notified that there was a claim. What effect did that have that you now knew that there was likely to be medical negligence litigation in relation to this matter? What effect did that have?

A. Absolutely nothing. I was able to divide myself into two and deal -- the inquest on one side of me and the claim on the other side of me, and the two did not, at that stage --

Q. You didn't regard that there was a potential conflict in you dealing with both matters?
A. No, not at all.
Q. Were you not, when you were dealing with the claim element --
A. And I beg your pardon, just to complete it, chairman, I wasn't advised that there would be an element of conflict. The same legal adviser to the Trust was dealing with both files.
Q. Yes.
A. I would have expected, in that circumstance, that if there was a conflict of interest, I would have been so advised. I wasn't.
Q. But when you were preparing yourself, not you personally, but preparing the Trust's position in relation to the litigation -- or were you preparing the Trust's position in relation to litigation prior to the inquest?
A. No.
Q. So --
A. As far as I can remember, no.
Q. So when we see references in the correspondence to difficulties that were likely to arise at the inquest and for you arranging for consultations between the clinicians, certainly Dr Taylor, and the Trust solicitor

to try and see how those difficulties could be met, if I can put it that way, that's still all part of just trying to get the information out for the coroner?

A. Absolutely, and for no other purpose.

Q. Not defensive at all?

A. Not at all. This was pure veritas and nothing more than that.

Q. Now that you have put it that way, perhaps we can just look at one of them. This is a letter you get on 7 June from the Trust solicitors. 059-014-038. So at this stage, you've seen the expert reports. It's 7 June. You've also seen the report of the pathologist in terms of the dilutional hyponatraemia issue. They all seem to be of pretty much one mind. As you know, this is the second paragraph:

"There are a substantial number of issues contained in the experts' reports, which will require to be carefully and exhaustively examined and investigated. In that regard, I have already had the benefit of very detailed instructions from Dr Taylor and these have now been reinforced for me by Dr Gaston."

Then there's a reference to Dr Sumner being in attendance. It goes on that:

"I understand that Dr Taylor has a full set of the working documents and whilst other witnesses will be

called to give evidence, I believe it is fair to say that the main focus of the coroner's interest will be on the anaesthetic management of this patient, particularly in the light of the cause of death as found by Dr Armour. It is important that Dr Taylor provides express instructions in relation to his view of the cause of death, which Dr Armour classifies as cerebral oedema due to dilutional hyponatraemia and impaired cerebral perfusion ..."

The anaesthetic colleagues of Dr Taylor, did they accept Dr Armour's report?

A. I can't remember.

Q. That would be quite an important issue.

A. Have they not given evidence?

Q. I'm asking you.

A. I don't remember is what I said. I am sorry, I don't remember.

Q. No, no, that's all right. But what's being put here is a clear recognition that Dr Taylor is going to face some fairly difficult questions because the main focus is going to be on what he did in terms of fluid management. And what appears to be the case is an attempt, rather than to say, "Those are the expert reports, they're independent, that's the pathologist's report, let's see what the coroner makes of that, we've already submitted

the statements, or we will be, from the clinicians", there seems to be a process of trying to provide a defence for Dr Taylor so that the -- or at least maybe to provide an opposing view to that of Dr Sumner and the pathologist. Would that be a fair categorisation of what was going on?

A. I certainly would prefer the second rather than the first. I wouldn't regard this as a defence at all.

Q. Then if we go --

A. And I would prefer it to be seen as being an attempt to be positive.

Q. An attempt to be positive?

A. Yes.

Q. Well, then if we go on and see what's dealt with here in the second page:

"This is really the starting point in relation to the instructions which I would require from Dr Taylor. And if he has any difficulties in relation to accepting that cause of death, then perhaps he would let me have a note of the same."

Of course he did have those:

"Turning to Dr Sumner's report, there are a number of veiled criticisms contained therein and these, in general terms, at the moment I would categorise as follows."

He then goes on to deal with them:

"A suggestion that Dr Taylor overestimated the fluid deficit."

And he deals with how that is raised in Dr Sumner's report. Then:

"Taking the electrolyte values. 3, the CVP readings."

Then at the bottom:

"Finally, at this stage I would like to raise two other issues. Dr Gaston has indicated that during the course of the procedure, Dr Taylor did not have an opportunity of accurately measuring urinary output due to the fact that the bladder had been opened early on in the surgery. This point will have to be made in very trenchant terms to Dr Sumner and he will be asked what other opportunities the anaesthetist had to measure urinary output."

Why does it have to be made in trenchant terms if it's not being mounted as a defence?

A. I didn't choose the word. That was the legal advisers.

Q. I appreciate that. Then if we go over the page, 040. He wants to be in a position to deal with that point:

"One additional point raised by Dr Gaston related to the potential for this child, for whatever cause, absorb fluid into the brain. I would like to see some

literature which might help us in propounding such a theory -- and I emphasise only as a theory -- and as something which simply cannot be excluded from the present position, and in particular that in some individuals the physiology is such that such an occurrence can happen. Obviously, if we suggest such a potential, then that of itself would be a factor which might, to some extent, explain the oedematous state of the brain."

Then Dr Taylor's being asked to look at drugs and so forth.

When you stand back and look at all that -- and I appreciate it's not your words, it's the words of the Trust solicitor -- but does that not appear as an exercise in trying to mount some sort of defence to the criticisms that are being anticipated as a result of the reports that the trust is likely to face?

A. Criticisms, yes, arose in Dr Sumner's report. These are the legal advisers' understanding of the responses, based on Dr Taylor's instructions --

Q. Yes --

A. -- verbally given --

Q. -- I accept that.

A. -- and backed up by written work.

Q. Backed up by Gaston?

A. And Dr Taylor. They were both in communication, they were both seen by Mr Brangam on more than one occasion and that's on record.

THE CHAIRMAN: But doctor, is it not the problem here that if Dr Sumner's evidence and the basis for his evidence was not challenged, and if that evidence was accepted by the coroner, the inevitable finding about the cause of Adam's death would be to point the finger fairly directly at Dr Taylor?

A. Yes.

THE CHAIRMAN: And that is supported by Dr Armour's autopsy report, which came after Dr Sumner's report, but in which she had accurately confirmed the cause of death, as was accepted by the coroner.

A. Yes. Can we come back a little bit before it being accepted by the coroner? Dr Taylor had a view which differed from Dr Sumner's view, and he received a degree of support from Dr Gaston in relation to his view. Now, I wasn't in a position to make a judgment on that. That wasn't within my professional expertise whatsoever.

MS ANYADIKE-DANES: I understand. So in fact, how that was going to get itself resolved, if I understood you correctly, was to await to see what the verdict on inquest would be.

A. Exactly, and the debate, chairman, that would happen.

THE CHAIRMAN: At the inquest?
A. At the inquest.
THE CHAIRMAN: Then let's move on to the inquest.
MS ANYADIKE-DANES: One final point just before we get to Dr Taylor giving his evidence at the inquest. You caused, did you not, two documents to be produced just prior to that? One was a set of recommendations and the other was a press release. The set of recommendations -- we can look at that just now. 011-014-107A. Ultimately, that is signed by Dr Taylor; isn't that right?
A. Dr Taylor, in his evidence, has explained why he signed that.
Q. That's not the point that I'm putting to you.
A. No, but you drew attention to the fact that it had been signed uniquely by Dr Taylor.
Q. Yes. But you are instrumental in causing this document to be produced?
A. I was involved in its production, yes.
Q. Yes. And what was it for?
A. The purpose of this document was to show to the coroner that, having considered the issues that had arisen, that the management of children undergoing major paediatric surgery in the future would involve the following issues. And that was not only for the coroner, but

through him, if he saw appropriate, to be passed along. And I understand that there's somewhere in the coroner's rules that he has authority to do that, to pass it up to the department or wherever.

Q. I think it might be the other way round. I don't think the coroner has said that he had any role in disseminating a document such as this. What he could have done is he could have issued a rule 23 report, which could have ended up being critical of the Trust. Some may say that the purpose of this document was to avoid that by pre-empting the final verdict and identifying what the Trust was going to do in the light of the receipt of the coroner's experts' reports. Of course, what this document doesn't do is confirm that those reports are accepted. And presumably that's why Dr Taylor can sign it.

MR FORTUNE: Sir, forgive me.

THE CHAIRMAN: Sorry, Dr Taylor signed this report as saying, I think, that he had received it.

MR FORTUNE: Yes.

A. That was my understanding of his evidence.

THE CHAIRMAN: It was Dr Taylor's signature on his evidence, whether I accept it or not, is a signature acknowledging receipt of the document, not approval of the document. But he did sign off the other document.

Sorry, Mr Fortune.

MR FORTUNE: Can I just correct my learned friend? The document we're looking at, the draft statement, would not have pre-empted the verdict; it would have encouraged HM Coroner not to make a rule 23 recommendation.

MS ANYADIKE-DANES: Thank you. What I meant by "pre-empted the verdict" is it would have come in ahead of the verdict, which it did do. It was part of his own deposition, submitted as C5 to his deposition.

MR FORTUNE: I understand that, but it wouldn't have pre-empted the verdict in the sense that the coroner would not have changed the verdict he returned. All that he would have done is said, "I'm satisfied that appropriate steps have been taken".

MS ANYADIKE-DANES: What I meant was preceded it.

THE CHAIRMAN: "And therefore I don't need to make a rule 23 recommendation."

MS ANYADIKE-DANES: That was the point I was getting at. What I meant to say is it came in ahead of the verdict. But what some might say is that its true purpose was to avoid a rule 23 report; would you accept that?

A. No, I'm not an expert on coronial law.

THE CHAIRMAN: Have you ever, in the position that you held from 1987, which of necessity involved you in liaising

with the coroner's office from time to time and in the context of previous inquests or knowledge you'd agreed generally, were you aware that the coroner had a power under his rules to make a recommendation that certain actions should be taken and then to follow up to ensure that that action had been taken?

A. Yes, I did, and I also know that he never did in relation to any of the inquests that I dealt with.

THE CHAIRMAN: That sort of begs the question, doctor -- and it is what you were being asked a moment ago -- was the intention of providing the coroner with this document to avoid a rule 23 recommendation by the coroner? In other words, by showing the coroner: look, we faced up to what has gone wrong, we're taking steps to make sure it doesn't happen again, therefore a recommendation to us, which is a quasi-requirement, would be unnecessary?

A. I don't think I could have put it much better, sir. Thank you very much. Except for the unnecessary part of it about the recommendation. We were attempting to show, through the coroner, for the reassurance of those who were involved directly that we had visited this issue and put in place the following steps. That was the purpose of it and no other: only for the reassurance. It wasn't to avoid a rule 23 or whatever.

THE CHAIRMAN: But in doing that -- [OVERSPEAKING]. In

doing that, would you not know that that makes a rule 23 recommendation far less likely?

A. At that time, I don't believe that I knew about rule 23. I've only discovered that more recently --

MS ANYADIKE-DANES: Well --

A. -- through other reasons.

Q. If we just go quickly to the letter that comes back from the Trust solicitors, 2 July 1996, 060-020-039. This is obviously after the verdict. He records his appreciation of Dr Gaston's help. The second paragraph:

"I trust that everyone involved was satisfied by the way in which matters progressed and, indeed, I believe it is not without note that the coroner did not issue a recommendation in this case [and he goes on to say, in fairness] which I believe was, in large part, due to the fact that the deponents gave their evidence in a fair, objective and professional manner, and at the same time, were alert and aware of those issues, which might cause an erosion of public confidence."

Does that reference to "alert to those issues which might cause an erosion of public confidence" refer to the fact that Dr Taylor had submitted, as part of his deposition, a document identifying to or describing to the coroner what the Trust was going to do about the very circumstance that had arisen in Adam's death?

A. No, I believe that the issue of -- just taking the erosion of public confidence issue, there was significant publicity --
Q. Yes.
A. -- in all the newspapers published in Belfast at that time regarding this inquest.
Q. Yes, but what did that mean then?
A. And --
Q. Sorry, just that line, that's the point that I'm trying to get at. What did that mean, "were alert and aware of those issues which might cause an erosion of public confidence"?
A. The purpose of that was called the draft statement.
Q. Yes.
A. It was to show that attention had been paid to the issues that had arisen and had been identified --
Q. Yes.
A. -- and that the consultant anaesthetists and all those under their supervision, in future, would do the following.
Q. Exactly. That's the point. So that --
A. That is the point.
Q. Part of being alert to that is the fact that such a document was submitted to the coroner, which would give him comfort on that point.

A. Exactly.
Q. In other words, what the Trust solicitors are pointing out, it's not just the way in which they gave their evidence, but in his view -- and it is only his view -- you avoided a recommendation from the coroner in this case because you had submitted or in part because that document had been submitted?
A. Chairman, I regret that counsel has lost me a little bit in that convoluted question. Could it be repeated to me? I lost the thread of it, I'm afraid.
Q. Okay, let me try and see if I can help. You, I think, have just said that the awareness of those issues, which might cause an erosion of public confidence, is related to being aware of what might do that and, therefore, having provided the coroner with a document to satisfy him on those types of issues. And that had actually achieved what had been desired, namely that there was no recommendation from the coroner. So if that is what you wanted to do by providing that document, you had achieved that.
A. Except that I am not too sure about the issue about the coroner issuing a recommendation. If we take it sequentially, my understanding at the time was that if we were able to show to the coroner that proper attention had been paid to what had happened here, and

insofar as is possible, that the proper fluids would be given and the proper monitoring would be applied, that these efforts would make a big difference to complicated paediatric surgery care.

Q. Yes.

A. That was the purpose of it.

Q. Right.

A. And insofar as there was public attention being paid to what was going on in the court in the Crumlin Road, we knew or we thought that it would be helpful if there was wider dissemination of these recommendations other than directly to the coroner. It was through the coroner that these recommendations would be published, therefore it was for the comfort of the staff in the Royal Belfast Hospital For Sick Children generally. And not only for the staff, but for those patients and their parents who were using that place --

Q. Yes.

A. -- because the standards had been called into question by this inquest.

Q. Well, let's deal with what it then says that you're going to do, which is part of what you're giving the coroner some comfort about. The second paragraph:

"In future, all patients undergoing major paediatric surgery who have a potential for electrolyte imbalance

will be carefully monitored according to their clinical needs."

And so forth.

THE CHAIRMAN: You'd better bring the statement back up again if you want to go through it. 011-014-107A, please.

MS ANYADIKE-DANES: Right. There we see it, I was reading from the second paragraph. Then if one goes literally to the end of that paragraph:

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

And did that happen?

A. This was in the context of practice in that hospital.

Q. Yes. Did that happen?

A. Yes.

Q. All --

A. It was very easy because there were four paediatric consultant anaesthetists. That's all. Doctors Taylor, Crean, McKaigue --

Q. Except for --

THE CHAIRMAN: I think that's it. I think there were three, actually, at the time.

A. Sorry, yes. There were two missing at the time, unfortunately.

MS ANYADIKE-DANES: How do you think they were going to be

made aware of that?
A. It's the use of language "made aware". They had contributed to the drafting of the statement so they were aware.
Q. They did.
A. Yes. So they were aware.
Q. How were all the anaesthetic staff going to be made aware?
A. And those that they were training in that place would have been shown and told what was to be done in future in relation --
THE CHAIRMAN: I was told last week that this did not reach the junior doctors. And in fact, the specific point raised last week was that this statement and the associated document was only ever seen beyond the inquest by the three paediatric anaesthetists who wrote it. If that's right, that's hopelessly inadequate, isn't it?
A. Well, I understood it to be different. That's all I can say about it. Because the intention was, where possible, to improve the service.
THE CHAIRMAN: Exactly. And to improve the service, you need to train the junior doctors. And if you have learnt lessons from a child's death, then it is up to the consultants to make sure that the junior doctors

find out about it.

A. Exactly. And that would have been my intention from a distance because I was in another place and I wasn't giving the anaesthetics.

THE CHAIRMAN: But you would read that and be reassured that the consultants would drive home the message with the junior doctors?

A. Yes, I would have --

THE CHAIRMAN: Both the junior doctors who are there now and the junior doctors who will come along in later sequences?

A. Thank you.

MS ANYADIKE-DANES: Did you actually do anything to see whether that was happening?

A. No.

Q. Then the final paragraph is:

"The Trust will continue to use its best endeavours to ensure that operating theatres are afforded access to full laboratory facilities to achieve timely receipt of reports on full blood picture and electrolyte values, thereby assisting rapid anaesthetic intervention when indicated."

The evidence that the inquiry received is that there was no specific action taken to achieve that as a result of Adam's death.

A. Oh, yes there was, chairman. Blood gas analysis was a significant issue and you've heard plenty of evidence about that.

MR UBEROI: Sir, can I rise -- I'm not sure if it could be established with the witness, in terms of the dissemination of this document, whether he is referring to individual consultants or whether there was a role for the ATICS directorate, which we've also heard mention of in the evidence? I'm just keen that the ATICS directorate is asked about in case there is relevant in that regard as well.

THE CHAIRMAN: Yes. When you say that you assumed that this would be made known to the junior doctors, with whom did that obligation lie?

A. That would have happened within the ATICS directorate.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: I think the question is: who ultimately had that obligation? Was that a matter for the clinical lead, which was of course Dr Gaston, to satisfy himself that that was happening? Or was that simply at the level of individual anaesthetists to ensure that they were doing that on an ad hoc basis, if I can put it that way?

A. I'm not certain and I have not been able to find on the website anything in relation to ATICS directorate

minutes where this may have been discussed.

THE CHAIRMAN: As long as it happens, it doesn't matter who does it, does it? It doesn't matter whether it's Dr Gaston or Dr Crean or Dr Crean or Dr McKaigue.

A. Right.

THE CHAIRMAN: But it does matter that it's done.

A. Yes, and there were opportunities. There was another opportunity at M&M, mortality and morbidity, at audit. And I cannot believe that it wasn't discussed in public at an audit meeting. And the anaesthetic directorate were very good at doing these.

MS ANYADIKE-DANES: I suppose, Dr Murnaghan, just the final point on that is --

A. They had a good reputation.

Q. -- if it had been a matter for the clinical director to do that, then it could have been formalised and he could have issued guidance actually, and then that becomes a more systematic way of addressing it rather than leaving it up to individual consultant anaesthetists as to how they communicate those lessons. So it might have been, if you're looking at your role as risk management and so forth, it might have been more appropriate that it be done by the clinical lead, raised in one of their meetings and some sort of document go out, "This is now what we expect". Maybe even this go out.

A. Yes.
Q. Thank you.
A. Now --
Q. Sorry?
A. You were asking me about lessons learned.
Q. I wasn't so much asking you about the blood gas machines. I was asking you about the operating theatres being afforded access to full laboratory facilities, which are different things from the blood gas machines. And I think this arose because there was an issue of when samples could be taken to the operating theatre, how that would be done, what the turnaround time would be and so forth. So the point that I'm asking you here is: what did you understand would be done in the light of this statement to improve or address the access to full laboratory facilities?
A. Chairman, with respect to counsel, blood gas analysis does have a direct relationship to laboratory services, insofar as there is near-patient testing, and that is what a blood gas analyser does, and what the laboratory can do.
Q. Yes.
A. I'm sure you've had it explained to you already, but let me go over it again one way or another.
THE CHAIRMAN: Let me see if I can short circuit this. As

I understand from the evidence of the Mr Shaw, blood gas analysers are now, in 2012, much more developed and advanced than they were in 1995. What you had in the Royal in 1995 was a good example of the then available blood gas analysers. But nowadays, blood gas analysers are better so the fact that they're there is clearly positive. So in 1995, they made a potentially important contribution, within limits.

A. Yes.

THE CHAIRMAN: The question which I think you were being asked is that this refers to full laboratory facilities. We accept that blood gas analysers are a contributor to laboratory facilities, but the question was, particularly if an operation is out of hours, there was a concern or there may be a concern about turnaround time and there's one porter who's available to collect the sample and come back with the analysis and so on. This statement effectively reassures the coroner and the public that the Trust will do its best to make sure that operating theatres are afforded access to full laboratory facilities. So what was done after the inquest in light of Adam's death to advance the endeavours to ensure that there was access to full facilities?

A. First of all, if you'll allow me one second, I want to

get blood gas analysers off my sheet. That is that as a result of this, funds were made available and a new blood gas analyser was made available for that theatre and that was perceived as being an improvement. Number two, the issues regarding portering were addressed with the business manager and the director, clinical director, in the Children's Hospital and there was an assurance that that matter would be addressed and dealt with appropriately.

Number three, the biochemistry laboratory. The biochemistry laboratory at that time was a two-stage process. There was a small biochemistry provision in the basement of the Royal Belfast Hospital For Sick Children. At the back of it was the main biochemistry laboratory, further away. Detailed discussions took place with the biochemistry staff in both locations and an assurance was given that better attention would be given in future to the provision of biochemistry services to the theatres in and out of hours.

Number four, if it was not possible to do haematology testing out of hours in the laboratory in the Children's Hospital, an assurance was given that microsample testing could be done in the haematology laboratory in the main hospital. Granted, that was at a distance removed from the Children's Hospital because

of the anatomy of the site. And related to that was that portering had to happen. If portering did not happen, I know that the roving security provision on the site, which was mobile, could be used instead if a porter wasn't available to bring the specimen from the children's theatre over to the haematology department, over close to the Grosvenor Road.

Q. Thank you.

A. So those are all issues that cascaded down.

Q. Thank you very much. I think you have clarified one point that we were unsure of, because both Professor Savage and certainly Dr Taylor were not convinced that that small laboratory that you've mentioned was actually functioning for the purposes of theatre other than for oncology, as I understand it. In fact, I think Dr Taylor referred to it as being not fit for purpose because the results were not reliable.

Now, is that correct or not?

A. I never heard that said, that the results were not reliable. I never heard that. And it was staffed by a very senior and highly graded technical officer and another.

Q. No, no. What he was suggesting is because of that, the samples were going to the main laboratory other than, as I say, for purposes of oncology. Not that they were

carrying on using results that were unreliable because there was a recognition that there was an issue to do with that laboratory, that is why the change was made. And it was the making of that change that produced an extra time factor, if I can put it that way, for the turnaround. Were you aware of that as an issue as at the time of Adam's surgery?

A. I was aware that there was a difficulty with portering --

Q. Okay.

A. -- and because of the site of the biochemistry laboratory.

Q. Okay.

A. Down below the dental hospital was quite a distance from --

Q. Thank you.

The coroner's verdict comes through and, in essence, what it does is confirm the pathologist's view. It's at 011-016-114. There you are. You can see the cause of death.

A. Yes.

Q. "Cerebral oedema due to dilutional hyponatraemia and impaired cerebral perfusion during a renal transplant operation for chronic renal failure."

Then the findings:

"The onset of cerebral oedema was caused by the acute onset of hyponatraemia from the excess administration of fluids containing only very small amounts of sodium and this was exacerbated by blood loss and, possibly, the overnight dialysis and the obstruction of the venous drainage to the head."

Your evidence earlier was that the plan was on to the inquest and deal with the matter there and see what the coroner's finding was. Well, now this is the coroner's finding, verdict and finding. So you produce a note or an aide-memoire after that. We can go to it, 059-001-001. If we go to that and perhaps pull up the second page as well next to it, 002.

There we are. So this is your note to self, in a way. You attended the coroner's court:

"Generally the outcome was satisfactory. Fair write-up ..."

Then:

"Other issues identified which relate to structure and process of paediatric renal transplant services."

What were they?

A. I can't remember back as far as 1996, especially what they were. But all that and those who were present would have known and, at the time, in the hall of the Coroner's Court, I raised this issue, and if you go on

to the next page -- and this is where, to this day, I am very distressed.

Q. No, we will go on to the next page, obviously.

A. I know you will.

Q. What I'm trying to find out --

A. One is related to the other.

Q. Then maybe that's how you have to explain it.

A. It's not how I might have to explain it; it's how I must explain it.

Q. The verdict that the coroner handed down was Adam's cause of death and that deals with, effectively, dilutional hyponatraemia.

A. Correct.

Q. So that's that. That has nothing to do necessarily with the paediatric renal transplant services. So this is a different point, ostensibly, that you are raising, which is that:

"Other issues identified which relate to the structure and process [so it seems] of paediatric renal transplant services."

And all I'm trying to see if you can help us with is what those other issues might be.

A. At this remove, I cannot remember.

THE CHAIRMAN: Okay. Then you were going to go on to the second page.

A. Yes.
THE CHAIRMAN: How does that help develop your memory about what you were going to do at the time and the discussions which you had at the corridors of the Coroner's Court?
A. The plan was that I would arrange a feedback seminar with all those involved -- doctors Mulholland, Hicks, Gaston, Taylor, Savage, O'Connor, Keane, medical director and myself present -- as soon as possible so that we could review all that had happened, particularly regarding Adam's care leading to his death and what had come out at the inquest.
MS ANYADIKE-DANES: You seem to have characterised it as an RM issue. Is that a risk management issue?
A. It was feedback, seminar, whatever you -- the totality of it --
Q. Yes.
A. -- we were to have a full discussion.
Q. Were there going to be any nurses there?
A. No. Not at that stage. It wasn't considered that nurses were to be invited, no. It might have arisen as a secondary issue, but not at that time.
Q. Okay.
A. If I may go on, chairman.
THE CHAIRMAN: Yes.

A. That was towards the end of June. And you will notice that I said "ASAP".

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Yes.

A. I asked my staff to see how quickly we could get all those identified there together. And I believe on the website there is a matrix with all those names and their availabilities or not; do you have that?

Q. No, I haven't seen it.

THE CHAIRMAN: We've seen something, a version of it, we saw it last week.

A. It's a squared ...

MS ANYADIKE-DANES: The difficulty we have is there were matrices in relation to people meeting prior to the verdict. I'm not sure that we have seen one that identifies itself as being a matrix having received the verdict.

THE CHAIRMAN: I accept your -- sorry.

MR FORTUNE: That's my recollection too.

THE CHAIRMAN: Dr Murnaghan, I accept your proposition from this note that you saw urgency in having this meeting and that's why "ASAP" is part of the note.

A. Well, particularly because of the date. This is the third week in June.

THE CHAIRMAN: Yes.

A. And July and August are fast approaching. Holiday time.
THE CHAIRMAN: Okay.
A. My staff, who are very good at organising meetings of this kind, and did always work on a matrix of availability, did their best to get colleagues together and failed to do it in the period before summer holiday time, July and August.
THE CHAIRMAN: Okay.
A. Next, I went on leave myself the second fortnight in July. And close to or during my holiday, the end of my holiday, I got sick.
THE CHAIRMAN: I don't want the dates, doctor, but can I ask roughly how long you were off for then?
A. I've checked with one of my GPs last night and he says that he doesn't remember because this was a recurring problem that I had. I'm quite happy to identify what I had. Recurrent renal colic, stones. And usually, the management was expectant with analgesia and fluids. One would hope that the stone would pass. And only on two occasions did I have to have stones removed surgically.
THE CHAIRMAN: Okay.
A. All the other times that I suffered with this, they passed spontaneously. But it would take two, three weeks. So here I was in this situation, holiday's a fortnight away, and back then -- and when I came back

to the office, I regret to this day that I forgot totally about this important issue. And there was a pile, as you would know, awaiting me on my desk and that overtook me. It's an explanation, it's not an excuse. And all I can do is say, hands up, I'm sorry.

THE CHAIRMAN: Dr Carson was to be at that meeting.

A. Yes.

THE CHAIRMAN: Did he understand the importance of that meeting?

A. I believe and hope that I gave him feedback at the time.

THE CHAIRMAN: Well, the fact that he's included in it and, in fact, the bottom of page 1, the page on the left, it says that you're agreeing this with Dr Carson.

A. Yes, I see that now.

THE CHAIRMAN: And Dr Carson was to attend the meeting.

A. Yes.

THE CHAIRMAN: You're off for the second half of July and then you take sick and, as I understand it, you're away for a further two to three weeks or so approximately?

A. I may have been in and out because with good pain management, it -- and it was as well for me to be distracted by work occasionally.

THE CHAIRMAN: The point I'm getting to is this: the meeting didn't take place when you wanted it to because the relevant people could not attend at the same time.

A. Yes.
THE CHAIRMAN: It's then delayed by holidays. It's then delayed by your illness. Although you want to be there, you do not have to take the meeting; Dr Carson could take it, couldn't he?
A. Well, it was a distributed task. I, on his behalf, am the lead in this matter. I had dealt --
THE CHAIRMAN: That's the point: on his behalf. And if you are disabled, even on a comparatively short-term basis, from handling this meeting, then if the meeting is regarded as urgent and if it is regarded as important, then he can take it up. And if he doesn't take it up, then he can remind you of it, and if he doesn't remind you of it, then a number of the other people who are also contacted because the meeting is urgent and important, they can take it up. As I understand it, doctor, not only did you forget it -- for which you have put your hands up -- but nobody else who was on that list reminded you of it. Is it right that nobody else reminded you of it?
A. Chairman, I'm the one to take all the blame for this.
THE CHAIRMAN: On one level, that's very good of you. On another level, it's too much, particularly if you go back to the issue which you mentioned before the break. That part of the plan was to go to the inquest, see how

Dr Taylor's views stood up to scrutiny, see how the matter is dealt with there and see what the coroner's findings are. The coroner's findings do not accept Dr Taylor's theory, so whatever there is about the structure and progress of the renal transplant service, the coroner's finding highlights that there is now a judicial finding --

A. Yes.

THE CHAIRMAN: -- on Dr Taylor.

A. That's true.

THE CHAIRMAN: And nothing happened about that, sure it didn't.

A. No. Well, this was the next step, so to speak.

THE CHAIRMAN: This was to be what you described as a feedback seminar with all of those involved to review everything that had happened.

A. Yes.

THE CHAIRMAN: You see, when we were talking earlier on today about what the processes are, and you said about all the good work that Dr Taylor's done and the high regard he's held in and he doesn't just do what's required, he often goes beyond that and does more than what's required. And I was told earlier in this inquiry that in 1995 there was not a culture or practice of doctors reporting each other to the GMC, but employers

did; right?

A. Yes.

THE CHAIRMAN: You now have, on foot of the inquest finding, a confirmed concern about Dr Taylor over and above the view of Dr Sumner. And the inquest verdict has to be accepted by the Trust, I assume. You don't go behind the inquest verdict.

A. Other than look for a judicial review. That was not our intention.

THE CHAIRMAN: That didn't happen and the reason it was never going to happen was because the inquest verdict was based, to a considerable extent, on Dr Sumner's evidence.

A. Correct.

THE CHAIRMAN: Well, is that not the point where, unpleasant as it is and reluctant as anybody might be to do it, somebody has to say: if Dr Taylor does not accept the inquest verdict now, we have to make this formal?

A. Well, I, in my time up to 1995/1996, in the Royal, had no experience of anybody being referred. And usually --

THE CHAIRMAN: By the Royal?

A. By the Royal, or the Eastern Board or any unit in Northern Ireland in my experience. So there wasn't a culture of referral to the GMC.

THE CHAIRMAN: Doctor, how could that be? How could it

be -- this is in all your career?
A. No, no, only when I was in this job.
THE CHAIRMAN: So from 1987 to 1995, whether it was the Eastern Board or the Royal Trust, as it became --
A. I had no knowledge of anybody being referred from within the hospital service.
THE CHAIRMAN: When you said "or any unit in Northern Ireland", was that --
A. Within the hospital service --
THE CHAIRMAN: Right.
A. -- which is where I would be much more likely to hear about it.
THE CHAIRMAN: Exactly. So you're far more likely to hear of that than you are of, say, a GP being referred.
A. Yes.
THE CHAIRMAN: What you are saying is, from 1987, you're not aware of a single doctor being referred to the GMC by the Eastern Board, Western Board, Southern Board or Northern Board?
A. No, I wasn't.
THE CHAIRMAN: Nor by any of the trusts which were established in 1993?
A. And gossip was a great thing in those days.
THE CHAIRMAN: So you would have heard?
A. I think I should have or would have.

THE CHAIRMAN: You would certainly have heard if, for the first time in Northern Ireland since 1987, a doctor had been referred to the GMC by his employer.

A. Mm-hm, I stand to be corrected. Maybe I didn't get the information.

THE CHAIRMAN: Doctor, can you understand why that, whatever the opposite of reassurance is, that's the effect it has on me? It's not just that clinicians were not referring each other to the GMC, employers weren't referring their employees to the GMC. What does that say about the Health Service in Northern Ireland?

A. It's capable of two interpretations.

THE CHAIRMAN: Okay.

A. Either that there wasn't a culture or the standards are fairly good and didn't require that people be referred; is that not correct?

THE CHAIRMAN: Well, sorry.

A. My apologies, I know I shouldn't ask you questions. Apologies for that.

THE CHAIRMAN: It's not that the standards are fairly good, it's the standards are so universally good that there isn't a single doctor in the hospital service in Northern Ireland who has been required to be reported to the GMC. I would love to think that we live in a place -- that's unrealistic, isn't it?

A. I'm thinking about professional and clinical practice. There are other issues like alcohol.

THE CHAIRMAN: I understand that.

A. That's separate.

THE CHAIRMAN: Right.

A. But that requires referral and will be referred by the courts or the police or whoever. And that happened routinely. If a doctor was founding to be abusing drink or drugs and driving or whatever.

THE CHAIRMAN: But then --

A. -- he would be referred.

THE CHAIRMAN: By who?

A. I would think that that would have been on the regulation side.

MR FORTUNE: Sir, the last answer would bring about performance issues and that in themselves there should have been a referral. So I anticipate that the inquiry -- and you, sir, in particular -- will want an enquiry made of the General Medical Council. Statistics will be available, perhaps not at short notice, but I anticipate that you can be told the number of referrals and perhaps the general bracket of the type of referrals being made over those years.

THE CHAIRMAN: Thank you.

Dr Murnaghan, let us suppose that I don't accept

that our doctors are so good, so universally good that none of them has had performance issues requiring a referral. Your fallback position, or your second alternative, is that there wasn't a culture. Is that really the explanation here, that there was not the culture in Northern Ireland to report a doctor to the GMC, even where a child had died?

A. My impression -- and I can't say more than my impression. I can't say my direct knowledge because that would not have been an issue that I would have done directly anyway.

THE CHAIRMAN: But you would have heard. You were saying that --

A. It wasn't in my job description.

THE CHAIRMAN: Sorry, you said to me a few minutes ago: it's a small place and there's gossip. You were saying that in order to let me know that if there had been referrals, you would know about them. And now I'm coming back to you on that point and saying that my understanding of your evidence is that even where a child dies, or for that matter where an adult dies, employers in Northern Ireland did not report their clinical staff to the GMC --

A. If a child -- it depends on the circumstances.

THE CHAIRMAN: -- in circumstances where there was reason to

1 believe or a coroner's verdict to the effect that there
2 were performance issues.
3 A. Yes. But they would have been in a significant
4 minority. A very significant minority.
5 THE CHAIRMAN: I certainly hope so. But even in those
6 situations, even where you have a coroner -- this is
7 a rather crude simplification, but Adam's death was
8 significantly brought about by the failings of
9 Dr Taylor. Even that isn't enough to persuade the Royal
10 Trust to refer Dr Taylor to the GMC?
11 A. In my experience, in the job I was then doing, this was
12 unique. I didn't come across any other death which was
13 ever attributed to malperformance, malpractice, omission
14 or commission, and I dealt with all the inquests that
15 were ordered by Mr Leckey.
16 THE CHAIRMAN: Well, I'm spectacularly unlucky because I'm
17 chairing an inquiry which is looking at questions about
18 more than one death.
19 A. This is in the Royal now I'm talking about.
20 THE CHAIRMAN: Okay.
21 MS ANYADIKE-DANES: Mr Chairman, I don't have --
22 A. I beg your pardon, just to finish that off: in my
23 knowledge in the time I was there.
24 THE CHAIRMAN: Yes.
25 MS ANYADIKE-DANES: Mr Chairman, in the light of your own

question -- I don't have very many more questions, subject to counsel for the interested parties -- on this.

THE CHAIRMAN: Doctor, it's 5.05. I know it's been a long day for you, but if you can bear with us for a few more minutes, I think we can finish your evidence this evening rather than ask you to come back again tomorrow.

A. I'm grateful to you.

THE CHAIRMAN: Is that okay?

A. I'm grateful to you.

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

You said that your staff were quite good at trying to make arrangements such as you required for this seminar to actually happen.

A. I wasn't good enough in the way I described my staff. They were excellent.

Q. Yes. Are we to understand that all these people listed as those who you thought should attend, at least, this seminar -- forget what might happen thereafter -- were actually contacted?

A. Yes.

Q. The difficulty is that the evidence that we've received from Dr O'Connor and, I believe, Dr Mulholland is that they didn't know anything about this seminar.

A. Well, the only way I can support this is that this is

a file note and it's in the file. And it got there and was put there when I put it in on my return from the Coroner's Court. And I know that I would have discussed with senior members of my staff -- and I had six or seven at that time --

Q. Yes.

A. -- what my need was.

Q. Is it possible --

A. And there's no way, because they were excellent staff.

Q. I understand that. Is it possible that you wanted, in the way that you had wanted to await the outcome of the inquest, that you wanted to see what came out of the litigation, for example?

A. Oh no, not at all. Totally separate. I've already told you earlier on that I ...

Q. Was slightly schizophrenic about that?

A. I don't like the word "schizophrenic", but I dichotomised myself.

THE CHAIRMAN: If you were going to wait for the outcomes of the litigation, you wouldn't have put "ASAP" in your note?

A. Absolutely not. Thank you very much.

MS ANYADIKE-DANES: Sorry, I meant by that when you came back and it hadn't already been organised. But in any event --

A. No.

THE CHAIRMAN: You forgot?

A. I forgot.

MS ANYADIKE-DANES: Okay. Can we go on then to the settlement of the litigation? If we go to 060-016-031. It's a bit difficult to read in the middle where it's a bit smudgy and some part has been redacted. It's a letter from the Trust solicitors to you, dated 19 March. There's a discussion as to the settlement of it and the plaintiff's solicitors are prepared to enter into discussions. In the second paragraph it says:

"I believe, from a liability point of view, this case cannot be defended, and this is based largely upon the information given by one of the independent experts retained by HM Coroner at the inquest."

And then:

"Additionally, I believe that it would be unwise for the Trust to engage in litigation in this matter given the particularly tragic circumstances of the death and the opportunity for the exploration of any differences of opinion which might exist between a number of the attending physicians."

Did that mean, as at 19 March 1997, after the verdict, that there were still differences of view amongst the clinicians?

A. Yes.
Q. And does that mean that Dr Taylor still had a different view from Professor Savage, for example?
A. Dr Taylor's given evidence to this inquiry that he held on to that view until very recently.
Q. I'm asking you about your knowledge of these things.
A. That was my knowledge.
Q. So you knew he had a different view?
A. Yes, then and thereafter.
Q. And we have heard evidence from Dr Crean, Dr Gaston. All of them accepted the verdict, the inquest. So that means, does it not -- you tell us. Did you understand Dr Taylor to be isolated in his view?
A. I think I might need to go back just one pace --
Q. Mm-hm.
A. -- and say that Dr Taylor accepted that there was hyponatraemia --
Q. Yes.
A. -- but I don't think he accepted the qualifying word "dilutional".
Q. Well, Dr Murnaghan, if I may say, it's not that it's a qualifying word, it's a whole way in which the cerebral oedema had developed. And therefore, from the point of view of understanding the mechanism for the development of cerebral oedema, the fact that it was

considered to be dilutional hyponatraemia is a lesson to be learned.

A. I accept all that. But I'm coming to it from Dr Taylor's perspective. I'm not here as his advocate --

Q. Yes.

A. -- at all.

Q. But did you --

A. Therefore, I don't need to be reminded of the various issues that arose.

THE CHAIRMAN: I'm sorry, doctor, counsel's question to you was a response to your suggestion that the difference between dilutional hyponatraemia and hyponatraemia is somehow just a qualifying word, like "quiet" and "very quiet".

A. Oh no, no, it's much more serious than that, chairman.

THE CHAIRMAN: That's the point, it is much, much more serious than that, and if it's much, much more serious than that and Dr Taylor doesn't get it, that's a problem.

A. At that time.

THE CHAIRMAN: But in March 1997, you knew that these differences still continued, right? Did that not remind you about the seminar in July 1996 that had never taken place?

A. I regret that it did not. Time had marched on. I did not see that file again. I didn't see that note and ...

MS ANYADIKE-DANES: But what did you think you should do about the fact that you knew that Dr Taylor did not accept that as a mechanism of the development of Adam's cerebral oedema?

A. In effect, I didn't know what to do and I was depending on my anaesthetic colleagues.

Q. But they'd accepted the verdict.

A. Yes. But they didn't say that they needed to do something about Bob Taylor.

THE CHAIRMAN: Is that because, in effect, they were keeping an eye on him and he had reverted to his consistently good practice, so if everybody crossed their fingers, this wouldn't happen again?

A. I would hope they didn't need to cross their fingers, but this was a singular aberration that he would have learned from as well as everybody else.

THE CHAIRMAN: The trouble is, of course, he didn't. He didn't learn. I mean, if Dr Taylor had said at the time that this was a singular aberration, then this would be an entirely different inquiry.

A. But he didn't do anything -- he didn't cause dilutional hyponatraemia again.

THE CHAIRMAN: But he didn't accept that it was an

aberration. He didn't begin to accept it was an aberration until February 2012.

A. I accept that, I know.

THE CHAIRMAN: And he didn't accept the extent of his aberration until April 2012. If he had been a good doctor who made this awful mistake and then faced up to it, as doctors I'm sure do, and said, "This was awful, that will not happen again", that's a situation in which you might feel reassured. If, on the other hand, you have a doctor who doesn't recognise what he did wrong or is in denial about what he did wrong, you don't -- and in fact, more than that, is advancing alternative theories and explanations, then you have no reassurance that it won't happen again; isn't that right?

A. I agree.

THE CHAIRMAN: So what in effect happened was that, without reassurance that this wouldn't happen again, Dr Taylor continued to work as a paediatric anaesthetist. As it turns out to the best of the information that's available to us, it hasn't happened again, but that's not quite the way the system is supposed to work, either now or even in 1995. Would you agree?

A. He continued to give excellent anaesthetics and no problem arose. I know that there I'm bringing in the

retrospectoscope.

THE CHAIRMAN: That's exactly the problem because nobody could have known --

A. Exactly, I'm agreeing with you, chairman.

MS ANYADIKE-DANES: What happened, of course, is ultimately there is a settlement. Can we pull up 060-013-024? Apart from the legal advice that you received in relation to the appropriateness of settling it, there are two elements in this settlement. One is that it's to be without any omission of liability. The other is that it's to include a confidentiality clause. Who formed the view that both of those things were appropriate in this case?

A. The legal advice was that that's how it should be constructed.

Q. If it's going to have a confidentiality clause, then nobody would know whether there was any admission of liability. It's going to be in full and final settlement in any event; isn't that right?

A. Yes.

Q. Couldn't that have been something you could have offered to Adam's family, the recognition that we did make that mistake, we accept liability for it? Isn't that something that might have, even at that stage, at least given her something? Given that your legal advice,

of course, was that it could not be defended?
A. Well, the -- I worked on the basis of the legal advice that was given and that was standard practice at that time. And the purpose of the confidentiality clause was commonly for the protection of plaintiffs.
Q. Sorry? Protection of?
A. Commonly for the protection of successful plaintiffs.
Q. Did she want it?
A. I don't know and I don't remember. Because these negotiations were undertaken between her representatives and our representatives on the legal side.
Q. Well, did you have any report as to whether it was Adam's family who were seeking to have a confidentiality clause in their --
A. No, I didn't.
THE CHAIRMAN: In fact, the fact that you say it's standard practice, in effect, concedes that the standard practice is driven by the hospital. Because it is the hospital which is typically the defendant in this case and Debra Strain is not the plaintiff. So if there's a standard practice, isn't it coming from the defendant's side, not the plaintiff's?
A. My understanding is that it was standard practice in personal injury claims generally, not specifically in medical negligence.

MR SIMPSON: Mr Chairman, I wanted to let the witness answer that question before I did interject, but those of us who did clinical negligence in that period always put those terms in whether we were instructed to or not. I personally would never have allowed an admission of liability to go into a settlement for a professional man. I still do it for architects, for any professional man -- solicitors, anything like that. We do that as a matter of pure standard -- I doubt if the hospital was ever asked about it. It was done through the solicitors and counsel every single time. It was standard practice, sir, and it was not something that was adverted to in any particular way. The doctor's absolutely right: many times I was asked by plaintiff's counsel not to allow it to be anything other than confidential because they did not want the world to know what they took. So it was not articulated in the way that you are suggesting, sir, is what I want to get across.

THE CHAIRMAN: There are two points about that. First of all, you can have confidentiality about the amount of the payment as opposed to the fact that there was a settlement.

MR SIMPSON: You could, but that was not what was being done at the time. And I have to say in every case that I was

involved in -- and still am in cases which are not clinical negligence -- I still have confidentiality in there. I insist on that as a term when there's a professional person involved and never an admission of liability. You'll know that, sir, from your own practice, that that that was not done.

MS ANYADIKE-DANES: Dr Murnaghan, is the upshot of the thing that Adam's family was left with nobody, ostensibly, taking responsibility? No apology, nothing, until the first apology, I think, which may have come in these proceedings?

A. If one differentiates between sympathy, expression of sympathy and apology, I certainly remember that I offered sympathy on behalf of the Trust at the conclusion of the inquest because that was my standard practice.

Q. I understand that, Dr Murnaghan, I'm not suggesting that you wouldn't do that or that any clinician wouldn't do that. That is very different from an acceptance of responsibility for something having happened.

I think there's just one --

THE CHAIRMAN: Sorry, let me reinforce that point.

When you have a coroner's verdict, which is to the effect that it was the hospital's fault, do you see how it would aggravate the family that, despite that

verdict, the hospital doesn't accept responsibility and the hospital doesn't apologise?

A. I know exactly what you're saying, chairman, but it wasn't within my gift. I was the manager of the process.

THE CHAIRMAN: Okay.

A. And it was known that I had had no clinical input to Adam's care.

THE CHAIRMAN: We'll move on.

MS ANYADIKE-DANES: One last document, and the only reason I raise this with you, Dr Murnaghan, is because it is your document to all the clinicians who were involved, directly involved in the sense of having provided statements and so forth. They have all been taken to it, so I think it's only fair that you, as the author, are asked about it.

A. Thank you.

Q. There is a series of them to Mr Crean, to Dr Taylor, to Dr Savage, Dr Webb, Mr Brown. I think that's it. We find they're all in the same format. I pick one at 060-010-018, which are happens to be the one to Dr Taylor. There it is, 9 May:

"I am sure you will be pleased to be informed that this claim has been successfully concluded by payment of a sum which is not greater than the normal and statutory

scale, subject to the confidentiality clause binding on both parties. From a liability position, the case could not have been defended, particularly in the light of the information provided by one of the independent experts ... Additionally, it would have been unwise for the Trust to engage in litigation in a public forum given the tragic circumstances of the death. It would not have been helpful for an opportunity to be provided to lawyers to explore any differences of opinion, which might exist between various professional witnesses who would have been called to give evidence. I am grateful for your generous assistance in arriving at this successful conclusion."

What actually was the purpose of sending that letter to those clinicians?

A. It was winding-up the issue, a conclusion, informing them. They wouldn't have known otherwise that the claim had been settled. That is the purpose of it --

Q. It didn't have to --

A. -- and no other.

Q. It didn't have to provide the detail that you've provided in the second paragraph -- alert everybody to the fact there are those differences, alert everybody to the fact that the case could not be defended -- but nonetheless it's all going to be kept from publication,

those details, by virtue of the fact that the case is settled, so the evidence won't now be heard and there's a confidentiality clause so Adam's family aren't going to be in a position to tell anybody what happened. Why would you be providing that information to the clinicians?

A. With respect, chairman, that's a matter of opinion.

Q. Well, why would you be providing that information to the clinicians?

A. Because they were involved and they needed to know what had happened.

Q. What had happened?

A. It's a courtesy, if nothing else, to let them know the matter had been determined.

Q. When you say "winding-up", "a successful conclusion", that's the end of it, isn't it? There's going to be nothing like a seminar, nothing like an investigation to see how we got here and how we may perhaps avoid this in the future. That's the end of it.

A. I have already explained about what happened about the feedback session. I'm sorry again and again and again. This took longer to sort out and all I wanted to do was to ensure that each and everybody who had contributed to the information gathering and so forth was told that the file was now closed.

Q. Yes, that's exactly the point, Dr Murnaghan. The file is now closed. So irrespective of whether you had forgotten about the seminar or whatever it is, the opportunity to disseminate any lessons that might have been learned, that's going to be an end of it because we've now reached a successful conclusion. And one way of looking at it would be that the successful conclusion is we haven't had a coroner's recommendation.

We haven't had a contested litigation and we have achieved a settlement with a confidentiality clause. So that is the end of it.

A. Chairman, how many times do I have to say sorry? Because that's the only way I can answer counsel.

THE CHAIRMAN: Okay, thank you very much. Thank you.

MS ANYADIKE-DANES: It is just one final point arising out of that because the coroner's been asked about it.

The coroner believed that something more would happen. In fact, if we can pull up the coroner's evidence to the inquiry. It's witness statement 091/1, at page 2, and could you please pull up page 3 alongside it?

It's a short statement:

"My understanding was that, so far as the Royal Belfast Hospital for Sick Children was concerned, the hospital would learn from what happened to Adam. As far

as I can recall, no specific commitment was given in relation to the future fluid management of children. I sensed that not everyone agreed with the views of Dr Sumner."

So that was an issue that had to be addressed. And then he was asked about dissemination in question 2 and he says:

"The consensus was that there was no effective means of doing so other than through the medical literature and Dr Sumner mentioned that else the editor and he undertook to arrange for Professor Arieff ..."

And he's not sure that there was anything that could be assisted through the Chief Medical Officer. And we know that Dr Armour took it upon herself to publish. Then if we look to the second page:

"Other points."

So this is volunteered by the coroner:

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

And isn't that the point, that by not having some

sort of review, whether you call it your seminar or when you have concluded the settlement of the civil litigation, you didn't take up that possibility?

A. First of all, to take your last point, the medical negligence issue had no bearing whatsoever on the other file. That was dealt with on its own merits, pure and simple.

To come back to what the coroner believed and what our belief was and what I was lead to believe at that time was that this was an issue that had arisen within our knowledge in major surgery in sick children. And major surgery in sick children, only as far as I was advised, occurred on the Falls Road in the RBHSC.

Q. Dilutional hyponatraemia could occur in any surgery.

A. I accept that, but as I was advised at that time and, as this arose, in a complex procedure.

Q. I think the chairman has those points and I will just leave it with: if you had settled the litigation on terms of confidentiality, there was going to be no prospect of doing what the coroner has indicated there, the details of the evidence and so forth. That would never happen.

A. Of course it could. It could have been anonymised. No problem about that at all, chairman.

THE CHAIRMAN: Thank you. Are there any further questions?

No?

Doctor, thank you very much. It has been a long day and I'm grateful for you staying with us so late.

(The witness withdrew)

Ladies and gentlemen, we'll start at 10 o'clock tomorrow morning with Ms Duffin. Tomorrow will be a shorter day. On Wednesday, we have Dr Carson and Mr McKee. I mentioned on Friday last week that we'll try and get through their evidence in a single day. Some of the ground that we're going to go over with them has already been gone over, but we need their perspective on it. We'll do our best to finish on Wednesday, but if we don't, we'll finish on Thursday and that will be the end of this week. Thank you.

(5.30 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X

DR GEORGE MURNAGHAN (called) 1

Questions from MS ANYADIKE-DANES 1