

Monday, 25 June 2012

1

2 (10.00 am)

3 THE CHAIRMAN: Good morning.

4 MS ANYADIKE-DANES: Good morning, Mr Chairman. Could

5 I call, please, Dr George Murnaghan.

6 DR GEORGE MURNAGHAN (called)

7 Questions from MS ANYADIKE-DANES

8 MS ANYADIKE-DANES: Good morning, Dr Murnaghan.

9 A. Good morning.

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

13 A. I do.

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

16 A. Yes.

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

22 "Medical administration. Dr George Murnaghan."

23 Was that your title in 1995?

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

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

5    Q. I understand that.

6    A. And that is not the reporting line.

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

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

11   Q. So you didn't --

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

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

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

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

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

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

24   A. Technically yes, but really no.

25   Q. Which was the technically yes?

1 A. Insofar as he was the boss, if I may use that term. We  
2 worked together in the same building. I was only  
3 separated by a large room between my office and his  
4 office. He was on one corridor, I was on the other.

5 Q. Does that mean you informed him as opposed to, from  
6 a institutional point of view, you were reporting to  
7 him?

8 A. Yes, I would have kept him in the loop so to speak.

9 THE CHAIRMAN: How far away was Dr Carson's office?

10 A. Next door to the chief executive's, so fairly adjacent.

11 MS ANYADIKE-DANES: Why I was asking you about your titles  
12 is that when you produced your first witness statement  
13 for us, which if we can pull up the first page because  
14 that has the title there. It's 015/1, page 1. There  
15 you see it. If you see under "Present position and  
16 institution", it has "Director of Medical  
17 Administration, the Royal Hospitals Trust".

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

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

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

9 THE CHAIRMAN: Okay.

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

16 MS ANYADIKE-DANES: I understand.

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

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

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

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

8 A. No.

9 Q. You were doing the same thing?

10 A. Absolutely.

11 Q. But with a different title?

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

20 Q. I understand.

21 A. -- as time went on.

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

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

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

14 A. Yes.

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

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

17 Q. Sorry?

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

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

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

23 A. Yes.

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

1 A. Correct.

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

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

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

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

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

23 A. I think so.

24 THE CHAIRMAN: And then Dr Ian Carson took over.

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

1 the best I can do from memory.

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

6 A. Exactly.

7 THE CHAIRMAN: Okay, thank you.

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

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

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

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

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

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

25 A. Yes.



1 Q. All right. If we then pull up your CV, 306-077-002. If  
2 you look under your key responsibilities, I understand  
3 that you've told the chairman that these are the  
4 responsibilities that span the period 1987 to 1998, but  
5 some of them may have developed or had added  
6 significance at different points in time.

7 A. That's correct.

8 Q. So then if we look at "coordination of medical audit",  
9 what did that mean?

10 A. Well, I know that medical/clinical -- because one  
11 developed into the other.

12 Q. Although they are different, aren't they?

13 A. They are because one involves medical personnel only and  
14 the other involves paramedics, to use shorthand again --

15 THE CHAIRMAN: Yes.

16 A. -- not to diminish the professions supplementary to  
17 medicine -- and nursing staff and others, as  
18 appropriate.

19 MS ANYADIKE-DANES: So clinical is much broader?

20 A. Absolutely, yes. And it looks at wherever relevant, all  
21 the things that go towards patient care and management.

22 Q. I understand. So what did it mean that you were  
23 a coordinator of medical audit?

24 A. The department, in its wisdom, when it decreed that  
25 clinical audit should develop -- and I have used

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

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

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

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

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

25 A. That's right.

1 Q. From whom and in what way?

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

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

7 THE CHAIRMAN: Please do that.

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

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

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

3 MS ANYADIKE-DANES: I understand.

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

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

21 A. Yes.

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

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

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

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

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

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

4 Q. Yes.

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

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

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

1 freedom.

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

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

6 A. It is, yes, but --

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

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

15 THE CHAIRMAN: Exactly.

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

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

22 A. Exactly, yes.

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

1 A. At that time.

2 THE CHAIRMAN: Thank you.

3 MS ANYADIKE-DANES: I recognise that I'm asking you to  
4 recall things over a very long period of time and things  
5 that changed and maybe changed gradually without any  
6 clear benchmarks to it, so it might be quite difficult  
7 to help us with exactly what was going on at any precise  
8 period of time. I may be able to help you with some of  
9 the documents that we've had that refer to this audit  
10 process and its development. If we go back a report to  
11 1993/1994 and I take you to 61/2 at page 58.

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

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

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

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



1 education."

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

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

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

20 A. Chairman, I'm amazed at this wonderful language here.

21 I don't have direct memory of composing all of this, but  
22 I must have had some hand in it, because it was under my  
23 remit, so to speak. Medical audit, as I've already  
24 explained, was in place in several directorates and for  
25 quite some time. Clinical audit, which I have explained

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

4 I can't particularly pick out one from another.

5 Q. I understand.

6 A. Nor do I want to.

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

10 A. As one does.

11 THE CHAIRMAN: In the way that reports do?

12 A. Yes, in the way one does.

13 MS ANYADIKE-DANES: Just to round that off, there's the HPSS  
14 management plan for 1995/1996 and going forward. The  
15 part of that that I would like to pull up is  
16 306-083-017. Then you will see just to the top  
17 right-hand side:

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

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

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

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

1 quality, not just clinical outcomes".

2 And then --

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

5 MS ANYADIKE-DANES: Yes.

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

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

10 A. What year is this?

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

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

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

23 A. Qualified by, chairman, resource constraints.

24 Q. Yes.

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

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

2   Q.   I understand.

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

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

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

20  MS ANYADIKE-DANES:  Yes.

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

1           that I held.

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

4   A.  Exactly, and robbing Peter to pay Paul and whatever.

5           And one was required to bring in a zero bottom line.

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

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

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

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

10 Q. So --

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

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

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

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

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

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

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

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

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

1 A. That, Chairman, is a wordy bullet point. It encompasses  
2 a whole lot, but there wasn't very much of it.

3 Q. Right.

4 A. Investigations and discipline --

5 Q. Yes.

6 A. -- arose -- investigations, yes, occasionally. And they  
7 could be of various things. If supervising clinician  
8 and/or directorates, as they evolved, weren't able to  
9 sort things out, they would occasionally come to me or  
10 the medical directorate, Dr Carson, and say, "Well,  
11 we have a problem here". It could be about timekeeping,  
12 it could be about attitude or it could be -- although  
13 I don't think it ever happened that somebody exceeded  
14 their authority and did something that they weren't  
15 competent to do in a clinical sense.

16 Q. That would be included as well?

17 A. It would, but I wouldn't have had primacy in all these  
18 matters.

19 Q. Before we get to that, Dr Murnaghan, were there audits  
20 of clinical competence that would come to you as part  
21 and parcel of this responsibility?

22 A. Chairman, in a word, I'd have to say no because that was  
23 something that developed after I left.

24 Q. I understand.

25 THE CHAIRMAN: Sorry, when did you leave, doctor?



1 A. 1998.

2 THE CHAIRMAN: Thank you.

3 A. June or July 1998.

4 MS ANYADIKE-DANES: Then when you say that if there was  
5 an issue with a medical colleague -- well, did you deal  
6 with nurses as well?

7 A. No.

8 Q. That would be the nursing director?

9 A. Yes, that was a totally different line. One would never  
10 stray.

11 Q. So if there was an issue, and I think you put it that  
12 the senior colleagues, perhaps in that directorate,  
13 couldn't resolve themselves, they might come to you or  
14 they might come to Dr Carson; I think that is what you  
15 were saying. Did you operate a system or were you aware  
16 of a system called the "three wise men"?

17 A. In a nebulous sort of way.

18 Q. Can you help us with that?

19 A. That's the best way I can describe it. I never had to  
20 involve that process. I know it was there somewhere.  
21 It's like cloud computing, I don't understand it.  
22 I know it's there, but I don't understand it. I used  
23 a bad analogy, but ...

24 THE CHAIRMAN: Was it an active concept in the Royal?

25 A. No, no. There were informal contacts, certainly.

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

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

17 Q. Yes, you're absolutely right about that. Just to help,  
18 we have that document, at least one of them, at  
19 306-091-001. It's actually a circular. So far as we've  
20 been able to research it, it really seemed to try to  
21 deal with colleagues, where there was some concern  
22 about -- you can see it under "General" -- their  
23 physical or mental ability. Perhaps there was an  
24 addiction problem or something of that sort which was  
25 affecting their way. And there's a way -- an

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

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

9 Q. I understand. I was --

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

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

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

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

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

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

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

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

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

9    Q. Well --

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

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

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

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

1 to resolving matters?

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

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

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

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

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

6   THE CHAIRMAN: Right.

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

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

10   A. But the process did work.

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

14   A. Of course.

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

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

1 properly because one has no other choice.

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

11 A. Of course, yes.

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

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

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

23 A. I can give you a particular example from my own  
24 specialty, but it didn't happen on the Royal site.  
25 A colleague was doing a major operative procedure

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

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

8 A. Yes.

9 THE CHAIRMAN: Okay.

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

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



1           was generally a good doctor?

2    A.   Yes.

3    THE CHAIRMAN:   Right.   So -- it's like me going to do a case  
4           in an area of law I know nothing about and going all  
5           wrong, except it's rather more serious when things go  
6           wrong with a doctor.

7    A.   It's like me going into commercial law, which I know  
8           nothing about.

9    THE CHAIRMAN:   So that's a doctor who's ended up, for  
10           whatever reason, straying outside his area of  
11           competence?

12   A.   Exactly.

13   THE CHAIRMAN:   What about a situation where you have an  
14           otherwise good doctor who is working within his area of  
15           competence and something goes wrong, which looks like  
16           it is his fault?  Can you give us an example, outside  
17           Adam's case, of how that had been dealt with in the  
18           past?

19   A.   Well, you know, chairman, I think, that I was  
20           responsible for litigation management on the Royal  
21           site --

22   THE CHAIRMAN:   Yes.

23   A.   -- and, therefore, things came regularly to my  
24           attention.  Yes, I see here that when this CV was  
25           composed, there was a £10 million reserve on the claims

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

8 THE CHAIRMAN: Mm-hm.

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

20 THE CHAIRMAN: Yes.

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

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

3   THE CHAIRMAN:   And that wasn't picked up?

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

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

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

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

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

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

10   A. Yes, of course.

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

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

17   THE CHAIRMAN: We'll come on to that.

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

20   THE CHAIRMAN: Yes.

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

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

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

5   A. I agree.

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

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

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

24   A. Exactly, exactly.

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

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

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

16 A. It does.

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

20 A. Of course.

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

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

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

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

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

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

1 A. Chairman, I know that you have heard about risk  
2 management and how it was evolving over recent days.

3 Q. Yes.

4 A. And that it was only recently invented, so to speak.  
5 And it had arrived in Northern Ireland and trickled down  
6 to the Royal. Among other things, I was regarded as the  
7 person who was to organise, through clinical audit as  
8 much as anything else, how to control risk. Now, there  
9 were risks in all sorts of ways identified in various  
10 ways. The Control of Substances Hazardous to Health,  
11 COSHH, for instance. Medicines administration, for  
12 instance. The simple changes required. And they still  
13 don't happen of -- the prescriber writing (a) the proper  
14 name of the drug, (b) writing it in capital letters, (c)  
15 signing his name and then either putting his name in  
16 capitals or an identifier such as a bleep number. One  
17 looks on a daily basis if one deals with charts, as  
18 I sometimes do, at drug kardexes. And there's risk  
19 there all the time and one hears about patients getting  
20 the wrong drug or the wrong dose of the drug. That's  
21 risk management, as I understand it, and how one deals  
22 with that and how one has to keep coming back to it and  
23 back to it and back to it. And it's a matter of  
24 attrition sometimes, unfortunately.

25 Q. Yes. Doctor, you have actually raised a very



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

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

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

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

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

25 A. An example, if I may, chairman?

1 Q. Yes.

2 A. There are certain types of obstetric forceps that  
3 doctors in training should not use, but they're there  
4 in the press or they're there in a pack, and there's the  
5 possibility of them using -- but they shouldn't use  
6 them.

7 Q. So that would be one of the set of risks that goes with  
8 that particular directorate?

9 A. Correct.

10 Q. Then is part of what you're doing establishing a system  
11 for monitoring the incidence of those risks actually  
12 occurring and then how you will address them to reduce  
13 that incidence? Is that part of what you would do?

14 A. Exactly, what the variances were and by whom and for  
15 what.

16 Q. If you might assist us with the particular document I'm  
17 going to show you, one of the things I want to ask you  
18 is whether that process really started with health and  
19 safety, which was pretty well identified as a risk --  
20 slips and trips and sharps and that sort of thing -- and  
21 then moved on to the more clinical areas where you're  
22 talking about the sort of thing that you've mentioned in  
23 your own experience, obs and gynae, somebody straying  
24 outside their competence into a procedure that they  
25 really didn't have the skills to deal with.

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

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

5   Q. Yes. Shall we take a break?

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

7   Q. Of course. (Pause).

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

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

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

19   A. Yes.

20   Q. So at the moment, though, we have this document that  
21          spans these five years and what we are not terribly  
22          clear on is which bit relates more to the 1993 end, if I  
23          can put it that way, and which bit relates more to the  
24          1998 end. If I just turn the next page, which will show  
25          you the table of contents so that -- do you recall

1           seeing this document? That should be my first question.

2   A. There are so many documents.

3   Q. I'm sure there are.

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

6   Q. I understand that.

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

8   Q. Right.

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

12   Q. I understand that. If we go to 258, there you see:  
13       "The Trust board has the ultimate responsibility to  
14       ensure compliance in the Trust's undertakings."  
15       Then:  
16       "The Hospital Council is responsible for the  
17       implementation of the Trust board's health and safety  
18       policy."  
19       And you can see the various elements that the  
20       Hospital Council is to do:  
21       "Ensure that the organisational arrangements  
22       contained within this policy are implemented."  
23       Then if one goes down to (f):  
24       "Ensure that the managers within the Trust  
25       understand and are competent to undertake their

1 responsibilities in relation to health and safety  
2 legislation."

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

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

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

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

16 Q. Yes.

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

1 Q. That's actually why I wanted to pull up the next page  
2 because I thought that might help you. If we pull up  
3 259, you will see that there's a Risk Management  
4 Standing Committee and the composition of it. We have  
5 the Medical Director, then we have you as the Director  
6 of Risk and Litigation Management and then you also have  
7 the Director of Occupational Health and Environment.  
8 A number of others as well, of course, but these are all  
9 the people that were thought to be part of this process  
10 of instituting some programme to manage these risks for  
11 the Trust.

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

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

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

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

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

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

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

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

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

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

1 reporting (clinical)".

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

10 Can you help us with whether this was the case in  
11 1995, what is described here?

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

14 Q. No, I understand.

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

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

25 "Untoward incident reporting (clinical)."



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

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

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

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

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

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

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

17 So, yes, they are going to be making sure that their  
18 own clinicians within their particular directorate know  
19 what they're doing in relation to managing risk, but  
20 ultimately it comes up to you, as the Director of Risk  
21 Litigation and Management, and the Trust Health and  
22 Safety Manager, to ensure that they are assessing those  
23 matters appropriately because the responsibility to make  
24 sure that risk is being properly managed is yours and  
25 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

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

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

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

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

25 Q. Yes.

1 A. And by doing that, I knew exactly what was going on.  
2 I won't say I gave direction, but I assured myself that  
3 things were happening as they needed to. I wasn't on  
4 them all.

5 Q. I understand that.

6 A. But the reps H and S group, for instance, I wasn't on.

7 Q. If we look at it from the level of directorates, part of  
8 what you had to do is make sure the clinicians within  
9 the directorates were appropriately trained, they were  
10 managing their risk and so on and so forth and that you  
11 were there to assist with that process, to make sure  
12 that that happened?

13 A. And particularly, if I may interrupt, chairman, through  
14 Mr Orchin.

15 Q. I understand that. So then there is a concern, a matter  
16 is flagged, which gives rise to a risk. Does that come  
17 from the director of the directorate to you or from the  
18 medical director to you? How does that work?

19 A. Most of these wouldn't have come in that way at all.  
20 They'd have come with a knock on my door.

21 Q. I appreciate that.

22 A. The informal route, but it was very formal informal.

23 Q. Yes. Do I understand you to be saying, though, that  
24 there is a route, whether it comes from the clinical  
25 director or the medical director, they are telling you

1 about these risk issues?

2 A. Yes.

3 Q. Right. So even though your reporting line for other  
4 matters may be to the medical director, when one is  
5 getting into these risk management points, because of  
6 your particular position, those risk issues are coming  
7 to you?

8 A. But I would have always involved the medical director  
9 when appropriate. Always.

10 Q. When appropriate, I understand.

11 A. We had a very good working relationship. He talked to  
12 me about things and I would talk to him. And that would  
13 have happened, if either of us were around, on a daily  
14 basis.

15 Q. I'm sure that's so. And when you are now reporting up  
16 about risk, who do you report directly to? Do you  
17 report directly to the Chief Executive or do you report  
18 to the Hospital Council and up it goes and finds its way  
19 to the Chief Executive? In practical terms, what  
20 happened?

21 A. In relation to this diagram -- and diagrams are never  
22 perfect.

23 Q. Yes, I understand.

24 A. There would have been a place on the Hospital Council  
25 agenda for a report.

1 Q. And that's --

2 A. A short form report. And that was my responsibility.

3 THE CHAIRMAN: That's a health and safety report to the  
4 Hospital Council?

5 A. Yes.

6 MS ANYADIKE-DANES: In that way, would the Chief Executive,  
7 who chaired that council, learn about that, even if you  
8 hadn't told him about it informally, he would formally  
9 learn about it?

10 A. Yes. And very occasionally, he might have required me  
11 to report on it to the Trust board.

12 Q. Yes.

13 A. I can't remember an example, but I'm sure I did.

14 Q. Yes. Then just one final point and I'm conscious of the  
15 time, in this document, and I ask it because of  
16 something you said in one of your witness statements.  
17 Can we go to page 277? If you look under the "Defect  
18 and investigation centre (adverse reporting)", the first  
19 paragraph says:

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

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



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

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

14        A. I should have known about it.

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

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

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

21        (11.33 am)

22                                (A short break)

23        (11.55 am)

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

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

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

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

25          The boxes simply have to be searched through for

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

10 THE CHAIRMAN: Or trust management.

11 MR SIMPSON: Or Trust management.

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

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

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

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

25 The importance of that is that, between DLS staff

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

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

15 THE CHAIRMAN: Yes.

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

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

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

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

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

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

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

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

16 MR SIMPSON: I certainly accept that, Mr Chairman.

17 THE CHAIRMAN: Thank you. Mr Uberoi?

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

1 THE CHAIRMAN: Can I ask, have you seen the documents yet?

2 MR UBEROI: They've been passed to me in the break.

3 THE CHAIRMAN: We'll go on with Dr Murnaghan until

4 lunchtime. Is Dr Taylor available to you today or not?

5 MR UBEROI: I don't know. The suggestion is he should be

6 here at lunchtime and we can make enquiries as to how

7 quickly we can get in contact with our client. I would

8 say, if I may, at an absolute longstop, if we were to

9 notify you of our position by first thing tomorrow

10 morning -- I would hope it would be by the end of

11 today -- but this is the first I've heard of the issue

12 and I would like the opportunity to take proper

13 instructions.

14 THE CHAIRMAN: Okay.

15 MR FORTUNE: Sir, putting aside the jokes of leading counsel

16 for the inquiry for the moment, I'm just wondering

17 whether the documents that have been disclosed to my

18 learned friend Mr Uberoi might not have some effect or

19 impact upon Professor Savage? Bearing in mind I was

20 trying to mention or elucidate what appears to be

21 a clear conflict of interest within the Trust as to the

22 representation by the solicitor taking instructions from

23 both Professor Savage and Dr Taylor, knowing that there

24 were two discrete accounts. I don't know how my learned

25 friend Mr Uberoi will be able to deal with that matter

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

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

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

18  THE CHAIRMAN:  Okay, thank you very much.

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



1           this has been raised with you?

2   MR SIMPSON:   Yes.

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

12          Do you have any observation on this?

13   MR SIMPSON:   Only from my own experience, which is,  
14          certainly at that time and before the recent changes in  
15          coronial procedure here, I find it very difficult to  
16          recall a case in which a doctor was separately  
17          represented as an inquisitorial type of hearing such as  
18          a coroner's inquest in 1995 and certainly into the  
19          2000s, but I will make enquiries --

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

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

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

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

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

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

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

23           My learned friend is right, the change after the  
24           1998 Act came into force changed the way in which  
25           coroners' inquests were carried out in this jurisdiction

1           considerably and it was fundamentally different in 1996.

2   THE CHAIRMAN:   Okay.   Thank you very much.

3   MR UBEROI:   Sir, can I raise a point about legally

4           privileged documents in response to an observation made

5           by my learned friend Mr Fortune.   And I hope this is

6           debate or a discussion we end up not needing to have at

7           all, so it may be entirely otiose.   I don't know off the

8           top of my head the definitive answer to the question,

9           but there is a question mark in my head about the true

10          position about the inquiry's rights with regard to

11          legally privileged documentation where legal privilege

12          is asserted, given that legal privilege is a protection

13          afforded under the Inquiry Act.   I don't know

14          the definitive answer on these documents and it may be

15          an argument we don't end up having or it may end up

16          being a submission I don't end up making as it were.

17   THE CHAIRMAN:   First of all, you'll remember this is not an

18          inquiry under the Inquiry Act, but the statutory powers

19          which I have do not allow me to compel the production of

20          a document which could be withheld on any one of the

21          recognised grounds in ordinary litigation.   So if it is

22          a privileged document, I cannot compel the party who

23          enjoys the privilege to produce it.

24   MR UBEROI:   Yes.

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

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

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

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

18 MS ANYADIKE-DANES: Thank you very much.

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

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

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

15 Q. Right.

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

1 depended, to a large extent, on my memory.

2 Q. Well, yes. I accept you say that except -- and  
3 I understood you to say that the documents sometimes  
4 make things appear a little more formal than they were.  
5 But if we look at just page 266 for example -- sorry,  
6 061/2, page 266. These are the responsibilities. If  
7 you look at those ascribed to you as Director of Risk  
8 and Litigation Management, you had the responsibility,  
9 as we've already discussed, for coordinating and  
10 monitoring the health and safety activities throughout  
11 the Trust area. You had to report to the  
12 Chief Executive, Risk Management Steering Group and the  
13 Trust Health and Safety all matters relating to health  
14 and safety and report also to these committees on the  
15 activities of the Clinical Risk Management as they  
16 affect health and safety.

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

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

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

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

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

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

24 A. No.

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

1 a risk management issue, would you not see that?

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

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

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

9 Q. Yes.

10 A. -- and I would find out.

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

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

22 THE CHAIRMAN: Okay. We've got it.

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



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

3 A. It does.

4 Q. Thank you. I wanted to ask you then about -- I'm not  
5 going to go into it overly in detail. I simply want to  
6 ask about the structure for it. We have had evidence  
7 from Professor Savage that he came to the view, at some  
8 point round about the late 1980s -- certainly before  
9 1990 -- that the paediatric renal transplant programme,  
10 which was being carried out on the Belfast City Hospital  
11 site should be extended to offer renal transplants to  
12 younger children and that those younger children should  
13 have their transplants carried out in the Children's  
14 Hospital because it was inappropriate that their  
15 transplants should be carried out in an adult setting,  
16 if I can put it that way. So that has been his evidence  
17 to the inquiry.

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

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

25 A. Yes.

1 Q. Yes. What sort of structures were put in place to  
2 monitor the risks that might be associated with that?

3 A. Simple answer: none. Because I didn't know anything  
4 about it.

5 Q. You didn't know --

6 A. I didn't know anything about this particular aspect of  
7 the service.

8 Q. When was the first time, Dr Murnaghan, that you  
9 appreciated that this service was now being carried out  
10 or offered from the Children's Hospital?

11 A. I think it was -- I'm nearly certain it was when I was  
12 told about the regrettable and unfortunate death of  
13 Adam.

14 Q. So you, as the Director of Risk and Litigation  
15 Management, charged with implementing a risk management  
16 programme and trying to manage that aspect of matters  
17 for the Trust, didn't appreciate at all that those  
18 procedures were being carried out in the Children's  
19 Hospital until that time?

20 A. That is correct, as far as I can remember.

21 Q. Had --

22 A. Let me explain, if I may, chairman. You know yourself  
23 the Royal site is a big, big place, and there were  
24 several islands on the Royal site and the Royal Belfast  
25 Hospital For Sick Children was one of those islands. So

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

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

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

1           this.

2   THE CHAIRMAN:   So it would go to paediatrics?

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

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

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

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

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

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

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

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

9    A.    If I had known about it --

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

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

15   A.    Exactly.

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

18   A.    Yes.

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

24   A.    And the medical director, chairman.

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

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

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

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

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

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

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

19 THE CHAIRMAN: Right.

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

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

1           went ahead?

2    A.   No.

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

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

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

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

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

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



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

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

14 A. Not necessarily at that time.

15 Q. Okay.

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

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

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

1 potentially for the patient also. So we've been  
2 provided with a letter. Let me pull it up for you.  
3 305-002-003. If we can pull up the second page just so  
4 that you can see who it's from. That'll be 004. So  
5 that's from the chief executive. And what this letter  
6 is doing is providing a guide on consent.

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

9 "Health and Social Services boards and trusts are  
10 asked to ensure that procedures are put in place to  
11 assure that consent is obtained along the lines set out  
12 in the handbook and to introduce revised documentation  
13 (preferably based on the new model consent forms) with  
14 adequate monitoring arrangements."

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

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

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

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

24 Q. Sorry?

25 A. Isn't that after the transplant?

1 THE CHAIRMAN: No, Adam was treated on 27 November.

2 A. Ah. So it's a month afterwards.

3 THE CHAIRMAN: Yes. This comes in on 6 October, Adam is  
4 treated on 27 November, and the Trust is asked to  
5 confirm by 31 December that this had been done. So on  
6 that reading, Dr Murnaghan, there's effectively  
7 a three-month period for the Trust to implement this  
8 directive and to confirm to the management executive  
9 that it has done so. But we're looking at it from two  
10 perspectives: one is -- and I think you'll be asked  
11 about this in a moment or two -- what steps, that you're  
12 aware, of were taken within the Royal to implement  
13 this -- not just a new patient consent form, but the  
14 whole new developed thinking which came with it. And  
15 that's one point.

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

21 A. Well, chairman, the circular would have arrived,  
22 addressed to the chief executive or general manager.

23 MS ANYADIKE-DANES: Yes.

24 A. That would have gone to his office.

25 Q. Mm-hm.

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

4 Q. Yes.

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

8 Q. Including yours?

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

10 Q. I understand.

11 A. For information, not for action.

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

15 A. Yes.

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

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

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

1 A. Yes.

2 THE CHAIRMAN: Right. And then if you look at the  
3 right-hand page below Mr Hunter's signature, it also  
4 goes to all GPs, all dentists. What does the third term  
5 "unit general managers" mean?

6 A. Well, departments where -- facilities were divided into  
7 units and we didn't have that in the Royal. There were  
8 no units. There may have been in other healthcare  
9 facilities.

10 THE CHAIRMAN: Okay.

11 A. I would be guessing if I suggested one especially rather  
12 than another.

13 THE CHAIRMAN: Okay. Then we'll move on down a bit. It  
14 goes to the secretary of the BMA Northern Ireland  
15 branch. So that's presumably for the BMA to circulate.

16 A. For information, yes. And possible discussion at their  
17 board meetings or whatever. All the rest there, I would  
18 think, is for information.

19 THE CHAIRMAN: Okay, thank you.

20 MS ANYADIKE-DANES: So it would have come to you for  
21 information?

22 A. Yes.

23 Q. Would you have been part of monitoring the extent to  
24 which this is being implemented and followed in your  
25 role as risk manager?

1 A. Directly, if I had been given an instruction from the  
2 chief executive's office to do it, yes, I would.

3 Q. Other than that?

4 A. Other than that, no, not at that time.

5 Q. At which point would you?

6 A. Because the cascade would have been the appropriate way  
7 to deal with that.

8 Q. Yes. At which stage would you have started to look at  
9 the implementation of this from a risk management point  
10 of view?

11 A. It would have come up for discussion at one of those  
12 committee meetings that you showed there and there have  
13 would have been encouragement from me to colleagues to  
14 act upon it and perhaps to remember that there was  
15 a return date.

16 Q. Yes. And would you be monitoring the extent to which it  
17 was being complied with?

18 A. If I would been required so to do.

19 Q. But even if you hadn't been required to do, given that  
20 it is something that could give rise to risk for the  
21 Trust, would you be monitoring it on that basis?

22 A. Not at that time; I had so many other things going on.

23 Q. I'm sure that's true. At which point would you start to  
24 look at the question of consent from a risk management  
25 point of view?

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

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

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

1           this form printed and properly used?"

2   Q.   So the effect of that is if you're -- for whatever

3           reason, constraint of resources and so forth -- are

4           essentially reacting to these things and using them as

5           learning points, that means that your risk management

6           programme is not operating to prevent something because

7           that thing will happen, come to you and you may

8           develop -- if you can do it -- some procedures arising

9           out of it.  Would that be a fair characterisation?

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

11          to improve.

12  THE CHAIRMAN:  As I understand it, what you're describing is

13          in this area, at least, your role is reactive.  But when

14          people came to knock on your door, surely at some point

15          they might have said to you rather than referring back

16          to an incident which had happened, "Look, doctor,

17          if we don't do this or we don't do that, something might

18          go wrong".  So the knock on your door could be proactive

19          rather than reactive, could it not?

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

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

22  A.   Yes.

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

24  A.   Yes.

25  THE CHAIRMAN:  Okay.



1 A. And that was part of the development of the process.

2 MS ANYADIKE-DANES: I understand. This was dealing, as the  
3 chairman has said, with a new way or approach to  
4 consent, communications with parents and their families  
5 and so forth. Were you aware of the consent regime  
6 before this was introduced? Just to help you, if you  
7 look at the second page --

8 THE CHAIRMAN: I think Dr Murnaghan must have been since  
9 he was a consultant in obs and gynae for a number of  
10 years.

11 MS ANYADIKE-DANES: Ah. Well, what was that regime?

12 A. Well, again, it was incremental, it was usually the  
13 lowest common denominator.

14 Q. What does that mean, sorry?

15 A. It means that a house doctor obtaining consent. And it  
16 was signed there and there was a witness signature by  
17 the doctor and that was it having filled in the form,  
18 but there was no real information imparted. There are  
19 various factors of information that needed to be  
20 imparted. I'm going back several years when I describe  
21 this.

22 THE CHAIRMAN: Yes.

23 MS ANYADIKE-DANES: Yes.

24 A. The medical defence organisations over the years  
25 published regularly, giving advice to their members,

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

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

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

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

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

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

1 A. The only thing I was aware of was a consent booklet.

2 Q. I understand.

3 A. And there was a copy kept of the consent in this

4 booklet.

5 Q. Yes. Were you aware of whether the confirmation to be

6 given to Mr Lunn in the General Hospitals Policy Branch

7 actually happened from the Trust? Were you aware of

8 that?

9 A. No, I was not.

10 Q. Were you aware of when the old forms were replaced by

11 the new specimens? I can pull one up in case that helps

12 you remember.

13 MR FORTUNE: Before my learned friend does that and we leave

14 this document, could we find out from Dr Murnaghan when

15 he first saw this document? And thereafter ask

16 Dr Murnaghan who was supposed to confirm that the

17 document had been cascaded down through the hospital?

18 MS ANYADIKE-DANES: Yes. Well, the first one is obvious.

19 When did you first see it?

20 A. Unless I saw the copy that came to my department and

21 I could see my initials on it, I'm afraid I can't tell

22 you.

23 Q. On the other side, you described it cascading down to

24 the various directorates.

25 A. Yes.

1 Q. Was your understanding -- and please say if you can't  
2 help -- that it would be for the various heads of  
3 directorates to go up the chain to say, "We've received  
4 it, this is what we've done in relation to it", or some  
5 sort of confirmation that they have addressed the  
6 matter; is that how you think it would have worked?

7 A. One or other of the troika in each directorate would  
8 have been charged. I use that word "troika", you  
9 understand who I'm talking about, clinical director,  
10 nurse manager, business manager. One or other or all of  
11 them would have been charged with closing the loop.

12 Q. And so far as you understand it, would the introduction  
13 of something new like this have been associated with  
14 a certain amount of training for people at a directorate  
15 by directorate level?

16 A. Yes, but I think most of it was self-evident or should  
17 have been.

18 THE CHAIRMAN: It would be self-evident to people who had  
19 good practices and who had received good training. The  
20 problem is of course that it would not be self-evident  
21 to people who were a bit sloppy around the edges or not  
22 very careful or who hadn't had good training. The  
23 purpose of this, as I understand it, is to set out in  
24 written form what is now regarded as good practice to  
25 make sure that it is followed universally; does that all

1           seem right to you?

2    A.   It does, of course.  You're now dealing with 200  
3           consultants and 400 non-consultant, medical staff on the  
4           Royal site.

5    THE CHAIRMAN:  Yes.

6    A.   And I am not sure that any -- each or any directorate  
7           would have copied that within their own directorate to  
8           their own medical staff.  It probably would have come up  
9           for mention at a directorate meeting, but what happened  
10          after that, I would only be speculating.

11   MS ANYADIKE-DANES:  I understand that.  When we were looking  
12          previously at that document, if you remember, the  
13          document that started in 1993 and was revised up to  
14          1998.  When we were looking at that document, I took you  
15          to a part where part of what you had to do was to ensure  
16          that there was sufficient training for people on risk  
17          management issues.  That was supposed to happen at  
18          directorate level, but you were there to assist with  
19          devising training.  Do I understand you to be saying to  
20          the chairman that this is the sort of thing that could  
21          receive training at directorate level?

22   A.   Yes, it could, but from whom it would be provided --  
23          maybe a medical records person would have that type of  
24          knowledge, if they had one available to them.

25   Q.   Thank you.  I was just going to take you to the new

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

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

13 Can you remember when that form came into use?

14 A. No.

15 Q. Do you remember it?

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

21 Q. Yes.

22 A. Probably.

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

24 A. I hope so.

25 Q. I understand.

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

5 A. I'm not.

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

8 A. Yes.

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

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

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

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

21 THE CHAIRMAN: Yes.

22 MS ANYADIKE-DANES: I understand.

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

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

5 A. I will apologise to --

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

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

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

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

19 Q. Ah.

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

24 Q. I understand.

25 A. -- as part of the learning exercise.



1 Q. Yes. Then finally --

2 A. Is that helpful?

3 Q. Yes, it is helpful. I wonder if we could pull up  
4 210-003-003. This is a report, part of the report from  
5 the inquiry's expert, Mr Ramsden, I believe. The point  
6 I want to take you to is clinical pathology  
7 accreditation, which I think is in there. It's what I'm  
8 looking for at the moment.

9 I beg your pardon, I may not have got the right page  
10 reference. I will come back to that matter later on.  
11 My apologies for that, although you may be able to help  
12 us in the absence of it. The laboratory service is  
13 obviously an important one for surgery and also is an  
14 area for risk also, as is radiology. Were you in your  
15 role as risk management or dealing with risk management,  
16 did you deal with issues to do with accreditation and  
17 standards and that sort of thing?

18 A. No, I didn't, chairman, but I did know when they were  
19 happening. It was very, very obvious that if you went  
20 near a laboratory or a place that was associated with  
21 a laboratory, like the pathology department, that  
22 everything was spick and span and ready for an  
23 inspection. And I was also pleased that these  
24 inspections were happening because it was an external  
25 audit of service delivery.

1 Q. That's really the point that I was getting at.

2 A. It was external and it was nationwide. I can't remember  
3 the acronym.

4 Q. I understand.

5 A. But it was a quality assessment exercise and I was  
6 always pleased to hear that when it had happened, the  
7 majority of the facilities examined got a gold star.

8 Q. Yes.

9 A. To use a --

10 Q. I understand. Can I ask you this: let's take another  
11 issue arising out of laboratories, and that's turnaround  
12 times. Turnaround times are part of standards in  
13 a slightly different way.

14 A. Yes.

15 Q. They have an impact on treatment, their delay may be  
16 significant. Were you involved in dealing with that  
17 aspect of laboratories?

18 A. Not at all.

19 Q. Not at all. Who would have been so far as you're aware?  
20 You may not be aware, but so far as you're aware.

21 A. I wasn't aware.

22 Q. Thank you. Then I wonder if we can come now to the  
23 detail of this case, or at least Adam's case. How did  
24 you first learn about Adam's case?

25 A. Chairman, if I may, before I even answer this

1 question --

2 Q. Yes.

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

8 THE CHAIRMAN: Thank you.

9 MS ANYADIKE-DANES: Thank you.

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

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

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

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

19 A. I don't remember.

20 Q. Let me pull up --

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

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

1           30 November. Adam died on the 28th. And if you see,  
2           he's alerting you to the fact that Dr Alexander is going  
3           to be preparing an anaesthetic report for him to use  
4           at the inquest. He says:

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

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

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

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

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

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

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

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

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

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

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

11 Q. Sorry, which chart?

12 A. Adam's chart.

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

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

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

18 A. Yes.

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

22 A. All the case records, volume 10.

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

25 A. Yes.

1 THE CHAIRMAN: Okay.

2 MS ANYADIKE-DANES: This is being written on 30 November.

3 It looks like it's received on 4 December. And that's

4 the coroner letting you know. Given what we've said

5 about reporting lines and so forth, who advises you that

6 this has happened from within the Trust?

7 A. Various or nobody.

8 Q. Sorry?

9 A. Various or nobody.

10 Q. Well, do you recall whether anybody from within the

11 Trust advised you that Adam had died following his

12 surgery?

13 A. I don't recall.

14 THE CHAIRMAN: Can I ask you, would you -- I can entirely

15 understand why you don't recall 17 years ago, but would

16 you expect that if a patient like Adam had died and the

17 circumstances were such that they had to be reported to

18 the coroner, who is likely to order an inquest, would

19 you expect that your first information about that would

20 come from a call from the coroner or would you expect to

21 be notified internally first of all, or would you have

22 any expectation one way or the other?

23 A. Well, I know that I would have heard from the coroner or

24 the coroner's officer or the police acting on behalf of

25 the coroner. Because there was an office in

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

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

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

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

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

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

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

10          A. That's correct.

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

16          A. Until I see the primary statement.

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

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

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



1 with?

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

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

9 A. Good.

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

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

23 Q. I appreciate that.

24 A. -- as quickly as he did.

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

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

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

10 Q. I understand.

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

13 Q. Yes.

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

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

19 A. Yes.

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

25 A. The details and circumstances surrounding the death.

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

5 Q. Yes.

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

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

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

1 memorandum.

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

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

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

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

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

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

23 A. Yes.

24 THE CHAIRMAN: Thank you. We'll start at 2 o'clock.  
25 (1.10 pm)

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(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

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

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

4    Q.   I understand.

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

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

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

14   Q.   Exactly.

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

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

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

21   Q.   If we go to the very final paragraph from Dr Taylor:  
22           "I remain extremely perplexed and concerned that  
23           this happened to Adam and cannot offer a physiological  
24           explanation for such severe pulmonary and cerebral  
25           oedema in the presence of normal monitoring signs."

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

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

5    Q.   Yes.

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

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

10   A.   Yes.

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

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

19   Q.   Yes.

20   A.   And, subsequently, from the nurses.

21   Q.   You sought statements from the nurses?

22   A.   Yes.

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

24   A.   I cannot.

25   Q.   But you are absolutely sure about that?

1 A. I'm almost certain that I would have done that, yes.

2 Q. The difficulty is that the nurses that were involved  
3 don't actually seem to recall them ever being part of  
4 the process.

5 THE CHAIRMAN: And there were no nurses' statements ever  
6 forwarded to the coroner.

7 A. That surprises me in the context of something like this.  
8 But if I didn't do it, I didn't do it.

9 THE CHAIRMAN: Let me ask you then, why would you have asked  
10 the nurses?

11 A. Because they would have had or might have had some  
12 information of help because they were involved, they  
13 were present. And if there was anything -- there might  
14 have been nothing that they noticed untoward whatsoever,  
15 or they might have.

16 THE CHAIRMAN: When you say that you're surprised that we  
17 don't have any statements from the nurses and it appears  
18 to us that they weren't asked, then in essence are you  
19 saying that, however important it is, that is a degree  
20 of failure in the investigation that the nurses were not  
21 involved?

22 A. Yes. It comes as a surprise to me now, but I didn't  
23 realise that I hadn't.

24 MS ANYADIKE-DANES: What the coroner had asked for is he  
25 wanted to have statements from all the clinicians



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

3   A.   In the context of a death, yes.

4   Q.   He also said:

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

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

12   A.   Well, arising from my telephone conversation with  
13           the coroner, I believe that he and I agreed that I would  
14           commission as independent a report as I could in the  
15           circumstances, and, therefore, request that the chief  
16           technical officer and another would -- and I think it  
17           was on a Saturday immediately after Adam's death on the  
18           27th -- that they would go over with Dr Fiona Gibson.

19   Q.   In fairness to you, it may be that you haven't entirely  
20           recollected the chronology of it.  You're quite right:  
21           you did have a conversation with the coroner about it.  
22           In fact, he refers to it in a note that he makes of  
23           8 December and we'll come to that.  But this is his  
24           first request to you and all he seems to be asking for  
25           here, if you leave aside the "statements from the

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

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

11 Q. Yes.

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

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

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

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

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

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

18        A. I did.

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

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

23                "I am writing to confirm."

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

1 THE CHAIRMAN: Yes.

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

8 MS ANYADIKE-DANES: Okay.

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

13 THE CHAIRMAN: The inspection?

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

17 THE CHAIRMAN: Okay.

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

20 MS ANYADIKE-DANES: I understand that.

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

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

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

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

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

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

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

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

23   A. I appreciate that.

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

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

3 A. I don't know.

4 Q. Well --

5 A. I do not know.

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

11 A. I'm sure it would.

12 Q. Yes. And what about Dr O'Connor? Would it not have  
13 been appropriate to have got a statement from  
14 Dr O'Connor because she is the only nephrologist who  
15 moves in and out of the theatre after some time around  
16 9.00, 9.30?

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

20 Q. But it's recorded --

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

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

1 Dr O'Connor had been in the operating theatre?

2 A. How many years ago is that? I can't remember.

3 THE CHAIRMAN: Sorry --

4 A. I cannot remember.

5 THE CHAIRMAN: Dr Savage has told the inquiry that he had

6 a number of conversations with you, not necessarily

7 in the days immediately after 28 November, but over the

8 following weeks.

9 A. Indeed he did, yes.

10 THE CHAIRMAN: And he made his position clear to you about

11 what he thought had gone wrong.

12 A. Indeed, yes.

13 THE CHAIRMAN: And particularly who he thought had gone

14 wrong.

15 A. Yes.

16 THE CHAIRMAN: This inquiry has heard from Dr O'Connor that

17 when she arrived at some point later on during Adam's

18 operation, she noticed and raised an issue with

19 Dr Taylor about the CVP readings. I think the point

20 which is being put to you, just as an example, is that

21 since Dr O'Connor's presence appears on the records that

22 that would have been an issue which was identifiable, if

23 not in the day or two after 28 November, at least

24 reasonably soon after that, to pick up with Dr O'Connor

25 because it's relevant to issues which are to be raised

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

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

12 THE CHAIRMAN: Okay.

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

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

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

22 Q. But do you accept that?

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

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



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

8   A.   Chairman, I've already accepted that.

9   Q.   Thank you.

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

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

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

20  THE CHAIRMAN:  In the sense that --

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

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

25  A.   Exactly.

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

1 THE CHAIRMAN: Okay.

2 MS ANYADIKE-DANES: Firstly, if we pull up 059-069-161.

3 This is the cover letter to you from Dr Gibson for her  
4 report. What does the expression "I hope this is  
5 suitable for your purposes" mean? What had you told her  
6 you wanted it for?

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

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

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

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

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

1 from memory.

2 Q. That's correct. It says so later on at the bottom.

3 A. That is the only common issue that they had. It wasn't

4 Dr Taylor that was the common issue at all.

5 Q. I understand. That actually is why I'm asking why were

6 you asking her to discuss the deaths of two other

7 children with Dr Taylor?

8 A. Again, I think we would have to ask Dr Gibson how she

9 came to construct that sentence in that way.

10 Q. Well, she says you've asked her.

11 A. I know she says that, but again I would like to enquire

12 of her how she came to form that view. I don't believe

13 that that was what she was asked to do.

14 Q. Well, what had you asked her to do?

15 A. She was asked to see if there was any common issue with

16 the three patients --

17 Q. And had you --

18 A. -- and, in addition, to look at the equipment --

19 Q. Yes. Had you asked her --

20 A. -- from a professional point of view.

21 Q. Sorry. Had you asked her to discuss anything with

22 Dr Taylor?

23 A. I don't think I did. And I think, again, not

24 100 per cent guaranteed, that the conversations

25 essentially with her were about Dr Gaston. Now, I know

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

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

6 A. Not at all.

7 THE CHAIRMAN: And would you add to that --

8 A. As far as I can remember.

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

12 A. Exactly.

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

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

17 Q. Yes.

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

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

23 A. Yes, it would.

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

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

7 A. I can't explain that.

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

10 A. Exactly.

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

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

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

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

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

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

8    A. I didn't do anything.

9    Q. Did you not ask her why or --

10   A. No.

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

12   A. No.

13   THE CHAIRMAN: Doctor, can I ask you a slightly variation on  
14           that? I understand that there was a separate technical  
15           report on the equipment and we've seen that and we'll  
16           probably come back to it in a moment or two.  
17           I understand that was obtained at the coroner's  
18           direction --

19   A. Correct.

20   THE CHAIRMAN: -- to rule out an equipment failure.  
21           What was the purpose of Dr Gibson's report?

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

24   THE CHAIRMAN: By who?

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

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

4 A. Indeed.

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

10 A. Mm. Yes.

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

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

18 THE CHAIRMAN: Three lines down:

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



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

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

12   THE CHAIRMAN:  Sorry, my point is slightly different.

13   A.   I see I'm tied into it.

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

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

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

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

22   MS ANYADIKE-DANES:  Thank you very much indeed.

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

1 A. No, it wasn't.

2 Q. This is not what the coroner wanted; the coroner wanted  
3 something in relation to the equipment.

4 A. Chairman, this was additionality.

5 THE CHAIRMAN: Yes.

6 MS ANYADIKE-DANES: Yes. Well, let's go to the report that  
7 you were getting in response to the coroner's request.  
8 We see that at 059-068-157. There we are. The report  
9 is by Wilson and McLaughlin and they go out on  
10 2 December. Then if you work your way down to the  
11 fourth paragraph and, in parentheses, you say:  
12 "The Siemens patient monitor is currently out for  
13 repair. A new display screen is being fitted and a loan  
14 monitor is in use."  
15 So that meant, didn't it, that they actually hadn't  
16 examined the monitor that was in use during Adam's  
17 surgery?

18 A. Chairman, my understanding of this is that a display  
19 screen had been fitted into the monitor, but everything  
20 else was the same. It was only a --

21 Q. But the display screen --

22 A. -- display screen, a TV screen, so to speak, on which  
23 various parameters --

24 Q. And it is those very parameters that are at issue, at  
25 least in part, in this case. And how those parameters

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

5   A.   It appears so.

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

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

15   Q.   Yes, but the --

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

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

24   A.   If you go to -- if one goes to the very last paragraph:  
25

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

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

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

8    A. That wasn't my job.

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

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

12   MS ANYADIKE-DANES: I understand that.

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

16   Q. Then if it's --

17   A. -- and I was a service officer.

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

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

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

4   Q.   Sorry?

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

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

11  A.   I didn't.

12  Q.   Why wouldn't you do that?

13  A.   I don't know.

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

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

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

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

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

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

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

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

17 If we come down to where you are recorded:

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

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

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

1 he might ..."

2 And that goes on to deal with something else. So  
3 it would appear, if one goes to "Today Dr Armour showed  
4 slides", today being the date of the note, which  
5 8 December, it would appear that when the coroner  
6 records that he spoke to you, he's speaking to you on  
7 8 December and that he is telling you that he now wants  
8 the equipment independently examined, which sounds like  
9 he hadn't asked for it to be independently examined  
10 before.

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

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

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

20 A. I remember that there were multiple conversations.

21 Q. Yes. I appreciate that.

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

25 Q. And then if we --

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

3 A. There wasn't.

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

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

9 THE CHAIRMAN: Well --

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

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

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

25 Then this memo is dated 6 December and you say:



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

5           So that may well have been his 30 November letter:

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

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

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

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

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

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

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

14 A. I'd have to see the file.

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

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

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

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

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

6 A. Yes.

7 MS ANYADIKE-DANES: Sorry, Dr Murnaghan, I just asked you  
8 when you think you provided this report to the coroner.  
9 I may be able to help you by pulling up this document,  
10 011-075-210A. This, so far as we understand it, which  
11 is a document from the coroner's file, is a list of  
12 those who are going to be witnesses at the inquest. So  
13 it would appear to have been generated at some point  
14 after that decision was made. Then if you see right  
15 at the bottom:

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

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

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

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

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

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

9 THE CHAIRMAN: Okay.

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

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

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

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

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

18 A. Saturday.

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

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

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

24 A. I'd put them all together.

25 Q. Put what all together?

1 A. The statements, rather than send them piecemeal.

2 Q. Can we now deal with what you actually asked Mr Wilson  
3 and Mr McLaughlin to do, what information you gave them  
4 for the purposes of their report?

5 A. I know that the one thing that I did not tell them is  
6 what had -- what was the reason for the examination.

7 Q. Yes. Is there a reason?

8 A. Yes. I wanted them to look without any prejudice at the  
9 equipment and tell me was it working properly so that  
10 they could put a report in to the coroner saying that  
11 the equipment was as per spec or it wasn't. Nothing  
12 more, nothing less. But certainly not to prejudice  
13 anything that they did and just to find out: was the  
14 equipment working properly, because that's what  
15 the coroner wanted to know.

16 Q. Yes. What they understood was that they had to look  
17 at the equipment that was in situ. They didn't  
18 understand, because they didn't know that, for example,  
19 Adam's case was a relevant case, so they didn't  
20 understand that what they should really be identifying  
21 is what was the equipment in situ on 27 November.

22 A. I'm not certain that your interpretation's correct.

23 Q. They say that in their witness statements to the  
24 inquiry.

25 THE CHAIRMAN: But the statement goes beyond that, doesn't

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

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

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

19   THE CHAIRMAN: Okay.

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

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

1           that I did not want to prejudice anything that they did.

2   Q.   Okay.  Why did you think they were independent?

3   A.   Because they didn't work in that area.

4   Q.   Well, Mr Wilson, who's the only one who signed it,

5           he was the chief medical technical officer for ATICS,

6           which is the directorate in which Dr Taylor was in.

7   A.   Correct.

8   Q.   So how did that make him independent since that was one

9           of the cases that was at issue and prompting the

10          inspection?

11  A.   He was looking at equipment solely.  He wasn't looking

12          at anything else other than equipment.  And equipment

13          that he didn't have dealings with on a day-to-day basis.

14  Q.   Yes, but they both refer to the fact that Dr Taylor was

15          there.  Dr Taylor was there, they say in their inquiry

16          witness statements, having conversations with Dr Gibson.

17          And you have sought to cover off the issue of

18          independence by having people who weren't connected,

19          but, as it happens, Dr Wilson, who's the only person who

20          signs the report, is actually in the same directorate as

21          Dr Taylor.  So how does that ensure independence?

22  A.   Chairman, I'm afraid that counsel and I are somewhat

23          opposed on the understanding of the word "independent",

24          and I can't help any further than that.  I've done my

25          best to explain.

1 Q. Let me pull this up.

2 A. I really don't understand how we can go on much further  
3 in trying to parse the semantic word "independence".  
4 I'd love to help.

5 THE CHAIRMAN: The issue, doctor, is whether actually there  
6 is independence. And your position, just to bring an  
7 end to this, is that because they didn't work -- let me  
8 get your words -- Mr Wilson didn't have dealings on  
9 a day-to-day basis with people like Dr Taylor.

10 A. Yes.

11 THE CHAIRMAN: And therefore, even if they're under the same  
12 heading of ATICS as Dr Taylor is, your position is that  
13 he's independent?

14 A. Yes.

15 THE CHAIRMAN: Okay.

16 A. That was my view at that time.

17 MS ANYADIKE-DANES: Just one further point and then we'll  
18 move on. It's a witness statement from Mr McLaughlin.  
19 Mr McLaughlin was in the Royal Group of Hospitals and  
20 what I had understood Dr Gaston to be saying is, yes,  
21 Mr Wilson was in ATICS, if I can call it that, but he'd  
22 sent along Mr McLaughlin as well, who was not in ATICS,  
23 and it was Mr McLaughlin actually who was providing the  
24 degree of independence, if I can put it that way.

25 But if one sees his witness statement, 109/2,



1 page 9. He's specifically asked at the top about it  
2 being undated. Then (b):  
3 "Why did you not countersign the report?"  
4 His answer to that is:  
5 "I was not asked to submit a report, but agreed with  
6 the content. The report was written by Mr Wilson."  
7 It doesn't appear to be exactly a joint report.  
8 And just finally, their report discloses some other  
9 matters which, given your risk management remit, might  
10 have been appropriate to consider. If we go to  
11 059-068-159. Then you see the first full paragraph, the  
12 penultimate sentence:  
13 "The anaesthetist using the machine is also expected  
14 to sign the log before commencing the list, but this  
15 does not happen on most occasions. A reason for this  
16 omission should be requested."  
17 What did you do about that, Dr Murnaghan?  
18 A. Nothing. The first I saw of this was when I read it on  
19 the website.  
20 Q. Sorry, the first you saw of this report?  
21 A. That particular issue.  
22 Q. But this is part of the report.  
23 A. I appreciate that. I don't remember reading that part  
24 of it.  
25 Q. So you got a report that you'd got for the purposes of

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

4 A. Correct.

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

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

14 What did you do about that?

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

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

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

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

23 A. They weren't able to tell me how it occurred and they're  
24 the experts. I'm not an expert in these machines.

25 I wouldn't even recognise one if you brought me to see

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

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

8   A. Indeed.

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

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

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

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

21   Q. No, sorry: did you?

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

25   Q. Thank you. Then it says:

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

7           And they list them down.

8   A. Correct.

9   Q. As to what they are:

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

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

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

24   Q. Yes.

25   A. That was his responsibility --

1 Q. I appreciate that, Dr Murnaghan --

2 A. -- on a distributed and cascaded risk management issue.

3 It wasn't possible for me physically, mentally or

4 otherwise, to go and follow up everything. I appreciate

5 that this was coming particularly to me, but I would not

6 have assumed, I would have known that Mr Wilson would

7 have dealt with that --

8 Q. I understand.

9 A. -- with his management hat on.

10 Q. That I understand and I can quite understand what you

11 say in relation to, say, matters such as number 1 and so

12 on. But if we go to item 2:

13 "If there was a possibility [and one's not saying

14 that there is, he's just identifying the sort of things

15 that could have gone awry] the anaesthetist did not

16 check the anaesthetic machine."

17 That's not really a matter within an MTO's remit.

18 That's a clinician, and that you'd have to take up in

19 a different way; isn't that the case?

20 A. Absolutely.

21 Q. And did you?

22 A. And if this refers to Dr Taylor, it is beyond belief

23 that Dr Taylor started any operation without checking

24 his machine thoroughly, because he was a most careful,

25 competent --

1 Q. Sorry, Dr Murnaghan, that's not my question to you.

2 A. But it relates to it.

3 Q. But this has been raised in a report as potential areas  
4 of poor practice, so what I'm asking you is: did you  
5 take up with his clinical lead or somebody else in ATICS  
6 the possibility that anaesthetists were not checking the  
7 anaesthetic machine? That's the point.

8 A. No, I didn't.

9 Q. Thank you.

10 THE CHAIRMAN: Is that quite how that reads? Does that not  
11 read by saying that: look, the protocols and procedures  
12 are there, if a reversal of cylinders had occurred, it  
13 meant that the following six items did not happen.

14 MS ANYADIKE-DANES: No. Sorry, Mr Chairman, it's a matter  
15 for you how to interpret that.

16 THE CHAIRMAN: Yes, let's move on.

17 MR UBEROI: [Inaudible: no microphone] one observation,  
18 simply for clarity. A few questions ago my learned  
19 friend referred to Dr Taylor being present in the  
20 theatre when Messrs McLaughlin and Wilson --

21 MS ANYADIKE-DANES: In a separate room with Dr Gibson,  
22 definitely not in the theatre.

23 MR UBEROI: Thank you very much.

24 MS ANYADIKE-DANES: If there's one thing that the MTOs are  
25 clear on, it's that neither Dr Gibson nor Dr Taylor were

1 in the theatre when they were checking.

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

6 A. In what regard?

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

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

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

15 Then you emphasised:

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

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

24 A. Well, we're coming downstream now.

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

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

3 THE CHAIRMAN: Well --

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

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

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

14 THE CHAIRMAN: Yes.

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

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



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

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

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

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

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

23   A. It certainly does not.

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

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

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

10   THE CHAIRMAN:  Yes.

11   A.  I'm not reluctant to answer.

12   THE CHAIRMAN:  I understand.  But let's just get it clear.

13           I understand this.  Let me make clear what my question  
14           is.

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

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

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

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

1 A. The anaesthetic side and the paediatric nephrology side.

2 Q. This is about patient care.

3 A. I appreciate that. And the paediatric anaesthetic

4 colleagues did not give me a steer, so to speak,

5 directly at that time.

6 Q. Well, did --

7 THE CHAIRMAN: The paediatric anaesthetic colleagues did not

8 give you a steer directly at that time?

9 A. Yes, to confirm to me that Dr Taylor had done something

10 seriously wrong.

11 THE CHAIRMAN: But is Dr Sumner not a consultant paediatric

12 anaesthetist?

13 A. He is. But I didn't know who he was other than ...

14 I don't even know whether at that stage I had seen his

15 written report.

16 MS ANYADIKE-DANES: I can help with you that.

17 A. I may or may not have.

18 THE CHAIRMAN: It's dated --

19 A. I know that he had been asked.

20 THE CHAIRMAN: He's engaged at the specific suggestion of

21 Dr Gaston.

22 A. No, Dr Crean.

23 THE CHAIRMAN: Sorry, the idea that an external expert

24 should be engaged comes from Dr Gaston and Dr Lyons.

25 A. Yes.

1 THE CHAIRMAN: The specific identity of the --

2 A. Came from Dr Crean, yes.

3 THE CHAIRMAN: So the suggestion that you need an external

4 expert paediatric anaesthetist comes from within the

5 Royal?

6 A. Yes.

7 THE CHAIRMAN: So when that external expert returns and

8 gives a report which is effectively critical of

9 Dr Taylor, you have -- to go back to Ms Anyadike-Danes'

10 question and the rock and the hard place. The rock, you

11 might say, is Adam's death.

12 A. Yes.

13 THE CHAIRMAN: The hard place is the cumulative view of the

14 paediatric anaesthetists who are not steering you to

15 believe that there is a general issue about Dr Taylor.

16 But also, if you look at the hard place side, you've got

17 Dr Sumner, who's saying, "I'm not talking about

18 Dr Taylor generally, but on this instance it looks very

19 problematic for him"; right? Did the paediatric

20 anaesthetists who you spoke to acknowledge that, however

21 good Dr Taylor is generally, on this occasion he had not

22 been good?

23 A. That is not my memory. They separately and severally,

24 chairman, were all totally supportive of Dr Taylor.

25 THE CHAIRMAN: Sorry, doctor, I understand that. I'm not

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

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

23 THE CHAIRMAN: I understand that.

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

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

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

9   A. Yes.

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

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

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

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

1 clinical director in ATICS or the paediatric  
2 anaesthetist colleagues?

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

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

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

24 THE CHAIRMAN: Okay.

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



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

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

6   A.  Looking after Dr Taylor's professional welfare.

7   Q.  In which way?

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

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

13  A.  Mentoring, or whatever the word is.

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

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

20  THE CHAIRMAN:  Were they doing both of those?

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

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

7 A. Yes.

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

10 A. Not only --

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

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

21 Q. No, but you can --

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

1 going to come in later, he's elsewhere. How can

2 Dr Taylor be supervised?

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

7 THE CHAIRMAN: Quite short in time and much simpler?

8 A. Yes.

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

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

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

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

1 believe that there is a file note.

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

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

7 THE CHAIRMAN: Yes. Well, let's try to simplify it.

8 Whatever the procedures were, however developed or  
9 advanced they were compared to now, you would still have  
10 had a concern: is it safe for a doctor to operate or be  
11 involved in operating on patients? How that is managed  
12 or controlled has developed, had developed before 1995  
13 and has developed since 1995; right?

14 A. Yes; but not very much before 1995.

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

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

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

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

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

13 THE CHAIRMAN: Yes.

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

16 THE CHAIRMAN: Okay. Thank you very much.

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

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

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

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

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

18 THE CHAIRMAN: Yes.

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

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

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

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

1           was informal. It wasn't formal.

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

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

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

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

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

19   MS ANYADIKE-DANES: On this point, yes.

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

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

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

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

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

11          Q. Yes.

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

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

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

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

23          A. I don't believe that I did.

24          THE CHAIRMAN: Thank you.

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



1 really to follow up --

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

5 THE CHAIRMAN: He was generally a good anaesthetist?

6 A. Not generally, always.

7 THE CHAIRMAN: Yes.

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

10 A. He went the extra mile always.

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

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

19 Over the page, 404:

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

1           In terms of the concern that Professor Savage --

2   A.   Chairman, it would be helpful if I knew which version of

3       Good Medical Practice this comes from.  There are

4       several versions.  What date is this?

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

6   THE CHAIRMAN:  If you go back six pages from 403.  Could we

7       try 396 or 397, please?

8   A.   1995.

9   THE CHAIRMAN:  Yes.

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

11  MR FORTUNE:  From recollection, sir, you'll find that the

12       previous guidance was similar.

13  THE CHAIRMAN:  I would hope so, Mr Fortune.

14  MS ANYADIKE-DANES:  The issue here is that Professor Savage

15       has identified a concern in Dr Taylor's fluid management

16       of Adam and he has relayed that concern to you

17       repeatedly, according to his evidence.  Dr Sumner has

18       come in with his report, which was an independent report

19       sought by the Trust, and his report identifies --

20  A.   Chairman --

21  Q.   Sought by the coroner?

22  THE CHAIRMAN:  At the Trust's instigation.

23  MS ANYADIKE-DANES:  Sorry, it was a bit of a short cut.

24       Anyway, that was something they wanted to have as well.

25       The result of that report is to refer to shortcomings

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

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

18 A. For renal transplants?

19 Q. Yes.

20 A. Not all the time.

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

22 A. I just wanted to make sure [OVERSPEAKING].

23 Q. I'm not seeking to make it larger than it is. Did you  
24 not think that you really ought to engage in something  
25 a little bit more formal than an understanding that he



1 by Adam's death."

2 And you ask her:

3 "So it's because of Adam's death?"

4 And she responds that yes, it was, and I'm sure she  
5 goes on later on. But in any event I wanted to draw  
6 that to your attention, Mr Chairman, because it's not  
7 correct that she was singling out all of Dr Taylor's  
8 cases or all his renal transplant cases. It was her  
9 practice --

10 MR FORTUNE: Would you read line 25 and onwards, please?

11 MS ANYADIKE-DANES: Yes, of course. Mr Stewart, my junior,  
12 asks:

13 "Question: Were you any more vigilant when  
14 Dr Taylor was undertaking performance of the  
15 anaesthetic?

16 "Answer: My behaviour was the same no matter who  
17 provided the anaesthetic. My preoperative plan, my  
18 discussion with them and my presence in theatre and my  
19 discussion about every single bag of fluid that was  
20 erected. Sometimes I think maybe they think I'm  
21 a nuisance in theatre but they've got used to me being  
22 present now for transplants."

23 That was her evidence and that was a step she took  
24 as a result of her experience.

25 I have been asked to draw your attention to one

1 particular document, which is a letter that you received  
2 from Dr Webb. I'm going to do that. You will recall  
3 that when I had the memo up of 6 December, when you were  
4 seeking statements, it's 059-071-164. You can see right  
5 down at the bottom left-hand side there's a number of  
6 people who whom this document is circulated. Those  
7 presumably are the people from whom you were seeking  
8 statements. And then, on the right-hand side, there are  
9 two names. One is Dr Webb and there is "action" against  
10 his name. And one is Dr Wilson and there is "action"  
11 against his name. I have assumed, but you can correct  
12 me if I'm wrong, that the action you were seeking from  
13 Mr Wilson was the report or at least a finalised report  
14 and get it to you. Maybe I'm wrong about that. What  
15 was the action Mr Wilson was to take?

16 A. Related to number 1.

17 Q. Ah. So then what was the action that Dr Webb was to  
18 take?

19 A. As far as I remember, chairman, Dr Webb was only  
20 involved in relation to brainstem tests.

21 Q. Yes. So what --

22 A. I'm trying to be as sympathetic as possible in this  
23 context.

24 Q. I understand.

25 THE CHAIRMAN: Well, that being so -- and I think that is

1 right -- he became involved at that very late stage.

2 A. Yes, and only then.

3 THE CHAIRMAN: Do you have any recollection of what action  
4 it was, which might have been required of him?

5 A. Purely to provide a report for the coroner that he had  
6 conducted the tests and the results thereof. It would  
7 have been purely a factual --

8 MS ANYADIKE-DANES: I understand. If I pull up this  
9 document, maybe you can help me if this is the response  
10 to the action you were speaking. 059-061-147. There  
11 you see it's from Dr Webb to you. It's dictated on  
12 12 December:

13 "I note your request for a statement from the  
14 clinicians involved in the medical care of this child."

15 Then he deals with that and says how he was  
16 contacted by the nephrology service to see the child.  
17 He says he examined him and then reviewed his CT scan  
18 and then his final statements are:

19 "I repeated Adam's brainstem assessment 12 hours  
20 later and confirmed he fulfilled the criteria for  
21 brainstem death. My impression was that he had suffered  
22 severe acute cerebral oedema, which was likely to have  
23 occurred on the basis of osmotic disequilibrium causing  
24 a sudden fluid shift."

25 So that's what Dr Webb thought it was at that stage,

1 at least the approximate cause of Adam's cerebral  
2 oedema, and therefore death.

3 How did you see that fitting in with the information  
4 that you were receiving from the other clinicians?

5 A. The only way I can answer that is to refer you back to  
6 what I've already said.

7 Q. Which is?

8 A. We were attempting -- at least I was attempting -- to  
9 put everything together and looking forward to how  
10 it would be dealt with at the inquest.

11 Q. Thank you. I'm going to ask you one further question  
12 in relation to this run-up phase to the inquest, if I  
13 can put it that way. You were copied into a letter from  
14 Dr Armour, who was the pathologist. The reference is  
15 011-023-123. It's dated 8 December. It's a very short  
16 letter. It's actually addressed to the  
17 State Pathologist, but you are cc'd in along with the  
18 coroner. Do you recall seeing this letter?

19 A. I do.

20 Q. And she says:

21 "I have been dealing with the case of Adam Strain.  
22 I am willing to attend any meeting about this case,  
23 including a meeting with clinicians, administrative  
24 staff, HM Coroner and whoever else wishes to attend. As  
25 I was the pathologist who carried out the autopsy,



1 I feel my opinion on the case is relevant to such  
2 a meeting and, as such, the case could be discussed in  
3 full."

4 What, so far as you are aware, generated that  
5 letter?

6 A. My memory in relation to this is not precise and  
7 I haven't read Dr Armour's evidence. It is probable  
8 that this matter came up, but at that time, my belief  
9 is that there was an element of disharmony between  
10 herself and the State Pathologist.

11 Q. How is that relevant to the case of Adam Strain?

12 A. There may have been a challenge within the department.

13 Q. What do you mean by that?

14 A. A challenge to Dr Armour by her clinical lead.

15 Q. You mean a suggestion that she may have got it wrong?

16 A. I don't know what was going on and I never did determine  
17 what was going on. But there is a clue here. I don't  
18 think it's relevant to this matter. The clue is the  
19 fact that Mr Calvin Spence, her representative at the  
20 BMA, is copied into this.

21 Q. Perhaps we shouldn't speculate.

22 THE CHAIRMAN: I think Dr Armour gave us her explanation for  
23 this letter, which is tangential even to a very broader  
24 inquiry than ours, so I think we can move on.

25 A. I'm semi-correct, I think. Thank you.

1 MS ANYADIKE-DANES: I don't want to get into that, the  
2 element you have just raised. What I want to know is  
3 what did you do about it, having --

4 A. I didn't do anything because it was only confirming to  
5 me that about which I had superficial knowledge and it  
6 certainly was not something that was within my remit or  
7 appropriate for me to do anything about. I don't know  
8 why she copied me, other than perhaps for protection.

9 Q. Before the inquest, there are a number of meetings and  
10 we have taken various parties through them. I don't  
11 intend to take you through them because you, I think,  
12 unless you correct me, have fairly said that you  
13 actually didn't regard yourself as carrying out an  
14 investigation at all.

15 A. At that time.

16 Q. You were simply gathering material for the coroner. And  
17 some of it post-dates when you were notified that there  
18 was a claim. What effect did that have that you now  
19 knew that there was likely to be medical negligence  
20 litigation in relation to this matter? What effect did  
21 that have?

22 A. Absolutely nothing. I was able to divide myself into  
23 two and deal -- the inquest on one side of me and the  
24 claim on the other side of me, and the two did not, at  
25 that stage --

1 Q. You didn't regard that there was a potential conflict in  
2 you dealing with both matters?

3 A. No, not at all.

4 Q. Were you not, when you were dealing with the claim  
5 element --

6 A. And I beg your pardon, just to complete it, chairman,  
7 I wasn't advised that there would be an element of  
8 conflict. The same legal adviser to the Trust was  
9 dealing with both files.

10 Q. Yes.

11 A. I would have expected, in that circumstance, that if  
12 there was a conflict of interest, I would have been so  
13 advised. I wasn't.

14 Q. But when you were preparing yourself, not you  
15 personally, but preparing the Trust's position  
16 in relation to the litigation -- or were you preparing  
17 the Trust's position in relation to litigation prior to  
18 the inquest?

19 A. No.

20 Q. So --

21 A. As far as I can remember, no.

22 Q. So when we see references in the correspondence to  
23 difficulties that were likely to arise at the inquest  
24 and for you arranging for consultations between the  
25 clinicians, certainly Dr Taylor, and the Trust solicitor

1 to try and see how those difficulties could be met, if I  
2 can put it that way, that's still all part of just  
3 trying to get the information out for the coroner?

4 A. Absolutely, and for no other purpose.

5 Q. Not defensive at all?

6 A. Not at all. This was pure veritas and nothing more than  
7 that.

8 Q. Now that you have put it that way, perhaps we can just  
9 look at one of them. This is a letter you get on 7 June  
10 from the Trust solicitors. 059-014-038. So at this  
11 stage, you've seen the expert reports. It's 7 June.  
12 You've also seen the report of the pathologist in terms  
13 of the dilutional hyponatraemia issue. They all seem to  
14 be of pretty much one mind. As you know, this is the  
15 second paragraph:

16 "There are a substantial number of issues contained  
17 in the experts' reports, which will require to be  
18 carefully and exhaustively examined and investigated.  
19 In that regard, I have already had the benefit of very  
20 detailed instructions from Dr Taylor and these have now  
21 been reinforced for me by Dr Gaston."

22 Then there's a reference to Dr Sumner being in  
23 attendance. It goes on that:

24 "I understand that Dr Taylor has a full set of the  
25 working documents and whilst other witnesses will be

1 called to give evidence, I believe it is fair to say  
2 that the main focus of the coroner's interest will be on  
3 the anaesthetic management of this patient, particularly  
4 in the light of the cause of death as found by  
5 Dr Armour. It is important that Dr Taylor provides  
6 express instructions in relation to his view of the  
7 cause of death, which Dr Armour classifies as cerebral  
8 oedema due to dilutional hyponatraemia and impaired  
9 cerebral perfusion ..."

10 The anaesthetic colleagues of Dr Taylor, did they  
11 accept Dr Armour's report?

12 A. I can't remember.

13 Q. That would be quite an important issue.

14 A. Have they not given evidence?

15 Q. I'm asking you.

16 A. I don't remember is what I said. I am sorry, I don't  
17 remember.

18 Q. No, no, that's all right. But what's being put here is  
19 a clear recognition that Dr Taylor is going to face some  
20 fairly difficult questions because the main focus is  
21 going to be on what he did in terms of fluid management.  
22 And what appears to be the case is an attempt, rather  
23 than to say, "Those are the expert reports, they're  
24 independent, that's the pathologist's report, let's see  
25 what the coroner makes of that, we've already submitted

1 the statements, or we will be, from the clinicians",  
2 there seems to be a process of trying to provide  
3 a defence for Dr Taylor so that the -- or at least maybe  
4 to provide an opposing view to that of Dr Sumner and the  
5 pathologist. Would that be a fair categorisation of  
6 what was going on?

7 A. I certainly would prefer the second rather than the  
8 first. I wouldn't regard this as a defence at all.

9 Q. Then if we go --

10 A. And I would prefer it to be seen as being an attempt to  
11 be positive.

12 Q. An attempt to be positive?

13 A. Yes.

14 Q. Well, then if we go on and see what's dealt with here  
15 in the second page:

16 "This is really the starting point in relation to  
17 the instructions which I would require from Dr Taylor.  
18 And if he has any difficulties in relation to accepting  
19 that cause of death, then perhaps he would let me have  
20 a note of the same."

21 Of course he did have those:

22 "Turning to Dr Sumner's report, there are a number  
23 of veiled criticisms contained therein and these, in  
24 general terms, at the moment I would categorise as  
25 follows."

1 He then goes on to deal with them:

2 "A suggestion that Dr Taylor overestimated the fluid  
3 deficit."

4 And he deals with how that is raised in Dr Sumner's  
5 report. Then:

6 "Taking the electrolyte values. 3, the CVP  
7 readings."

8 Then at the bottom:

9 "Finally, at this stage I would like to raise two  
10 other issues. Dr Gaston has indicated that during the  
11 course of the procedure, Dr Taylor did not have an  
12 opportunity of accurately measuring urinary output due  
13 to the fact that the bladder had been opened early on in  
14 the surgery. This point will have to be made in very  
15 trenchant terms to Dr Sumner and he will be asked what  
16 other opportunities the anaesthetist had to measure  
17 urinary output."

18 Why does it have to be made in trenchant terms if  
19 it's not being mounted as a defence?

20 A. I didn't choose the word. That was the legal advisers.

21 Q. I appreciate that. Then if we go over the page, 040.

22 He wants to be in a position to deal with that point:

23 "One additional point raised by Dr Gaston related to  
24 the potential for this child, for whatever cause, absorb  
25 fluid into the brain. I would like to see some

1 literature which might help us in propounding such  
2 a theory -- and I emphasise only as a theory -- and as  
3 something which simply cannot be excluded from the  
4 present position, and in particular that in some  
5 individuals the physiology is such that such an  
6 occurrence can happen. Obviously, if we suggest such  
7 a potential, then that of itself would be a factor which  
8 might, to some extent, explain the oedematous state of  
9 the brain."

10 Then Dr Taylor's being asked to look at drugs and so  
11 forth.

12 When you stand back and look at all that -- and  
13 I appreciate it's not your words, it's the words of the  
14 Trust solicitor -- but does that not appear as an  
15 exercise in trying to mount some sort of defence to the  
16 criticisms that are being anticipated as a result of the  
17 reports that the trust is likely to face?

18 A. Criticisms, yes, arose in Dr Sumner's report. These are  
19 the legal advisers' understanding of the responses,  
20 based on Dr Taylor's instructions --

21 Q. Yes --

22 A. -- verbally given --

23 Q. -- I accept that.

24 A. -- and backed up by written work.

25 Q. Backed up by Gaston?



1 A. And Dr Taylor. They were both in communication, they  
2 were both seen by Mr Brangam on more than one occasion  
3 and that's on record.

4 THE CHAIRMAN: But doctor, is it not the problem here that  
5 if Dr Sumner's evidence and the basis for his evidence  
6 was not challenged, and if that evidence was accepted by  
7 the coroner, the inevitable finding about the cause of  
8 Adam's death would be to point the finger fairly  
9 directly at Dr Taylor?

10 A. Yes.

11 THE CHAIRMAN: And that is supported by Dr Armour's autopsy  
12 report, which came after Dr Sumner's report, but in  
13 which she had accurately confirmed the cause of death,  
14 as was accepted by the coroner.

15 A. Yes. Can we come back a little bit before it being  
16 accepted by the coroner? Dr Taylor had a view which  
17 differed from Dr Sumner's view, and he received a degree  
18 of support from Dr Gaston in relation to his view. Now,  
19 I wasn't in a position to make a judgment on that. That  
20 wasn't within my professional expertise whatsoever.

21 MS ANYADIKE-DANES: I understand. So in fact, how that was  
22 going to get itself resolved, if I understood you  
23 correctly, was to await to see what the verdict on  
24 inquest would be.

25 A. Exactly, and the debate, chairman, that would happen.

1 THE CHAIRMAN: At the inquest?

2 A. At the inquest.

3 THE CHAIRMAN: Then let's move on to the inquest.

4 MS ANYADIKE-DANES: One final point just before we get to  
5 Dr Taylor giving his evidence at the inquest. You  
6 caused, did you not, two documents to be produced just  
7 prior to that? One was a set of recommendations and the  
8 other was a press release. The set of  
9 recommendations -- we can look at that just now.  
10 011-014-107A. Ultimately, that is signed by Dr Taylor;  
11 isn't that right?

12 A. Dr Taylor, in his evidence, has explained why he signed  
13 that.

14 Q. That's not the point that I'm putting to you.

15 A. No, but you drew attention to the fact that it had been  
16 signed uniquely by Dr Taylor.

17 Q. Yes. But you are instrumental in causing this document  
18 to be produced?

19 A. I was involved in its production, yes.

20 Q. Yes. And what was it for?

21 A. The purpose of this document was to show to the coroner  
22 that, having considered the issues that had arisen, that  
23 the management of children undergoing major paediatric  
24 surgery in the future would involve the following  
25 issues. And that was not only for the coroner, but

1 through him, if he saw appropriate, to be passed along.  
2 And I understand that there's somewhere in the coroner's  
3 rules that he has authority to do that, to pass it up to  
4 the department or wherever.

5 Q. I think it might be the other way round. I don't think  
6 the coroner has said that he had any role in  
7 disseminating a document such as this. What he could  
8 have done is he could have issued a rule 23 report,  
9 which could have ended up being critical of the Trust.  
10 Some may say that the purpose of this document was to  
11 avoid that by pre-empting the final verdict and  
12 identifying what the Trust was going to do in the light  
13 of the receipt of the coroner's experts' reports. Of  
14 course, what this document doesn't do is confirm that  
15 those reports are accepted. And presumably that's why  
16 Dr Taylor can sign it.

17 MR FORTUNE: Sir, forgive me.

18 THE CHAIRMAN: Sorry, Dr Taylor signed this report as  
19 saying, I think, that he had received it.

20 MR FORTUNE: Yes.

21 A. That was my understanding of his evidence.

22 THE CHAIRMAN: It was Dr Taylor's signature on his evidence,  
23 whether I accept it or not, is a signature acknowledging  
24 receipt of the document, not approval of the document.  
25 But he did sign off the other document.

1                   Sorry, Mr Fortune.

2   MR FORTUNE:   Can I just correct my learned friend?  The  
3                   document we're looking at, the draft statement, would  
4                   not have pre-empted the verdict; it would have  
5                   encouraged HM Coroner not to make a rule 23  
6                   recommendation.

7   MS ANYADIKE-DANES:  Thank you.  What I meant by "pre-empted  
8                   the verdict" is it would have come in ahead of the  
9                   verdict, which it did do.  It was part of his own  
10                  deposition, submitted as C5 to his deposition.

11  MR FORTUNE:  I understand that, but it wouldn't have  
12                  pre-empted the verdict in the sense that the coroner  
13                  would not have changed the verdict he returned.  All  
14                  that he would have done is said, "I'm satisfied that  
15                  appropriate steps have been taken".

16  MS ANYADIKE-DANES:  What I meant was preceded it.

17  THE CHAIRMAN:  "And therefore I don't need to make a rule 23  
18                  recommendation."

19  MS ANYADIKE-DANES:  That was the point I was getting at.  
20                  What I meant to say is it came in ahead of the verdict.  
21                  But what some might say is that its true purpose was to  
22                  avoid a rule 23 report; would you accept that?

23  A.  No, I'm not an expert on coronial law.

24  THE CHAIRMAN:  Have you ever, in the position that you held  
25                  from 1987, which of necessity involved you in liaising

1 with the coroner's office from time to time and in the  
2 context of previous inquests or knowledge you'd agreed  
3 generally, were you aware that the coroner had a power  
4 under his rules to make a recommendation that certain  
5 actions should be taken and then to follow up to ensure  
6 that that action had been taken?

7 A. Yes, I did, and I also know that he never did  
8 in relation to any of the inquests that I dealt with.

9 THE CHAIRMAN: That sort of begs the question, doctor -- and  
10 it is what you were being asked a moment ago -- was the  
11 intention of providing the coroner with this document to  
12 avoid a rule 23 recommendation by the coroner? In other  
13 words, by showing the coroner: look, we faced up to what  
14 has gone wrong, we're taking steps to make sure it  
15 doesn't happen again, therefore a recommendation to us,  
16 which is a quasi-requirement, would be unnecessary?

17 A. I don't think I could have put it much better, sir.  
18 Thank you very much. Except for the unnecessary part of  
19 it about the recommendation. We were attempting to  
20 show, through the coroner, for the reassurance of those  
21 who were involved directly that we had visited this  
22 issue and put in place the following steps. That was  
23 the purpose of it and no other: only for the  
24 reassurance. It wasn't to avoid a rule 23 or whatever.

25 THE CHAIRMAN: But in doing that -- [OVERSPEAKING]. In

1           doing that, would you not know that that makes a rule 23  
2           recommendation far less likely?

3    A.   At that time, I don't believe that I knew about rule 23.  
4           I've only discovered that more recently --

5    MS ANYADIKE-DANES:   Well --

6    A.   -- through other reasons.

7    Q.   If we just go quickly to the letter that comes back from  
8           the Trust solicitors, 2 July 1996, 060-020-039.  This is  
9           obviously after the verdict.  He records his  
10          appreciation of Dr Gaston's help.  The second paragraph:

11                 "I trust that everyone involved was satisfied by the  
12                 way in which matters progressed and, indeed, I believe  
13                 it is not without note that the coroner did not issue a  
14                 recommendation in this case [and he goes on to say, in  
15                 fairness] which I believe was, in large part, due to the  
16                 fact that the deponents gave their evidence in a fair,  
17                 objective and professional manner, and at the same time,  
18                 were alert and aware of those issues, which might cause  
19                 an erosion of public confidence."

20                 Does that reference to "alert to those issues which  
21                 might cause an erosion of public confidence" refer to  
22                 the fact that Dr Taylor had submitted, as part of his  
23                 deposition, a document identifying to or describing to  
24                 the coroner what the Trust was going to do about the  
25                 very circumstance that had arisen in Adam's death?

1 A. No, I believe that the issue of -- just taking the  
2 erosion of public confidence issue, there was  
3 significant publicity --

4 Q. Yes.

5 A. -- in all the newspapers published in Belfast at that  
6 time regarding this inquest.

7 Q. Yes, but what did that mean then?

8 A. And --

9 Q. Sorry, just that line, that's the point that I'm trying  
10 to get at. What did that mean, "were alert and aware of  
11 those issues which might cause an erosion of public  
12 confidence"?

13 A. The purpose of that was called the draft statement.

14 Q. Yes.

15 A. It was to show that attention had been paid to the  
16 issues that had arisen and had been identified --

17 Q. Yes.

18 A. -- and that the consultant anaesthetists and all those  
19 under their supervision, in future, would do the  
20 following.

21 Q. Exactly. That's the point. So that --

22 A. That is the point.

23 Q. Part of being alert to that is the fact that such  
24 a document was submitted to the coroner, which would  
25 give him comfort on that point.

1 A. Exactly.

2 Q. In other words, what the Trust solicitors are pointing  
3 out, it's not just the way in which they gave their  
4 evidence, but in his view -- and it is only his view --  
5 you avoided a recommendation from the coroner in this  
6 case because you had submitted or in part because that  
7 document had been submitted?

8 A. Chairman, I regret that counsel has lost me a little bit  
9 in that convoluted question. Could it be repeated to  
10 me? I lost the thread of it, I'm afraid.

11 Q. Okay, let me try and see if I can help. You, I think,  
12 have just said that the awareness of those issues, which  
13 might cause an erosion of public confidence, is related  
14 to being aware of what might do that and, therefore,  
15 having provided the coroner with a document to satisfy  
16 him on those types of issues. And that had actually  
17 achieved what had been desired, namely that there was no  
18 recommendation from the coroner. So if that is what you  
19 wanted to do by providing that document, you had  
20 achieved that.

21 A. Except that I am not too sure about the issue about  
22 the coroner issuing a recommendation. If we take it  
23 sequentially, my understanding at the time was that  
24 if we were able to show to the coroner that proper  
25 attention had been paid to what had happened here, and



1           insofar as is possible, that the proper fluids would be  
2           given and the proper monitoring would be applied, that  
3           these efforts would make a big difference to complicated  
4           paediatric surgery care.

5   Q.   Yes.

6   A.   That was the purpose of it.

7   Q.   Right.

8   A.   And insofar as there was public attention being paid to  
9           what was going on in the court in the Crumlin Road, we  
10          knew or we thought that it would be helpful if there was  
11          wider dissemination of these recommendations other than  
12          directly to the coroner.  It was through the coroner  
13          that these recommendations would be published, therefore  
14          it was for the comfort of the staff in the Royal Belfast  
15          Hospital For Sick Children generally.  And not only for  
16          the staff, but for those patients and their parents who  
17          were using that place --

18  Q.   Yes.

19  A.   -- because the standards had been called into question  
20          by this inquest.

21  Q.   Well, let's deal with what it then says that you're  
22          going to do, which is part of what you're giving  
23          the coroner some comfort about.  The second paragraph:

24                 "In future, all patients undergoing major paediatric  
25                 surgery who have a potential for electrolyte imbalance

1 will be carefully monitored according to their clinical  
2 needs."

3 And so forth.

4 THE CHAIRMAN: You'd better bring the statement back up  
5 again if you want to go through it. 011-014-107A,  
6 please.

7 MS ANYADIKE-DANES: Right. There we see it, I was reading  
8 from the second paragraph. Then if one goes literally  
9 to the end of that paragraph:

10 "All anaesthetic staff will be made aware of these  
11 particular phenomena and advised to act appropriately."

12 And did that happen?

13 A. This was in the context of practice in that hospital.

14 Q. Yes. Did that happen?

15 A. Yes.

16 Q. All --

17 A. It was very easy because there were four paediatric  
18 consultant anaesthetists. That's all. Doctors Taylor,  
19 Crean, McKaigue --

20 Q. Except for --

21 THE CHAIRMAN: I think that's it. I think there were three,  
22 actually, at the time.

23 A. Sorry, yes. There were two missing at the time,  
24 unfortunately.

25 MS ANYADIKE-DANES: How do you think they were going to be

1           made aware of that?

2    A.   It's the use of language "made aware".  They had  
3           contributed to the drafting of the statement so they  
4           were aware.

5    Q.   They did.

6    A.   Yes.  So they were aware.

7    Q.   How were all the anaesthetic staff going to be made  
8           aware?

9    A.   And those that they were training in that place would  
10           have been shown and told what was to be done in future  
11           in relation --

12   THE CHAIRMAN:  I was told last week that this did not reach  
13           the junior doctors.  And in fact, the specific point  
14           raised last week was that this statement and the  
15           associated document was only ever seen beyond the  
16           inquest by the three paediatric anaesthetists who wrote  
17           it.  If that's right, that's hopelessly inadequate,  
18           isn't it?

19   A.   Well, I understood it to be different.  That's all I can  
20           say about it.  Because the intention was, where  
21           possible, to improve the service.

22   THE CHAIRMAN:  Exactly.  And to improve the service, you  
23           need to train the junior doctors.  And if you have  
24           learnt lessons from a child's death, then it is up to  
25           the consultants to make sure that the junior doctors

1 find out about it.

2 A. Exactly. And that would have been my intention from  
3 a distance because I was in another place and I wasn't  
4 giving the anaesthetics.

5 THE CHAIRMAN: But you would read that and be reassured that  
6 the consultants would drive home the message with the  
7 junior doctors?

8 A. Yes, I would have --

9 THE CHAIRMAN: Both the junior doctors who are there now and  
10 the junior doctors who will come along in later  
11 sequences?

12 A. Thank you.

13 MS ANYADIKE-DANES: Did you actually do anything to see  
14 whether that was happening?

15 A. No.

16 Q. Then the final paragraph is:

17 "The Trust will continue to use its best endeavours  
18 to ensure that operating theatres are afforded access to  
19 full laboratory facilities to achieve timely receipt of  
20 reports on full blood picture and electrolyte values,  
21 thereby assisting rapid anaesthetic intervention when  
22 indicated."

23 The evidence that the inquiry received is that there  
24 was no specific action taken to achieve that as a result  
25 of Adam's death.

1 A. Oh, yes there was, chairman. Blood gas analysis was  
2 a significant issue and you've heard plenty of evidence  
3 about that.

4 MR UBEROI: Sir, can I rise -- I'm not sure if it could be  
5 established with the witness, in terms of the  
6 dissemination of this document, whether he is referring  
7 to individual consultants or whether there was a role  
8 for the ATICS directorate, which we've also heard  
9 mention of in the evidence? I'm just keen that the  
10 ATICS directorate is asked about in case there is  
11 relevant in that regard as well.

12 THE CHAIRMAN: Yes. When you say that you assumed that this  
13 would be made known to the junior doctors, with whom did  
14 that obligation lie?

15 A. That would have happened within the ATICS directorate.

16 THE CHAIRMAN: Right.

17 MS ANYADIKE-DANES: I think the question is: who ultimately  
18 had that obligation? Was that a matter for the clinical  
19 lead, which was of course Dr Gaston, to satisfy himself  
20 that that was happening? Or was that simply at the  
21 level of individual anaesthetists to ensure that they  
22 were doing that on an ad hoc basis, if I can put it that  
23 way?

24 A. I'm not certain and I have not been able to find on the  
25 website anything in relation to ATICS directorate

1 minutes where this may have been discussed.

2 THE CHAIRMAN: As long as it happens, it doesn't matter who  
3 does it, does it? It doesn't matter whether it's  
4 Dr Gaston or Dr Crean or Dr Crean or Dr McKaigue.

5 A. Right.

6 THE CHAIRMAN: But it does matter that it's done.

7 A. Yes, and there were opportunities. There was another  
8 opportunity at M&M, mortality and morbidity, at audit.  
9 And I cannot believe that it wasn't discussed in public  
10 at an audit meeting. And the anaesthetic directorate  
11 were very good at doing these.

12 MS ANYADIKE-DANES: I suppose, Dr Murnaghan, just the final  
13 point on that is --

14 A. They had a good reputation.

15 Q. -- if it had been a matter for the clinical director to  
16 do that, then it could have been formalised and he could  
17 have issued guidance actually, and then that becomes  
18 a more systematic way of addressing it rather than  
19 leaving it up to individual consultant anaesthetists as  
20 to how they communicate those lessons. So it might have  
21 been, if you're looking at your role as risk management  
22 and so forth, it might have been more appropriate that  
23 it be done by the clinical lead, raised in one of their  
24 meetings and some sort of document go out, "This is now  
25 what we expect". Maybe even this go out.

1 A. Yes.

2 Q. Thank you.

3 A. Now --

4 Q. Sorry?

5 A. You were asking me about lessons learned.

6 Q. I wasn't so much asking you about the blood gas  
7 machines. I was asking you about the operating theatres  
8 being afforded access to full laboratory facilities,  
9 which are different things from the blood gas machines.  
10 And I think this arose because there was an issue of  
11 when samples could be taken to the operating theatre,  
12 how that would be done, what the turnaround time would  
13 be and so forth. So the point that I'm asking you here  
14 is: what did you understand would be done in the light  
15 of this statement to improve or address the access to  
16 full laboratory facilities?

17 A. Chairman, with respect to counsel, blood gas analysis  
18 does have a direct relationship to laboratory services,  
19 insofar as there is near-patient testing, and that is  
20 what a blood gas analyser does, and what the laboratory  
21 can do.

22 Q. Yes.

23 A. I'm sure you've had it explained to you already, but let  
24 me go over it again one way or another.

25 THE CHAIRMAN: Let me see if I can short circuit this. As

1 I understand from the evidence of the Mr Shaw, blood gas  
2 analysers are now, in 2012, much more developed and  
3 advanced than they were in 1995. What you had in the  
4 Royal in 1995 was a good example of the then available  
5 blood gas analysers. But nowadays, blood gas analysers  
6 are better so the fact that they're there is clearly  
7 positive. So in 1995, they made a potentially important  
8 contribution, within limits.

9 A. Yes.

10 THE CHAIRMAN: The question which I think you were being  
11 asked is that this refers to full laboratory facilities.  
12 We accept that blood gas analysers are a contributor to  
13 laboratory facilities, but the question was,  
14 particularly if an operation is out of hours, there was  
15 a concern or there may be a concern about turnaround  
16 time and there's one porter who's available to collect  
17 the sample and come back with the analysis and so on.  
18 This statement effectively reassures the coroner and the  
19 public that the Trust will do its best to make sure that  
20 operating theatres are afforded access to full  
21 laboratory facilities. So what was done after the  
22 inquest in light of Adam's death to advance the  
23 endeavours to ensure that there was access to full  
24 facilities?

25 A. First of all, if you'll allow me one second, I want to



1 get blood gas analysers off my sheet. That is that as  
2 a result of this, funds were made available and a new  
3 blood gas analyser was made available for that theatre  
4 and that was perceived as being an improvement. Number  
5 two, the issues regarding portering were addressed with  
6 the business manager and the director, clinical  
7 director, in the Children's Hospital and there was an  
8 assurance that that matter would be addressed and dealt  
9 with appropriately.

10 Number three, the biochemistry laboratory. The  
11 biochemistry laboratory at that time was a two-stage  
12 process. There was a small biochemistry provision in  
13 the basement of the Royal Belfast Hospital For Sick  
14 Children. At the back of it was the main biochemistry  
15 laboratory, further away. Detailed discussions took  
16 place with the biochemistry staff in both locations and  
17 an assurance was given that better attention would be  
18 given in future to the provision of biochemistry  
19 services to the theatres in and out of hours.

20 Number four, if it was not possible to do  
21 haematology testing out of hours in the laboratory  
22 in the Children's Hospital, an assurance was given that  
23 microsample testing could be done in the haematology  
24 laboratory in the main hospital. Granted, that was at  
25 a distance removed from the Children's Hospital because

1 of the anatomy of the site. And related to that was  
2 that portering had to happen. If portering did not  
3 happen, I know that the roving security provision on the  
4 site, which was mobile, could be used instead if  
5 a porter wasn't available to bring the specimen from the  
6 children's theatre over to the haematology department,  
7 over close to the Grosvenor Road.

8 Q. Thank you.

9 A. So those are all issues that cascaded down.

10 Q. Thank you very much. I think you have clarified one  
11 point that we were unsure of, because both  
12 Professor Savage and certainly Dr Taylor were not  
13 convinced that that small laboratory that you've  
14 mentioned was actually functioning for the purposes of  
15 theatre other than for oncology, as I understand it. In  
16 fact, I think Dr Taylor referred to it as being not fit  
17 for purpose because the results were not reliable.

18 Now, is that correct or not?

19 A. I never heard that said, that the results were not  
20 reliable. I never heard that. And it was staffed by  
21 a very senior and highly graded technical officer and  
22 another.

23 Q. No, no. What he was suggesting is because of that, the  
24 samples were going to the main laboratory other than, as  
25 I say, for purposes of oncology. Not that they were

1 carrying on using results that were unreliable because  
2 there was a recognition that there was an issue to do  
3 with that laboratory, that is why the change was made.  
4 And it was the making of that change that produced an  
5 extra time factor, if I can put it that way, for the  
6 turnaround. Were you aware of that as an issue as at  
7 the time of Adam's surgery?

8 A. I was aware that there was a difficulty with  
9 portering --

10 Q. Okay.

11 A. -- and because of the site of the biochemistry  
12 laboratory.

13 Q. Okay.

14 A. Down below the dental hospital was quite a distance  
15 from --

16 Q. Thank you.

17 The coroner's verdict comes through and, in essence,  
18 what it does is confirm the pathologist's view. It's at  
19 011-016-114. There you are. You can see the cause of  
20 death.

21 A. Yes.

22 Q. "Cerebral oedema due to dilutional hyponatraemia and  
23 impaired cerebral perfusion during a renal transplant  
24 operation for chronic renal failure."

25 Then the findings:

1           "The onset of cerebral oedema was caused by the  
2           acute onset of hyponatraemia from the excess  
3           administration of fluids containing only very small  
4           amounts of sodium and this was exacerbated by blood loss  
5           and, possibly, the overnight dialysis and the  
6           obstruction of the venous drainage to the head."

7           Your evidence earlier was that the plan was on to  
8           the inquest and deal with the matter there and see what  
9           the coroner's finding was. Well, now this is  
10          the coroner's finding, verdict and finding. So you  
11          produce a note or an aide-memoire after that. We can go  
12          to it, 059-001-001. If we go to that and perhaps pull  
13          up the second page as well next to it, 002.

14          There we are. So this is your note to self, in  
15          a way. You attended the coroner's court:

16          "Generally the outcome was satisfactory. Fair  
17          write-up ..."

18          Then:

19          "Other issues identified which relate to structure  
20          and process of paediatric renal transplant services."

21          What were they?

22    A. I can't remember back as far as 1996, especially what  
23          they were. But all that and those who were present  
24          would have known and, at the time, in the hall of the  
25          Coroner's Court, I raised this issue, and if you go on

1 to the next page -- and this is where, to this day, I am  
2 very distressed.

3 Q. No, we will go on to the next page, obviously.

4 A. I know you will.

5 Q. What I'm trying to find out --

6 A. One is related to the other.

7 Q. Then maybe that's how you have to explain it.

8 A. It's not how I might have to explain it; it's how I must  
9 explain it.

10 Q. The verdict that the coroner handed down was Adam's  
11 cause of death and that deals with, effectively,  
12 dilutional hyponatraemia.

13 A. Correct.

14 Q. So that's that. That has nothing to do necessarily with  
15 the paediatric renal transplant services. So this is  
16 a different point, ostensibly, that you are raising,  
17 which is that:

18 "Other issues identified which relate to the  
19 structure and process [so it seems] of paediatric renal  
20 transplant services."

21 And all I'm trying to see if you can help us with is  
22 what those other issues might be.

23 A. At this remove, I cannot remember.

24 THE CHAIRMAN: Okay. Then you were going to go on to the  
25 second page.

1 A. Yes.

2 THE CHAIRMAN: How does that help develop your memory about  
3 what you were going to do at the time and the  
4 discussions which you had at the corridors of the  
5 Coroner's Court?

6 A. The plan was that I would arrange a feedback seminar  
7 with all those involved -- doctors Mulholland, Hicks,  
8 Gaston, Taylor, Savage, O'Connor, Keane, medical  
9 director and myself present -- as soon as possible so  
10 that we could review all that had happened, particularly  
11 regarding Adam's care leading to his death and what had  
12 come out at the inquest.

13 MS ANYADIKE-DANES: You seem to have characterised it as an  
14 RM issue. Is that a risk management issue?

15 A. It was feedback, seminar, whatever you -- the totality  
16 of it --

17 Q. Yes.

18 A. -- we were to have a full discussion.

19 Q. Were there going to be any nurses there?

20 A. No. Not at that stage. It wasn't considered that  
21 nurses were to be invited, no. It might have arisen as  
22 a secondary issue, but not at that time.

23 Q. Okay.

24 A. If I may go on, chairman.

25 THE CHAIRMAN: Yes.

1 A. That was towards the end of June. And you will notice  
2 that I said "ASAP".

3 THE CHAIRMAN: Yes.

4 MS ANYADIKE-DANES: Yes.

5 A. I asked my staff to see how quickly we could get all  
6 those identified there together. And I believe on the  
7 website there is a matrix with all those names and their  
8 availabilities or not; do you have that?

9 Q. No, I haven't seen it.

10 THE CHAIRMAN: We've seen something, a version of it, we saw  
11 it last week.

12 A. It's a squared ...

13 MS ANYADIKE-DANES: The difficulty we have is there were  
14 matrices in relation to people meeting prior to the  
15 verdict. I'm not sure that we have seen one that  
16 identifies itself as being a matrix having received the  
17 verdict.

18 THE CHAIRMAN: I accept your -- sorry.

19 MR FORTUNE: That's my recollection too.

20 THE CHAIRMAN: Dr Murnaghan, I accept your proposition from  
21 this note that you saw urgency in having this meeting  
22 and that's why "ASAP" is part of the note.

23 A. Well, particularly because of the date. This is the  
24 third week in June.

25 THE CHAIRMAN: Yes.

1 A. And July and August are fast approaching. Holiday time.

2 THE CHAIRMAN: Okay.

3 A. My staff, who are very good at organising meetings of  
4 this kind, and did always work on a matrix of  
5 availability, did their best to get colleagues together  
6 and failed to do it in the period before summer holiday  
7 time, July and August.

8 THE CHAIRMAN: Okay.

9 A. Next, I went on leave myself the second fortnight  
10 in July. And close to or during my holiday, the end of  
11 my holiday, I got sick.

12 THE CHAIRMAN: I don't want the dates, doctor, but can I ask  
13 roughly how long you were off for then?

14 A. I've checked with one of my GPs last night and he says  
15 that he doesn't remember because this was a recurring  
16 problem that I had. I'm quite happy to identify what  
17 I had. Recurrent renal colic, stones. And usually, the  
18 management was expectant with analgesia and fluids. One  
19 would hope that the stone would pass. And only on two  
20 occasions did I have to have stones removed surgically.

21 THE CHAIRMAN: Okay.

22 A. All the other times that I suffered with this, they  
23 passed spontaneously. But it would take two, three  
24 weeks. So here I was in this situation, holiday's  
25 a fortnight away, and back then -- and when I came back



1 to the office, I regret to this day that I forgot  
2 totally about this important issue. And there was  
3 a pile, as you would know, awaiting me on my desk and  
4 that overtook me. It's an explanation, it's not an  
5 excuse. And all I can do is say, hands up, I'm sorry.

6 THE CHAIRMAN: Dr Carson was to be at that meeting.

7 A. Yes.

8 THE CHAIRMAN: Did he understand the importance of that  
9 meeting?

10 A. I believe and hope that I gave him feedback at the time.

11 THE CHAIRMAN: Well, the fact that he's included in it and,  
12 in fact, the bottom of page 1, the page on the left, it  
13 says that you're agreeing this with Dr Carson.

14 A. Yes, I see that now.

15 THE CHAIRMAN: And Dr Carson was to attend the meeting.

16 A. Yes.

17 THE CHAIRMAN: You're off for the second half of July and  
18 then you take sick and, as I understand it, you're away  
19 for a further two to three weeks or so approximately?

20 A. I may have been in and out because with good pain  
21 management, it -- and it was as well for me to be  
22 distracted by work occasionally.

23 THE CHAIRMAN: The point I'm getting to is this: the meeting  
24 didn't take place when you wanted it to because the  
25 relevant people could not attend at the same time.

1 A. Yes.

2 THE CHAIRMAN: It's then delayed by holidays. It's then  
3 delayed by your illness. Although you want to be there,  
4 you do not have to take the meeting; Dr Carson could  
5 take it, couldn't he?

6 A. Well, it was a distributed task. I, on his behalf, am  
7 the lead in this matter. I had dealt --

8 THE CHAIRMAN: That's the point: on his behalf. And if  
9 you are disabled, even on a comparatively short-term  
10 basis, from handling this meeting, then if the meeting  
11 is regarded as urgent and if it is regarded as  
12 important, then he can take it up. And if he doesn't  
13 take it up, then he can remind you of it, and if he  
14 doesn't remind you of it, then a number of the other  
15 people who are also contacted because the meeting is  
16 urgent and important, they can take it up. As  
17 I understand it, doctor, not only did you forget it --  
18 for which you have put your hands up -- but nobody else  
19 who was on that list reminded you of it. Is it right  
20 that nobody else reminded you of it?

21 A. Chairman, I'm the one to take all the blame for this.

22 THE CHAIRMAN: On one level, that's very good of you. On  
23 another level, it's too much, particularly if you go  
24 back to the issue which you mentioned before the break.  
25 That part of the plan was to go to the inquest, see how

1 Dr Taylor's views stood up to scrutiny, see how the  
2 matter is dealt with there and see what the coroner's  
3 findings are. The coroner's findings do not accept  
4 Dr Taylor's theory, so whatever there is about the  
5 structure and progress of the renal transplant service,  
6 the coroner's finding highlights that there is now  
7 a judicial finding --

8 A. Yes.

9 THE CHAIRMAN: -- on Dr Taylor.

10 A. That's true.

11 THE CHAIRMAN: And nothing happened about that, sure it  
12 didn't.

13 A. No. Well, this was the next step, so to speak.

14 THE CHAIRMAN: This was to be what you described as  
15 a feedback seminar with all of those involved to review  
16 everything that had happened.

17 A. Yes.

18 THE CHAIRMAN: You see, when we were talking earlier on  
19 today about what the processes are, and you said about  
20 all the good work that Dr Taylor's done and the high  
21 regard he's held in and he doesn't just do what's  
22 required, he often goes beyond that and does more than  
23 what's required. And I was told earlier in this inquiry  
24 that in 1995 there was not a culture or practice of  
25 doctors reporting each other to the GMC, but employers

1           did; right?

2    A.   Yes.

3    THE CHAIRMAN:  You now have, on foot of the inquest finding,  
4           a confirmed concern about Dr Taylor over and above the  
5           view of Dr Sumner.  And the inquest verdict has to be  
6           accepted by the Trust, I assume.  You don't go behind  
7           the inquest verdict.

8    A.   Other than look for a judicial review.  That was not our  
9           intention.

10   THE CHAIRMAN:  That didn't happen and the reason it was  
11           never going to happen was because the inquest verdict  
12           was based, to a considerable extent, on Dr Sumner's  
13           evidence.

14   A.   Correct.

15   THE CHAIRMAN:  Well, is that not the point where, unpleasant  
16           as it is and reluctant as anybody might be to do it,  
17           somebody has to say: if Dr Taylor does not accept the  
18           inquest verdict now, we have to make this formal?

19   A.   Well, I, in my time up to 1995/1996, in the Royal, had  
20           no experience of anybody being referred.  And usually --

21   THE CHAIRMAN:  By the Royal?

22   A.   By the Royal, or the Eastern Board or any unit in  
23           Northern Ireland in my experience.  So there wasn't  
24           a culture of referral to the GMC.

25   THE CHAIRMAN:  Doctor, how could that be?  How could it

1           be -- this is in all your career?

2    A.  No, no, only when I was in this job.

3    THE CHAIRMAN:  So from 1987 to 1995, whether it was the

4           Eastern Board or the Royal Trust, as it became --

5    A.  I had no knowledge of anybody being referred from within

6           the hospital service.

7    THE CHAIRMAN:  When you said "or any unit in

8           Northern Ireland", was that --

9    A.  Within the hospital service --

10   THE CHAIRMAN:  Right.

11   A.  -- which is where I would be much more likely to hear

12           about it.

13   THE CHAIRMAN:  Exactly.  So you're far more likely to hear

14           of that than you are of, say, a GP being referred.

15   A.  Yes.

16   THE CHAIRMAN:  What you are saying is, from 1987, you're not

17           aware of a single doctor being referred to the GMC by

18           the Eastern Board, Western Board, Southern Board or

19           Northern Board?

20   A.  No, I wasn't.

21   THE CHAIRMAN:  Nor by any of the trusts which were

22           established in 1993?

23   A.  And gossip was a great thing in those days.

24   THE CHAIRMAN:  So you would have heard?

25   A.  I think I should have or would have.

1 THE CHAIRMAN: You would certainly have heard if, for the  
2 first time in Northern Ireland since 1987, a doctor had  
3 been referred to the GMC by his employer.

4 A. Mm-hm, I stand to be corrected. Maybe I didn't get the  
5 information.

6 THE CHAIRMAN: Doctor, can you understand why that, whatever  
7 the opposite of reassurance is, that's the effect it has  
8 on me? It's not just that clinicians were not referring  
9 each other to the GMC, employers weren't referring their  
10 employees to the GMC. What does that say about the  
11 Health Service in Northern Ireland?

12 A. It's capable of two interpretations.

13 THE CHAIRMAN: Okay.

14 A. Either that there wasn't a culture or the standards are  
15 fairly good and didn't require that people be referred;  
16 is that not correct?

17 THE CHAIRMAN: Well, sorry.

18 A. My apologies, I know I shouldn't ask you questions.  
19 Apologies for that.

20 THE CHAIRMAN: It's not that the standards are fairly good,  
21 it's the standards are so universally good that there  
22 isn't a single doctor in the hospital service in  
23 Northern Ireland who has been required to be reported to  
24 the GMC. I would love to think that we live in a  
25 place -- that's unrealistic, isn't it?

1 A. I'm thinking about professional and clinical practice.  
2 There are other issues like alcohol.

3 THE CHAIRMAN: I understand that.

4 A. That's separate.

5 THE CHAIRMAN: Right.

6 A. But that requires referral and will be referred by the  
7 courts or the police or whoever. And that happened  
8 routinely. If a doctor was found to be abusing drink  
9 or drugs and driving or whatever.

10 THE CHAIRMAN: But then --

11 A. -- he would be referred.

12 THE CHAIRMAN: By who?

13 A. I would think that that would have been on the  
14 regulation side.

15 MR FORTUNE: Sir, the last answer would bring about  
16 performance issues and that in themselves there should  
17 have been a referral. So I anticipate that the  
18 inquiry -- and you, sir, in particular -- will want an  
19 enquiry made of the General Medical Council. Statistics  
20 will be available, perhaps not at short notice, but  
21 I anticipate that you can be told the number of  
22 referrals and perhaps the general bracket of the type of  
23 referrals being made over those years.

24 THE CHAIRMAN: Thank you.

25 Dr Murnaghan, let us suppose that I don't accept

1           that our doctors are so good, so universally good that  
2           none of them has had performance issues requiring  
3           a referral. Your fallback position, or your second  
4           alternative, is that there wasn't a culture. Is that  
5           really the explanation here, that there was not the  
6           culture in Northern Ireland to report a doctor to the  
7           GMC, even where a child had died?

8    A. My impression -- and I can't say more than my  
9           impression. I can't say my direct knowledge because  
10           that would not have been an issue that I would have done  
11           directly anyway.

12   THE CHAIRMAN: But you would have heard. You were saying  
13           that --

14   A. It wasn't in my job description.

15   THE CHAIRMAN: Sorry, you said to me a few minutes ago: it's  
16           a small place and there's gossip. You were saying that  
17           in order to let me know that if there had been  
18           referrals, you would know about them. And now I'm  
19           coming back to you on that point and saying that my  
20           understanding of your evidence is that even where  
21           a child dies, or for that matter where an adult dies,  
22           employers in Northern Ireland did not report their  
23           clinical staff to the GMC --

24   A. If a child -- it depends on the circumstances.

25   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

1 question -- I don't have very many more questions,  
2 subject to counsel for the interested parties -- on  
3 this.

4 THE CHAIRMAN: Doctor, it's 5.05. I know it's been a long  
5 day for you, but if you can bear with us for a few more  
6 minutes, I think we can finish your evidence this  
7 evening rather than ask you to come back again tomorrow.

8 A. I'm grateful to you.

9 THE CHAIRMAN: Is that okay?

10 A. I'm grateful to you.

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

12 You said that your staff were quite good at trying  
13 to make arrangements such as you required for this  
14 seminar to actually happen.

15 A. I wasn't good enough in the way I described my staff.  
16 They were excellent.

17 Q. Yes. Are we to understand that all these people listed  
18 as those who you thought should attend, at least, this  
19 seminar -- forget what might happen thereafter -- were  
20 actually contacted?

21 A. Yes.

22 Q. The difficulty is that the evidence that we've received  
23 from Dr O'Connor and, I believe, Dr Mulholland is that  
24 they didn't know anything about this seminar.

25 A. Well, the only way I can support this is that this is

1 a file note and it's in the file. And it got there and  
2 was put there when I put it in on my return from  
3 the Coroner's Court. And I know that I would have  
4 discussed with senior members of my staff -- and I had  
5 six or seven at that time --

6 Q. Yes.

7 A. -- what my need was.

8 Q. Is it possible --

9 A. And there's no way, because they were excellent staff.

10 Q. I understand that. Is it possible that you wanted,  
11 in the way that you had wanted to await the outcome of  
12 the inquest, that you wanted to see what came out of the  
13 litigation, for example?

14 A. Oh no, not at all. Totally separate. I've already told  
15 you earlier on that I ...

16 Q. Was slightly schizophrenic about that?

17 A. I don't like the word "schizophrenic", but I  
18 dichotomised myself.

19 THE CHAIRMAN: If you were going to wait for the outcomes of  
20 the litigation, you wouldn't have put "ASAP" in your  
21 note?

22 A. Absolutely not. Thank you very much.

23 MS ANYADIKE-DANES: Sorry, I meant by that when you came  
24 back and it hadn't already been organised. But in any  
25 event --

1 A. No.

2 THE CHAIRMAN: You forgot?

3 A. I forgot.

4 MS ANYADIKE-DANES: Okay. Can we go on then to the  
5 settlement of the litigation? If we go to 060-016-031.  
6 It's a bit difficult to read in the middle where it's  
7 a bit smudgy and some part has been redacted. It's  
8 a letter from the Trust solicitors to you, dated  
9 19 March. There's a discussion as to the settlement of  
10 it and the plaintiff's solicitors are prepared to enter  
11 into discussions. In the second paragraph it says:

12 "I believe, from a liability point of view, this  
13 case cannot be defended, and this is based largely upon  
14 the information given by one of the independent experts  
15 retained by HM Coroner at the inquest."

16 And then:

17 "Additionally, I believe that it would be unwise for  
18 the Trust to engage in litigation in this matter given  
19 the particularly tragic circumstances of the death and  
20 the opportunity for the exploration of any differences  
21 of opinion which might exist between a number of the  
22 attending physicians."

23 Did that mean, as at 19 March 1997, after the  
24 verdict, that there were still differences of view  
25 amongst the clinicians?

1 A. Yes.

2 Q. And does that mean that Dr Taylor still had a different  
3 view from Professor Savage, for example?

4 A. Dr Taylor's given evidence to this inquiry that he held  
5 on to that view until very recently.

6 Q. I'm asking you about your knowledge of these things.

7 A. That was my knowledge.

8 Q. So you knew he had a different view?

9 A. Yes, then and thereafter.

10 Q. And we have heard evidence from Dr Crean, Dr Gaston.  
11 All of them accepted the verdict, the inquest. So that  
12 means, does it not -- you tell us. Did you understand  
13 Dr Taylor to be isolated in his view?

14 A. I think I might need to go back just one pace --

15 Q. Mm-hm.

16 A. -- and say that Dr Taylor accepted that there was  
17 hyponatraemia --

18 Q. Yes.

19 A. -- but I don't think he accepted the qualifying word  
20 "dilutional".

21 Q. Well, Dr Murnaghan, if I may say, it's not that it's  
22 a qualifying word, it's a whole way in which the  
23 cerebral oedema had developed. And therefore, from the  
24 point of view of understanding the mechanism for the  
25 development of cerebral oedema, the fact that it was

1           considered to be dilutional hyponatraemia is a lesson to  
2           be learned.

3    A.   I accept all that.  But I'm coming to it from  
4           Dr Taylor's perspective.  I'm not here as his  
5           advocate --

6    Q.   Yes.

7    A.   -- at all.

8    Q.   But did you --

9    A.   Therefore, I don't need to be reminded of the various  
10           issues that arose.

11   THE CHAIRMAN:  I'm sorry, doctor, counsel's question to you  
12           was a response to your suggestion that the difference  
13           between dilutional hyponatraemia and hyponatraemia is  
14           somehow just a qualifying word, like "quiet" and "very  
15           quiet".

16   A.   Oh no, no, it's much more serious than that, chairman.

17   THE CHAIRMAN:  That's the point, it is much, much more  
18           serious than that, and if it's much, much more serious  
19           than that and Dr Taylor doesn't get it, that's  
20           a problem.

21   A.   At that time.

22   THE CHAIRMAN:  But in March 1997, you knew that these  
23           differences still continued, right?  Did that not remind  
24           you about the seminar in July 1996 that had never taken  
25           place?

1 A. I regret that it did not. Time had marched on. I did  
2 not see that file again. I didn't see that note and ...

3 MS ANYADIKE-DANES: But what did you think you should do  
4 about the fact that you knew that Dr Taylor did not  
5 accept that as a mechanism of the development of Adam's  
6 cerebral oedema?

7 A. In effect, I didn't know what to do and I was depending  
8 on my anaesthetic colleagues.

9 Q. But they'd accepted the verdict.

10 A. Yes. But they didn't say that they needed to do  
11 something about Bob Taylor.

12 THE CHAIRMAN: Is that because, in effect, they were keeping  
13 an eye on him and he had reverted to his consistently  
14 good practice, so if everybody crossed their fingers,  
15 this wouldn't happen again?

16 A. I would hope they didn't need to cross their fingers,  
17 but this was a singular aberration that he would have  
18 learned from as well as everybody else.

19 THE CHAIRMAN: The trouble is, of course, he didn't. He  
20 didn't learn. I mean, if Dr Taylor had said at the time  
21 that this was a singular aberration, then this would be  
22 an entirely different inquiry.

23 A. But he didn't do anything -- he didn't cause dilutional  
24 hyponatraemia again.

25 THE CHAIRMAN: But he didn't accept that it was an

1 aberration. He didn't begin to accept it was an  
2 aberration until February 2012.

3 A. I accept that, I know.

4 THE CHAIRMAN: And he didn't accept the extent of his  
5 aberration until April 2012. If he had been a good  
6 doctor who made this awful mistake and then faced up to  
7 it, as doctors I'm sure do, and said, "This was awful,  
8 that will not happen again", that's a situation in which  
9 you might feel reassured. If, on the other hand,  
10 you have a doctor who doesn't recognise what he did  
11 wrong or is in denial about what he did wrong, you  
12 don't -- and in fact, more than that, is advancing  
13 alternative theories and explanations, then you have no  
14 reassurance that it won't happen again; isn't that  
15 right?

16 A. I agree.

17 THE CHAIRMAN: So what in effect happened was that, without  
18 reassurance that this wouldn't happen again, Dr Taylor  
19 continued to work as a paediatric anaesthetist. As it  
20 turns out to the best of the information that's  
21 available to us, it hasn't happened again, but that's  
22 not quite the way the system is supposed to work, either  
23 now or even in 1995. Would you agree?

24 A. He continued to give excellent anaesthetics and no  
25 problem arose. I know that there I'm bringing in the



1           retrospectoscope.

2   THE CHAIRMAN:  That's exactly the problem because nobody  
3           could have known --

4   A.  Exactly, I'm agreeing with you, chairman.

5   MS ANYADIKE-DANES:  What happened, of course, is ultimately  
6           there is a settlement.  Can we pull up 060-013-024?  
7           Apart from the legal advice that you received  
8           in relation to the appropriateness of settling it, there  
9           are two elements in this settlement.  One is that it's  
10          to be without any omission of liability.  The other  
11          is that it's to include a confidentiality clause.  Who  
12          formed the view that both of those things were  
13          appropriate in this case?

14  A.  The legal advice was that that's how it should be  
15          constructed.

16  Q.  If it's going to have a confidentiality clause, then  
17          nobody would know whether there was any admission of  
18          liability.  It's going to be in full and final  
19          settlement in any event; isn't that right?

20  A.  Yes.

21  Q.  Couldn't that have been something you could have offered  
22          to Adam's family, the recognition that we did make that  
23          mistake, we accept liability for it?  Isn't that  
24          something that might have, even at that stage, at least  
25          given her something?  Given that your legal advice,

1 of course, was that it could not be defended?

2 A. Well, the -- I worked on the basis of the legal advice  
3 that was given and that was standard practice at that  
4 time. And the purpose of the confidentiality clause was  
5 commonly for the protection of plaintiffs.

6 Q. Sorry? Protection of?

7 A. Commonly for the protection of successful plaintiffs.

8 Q. Did she want it?

9 A. I don't know and I don't remember. Because these  
10 negotiations were undertaken between her representatives  
11 and our representatives on the legal side.

12 Q. Well, did you have any report as to whether it was  
13 Adam's family who were seeking to have a confidentiality  
14 clause in their --

15 A. No, I didn't.

16 THE CHAIRMAN: In fact, the fact that you say it's standard  
17 practice, in effect, concedes that the standard practice  
18 is driven by the hospital. Because it is the hospital  
19 which is typically the defendant in this case and  
20 Debra Strain is not the plaintiff. So if there's  
21 a standard practice, isn't it coming from the  
22 defendant's side, not the plaintiff's?

23 A. My understanding is that it was standard practice in  
24 personal injury claims generally, not specifically in  
25 medical negligence.

1 MR SIMPSON: Mr Chairman, I wanted to let the witness answer  
2 that question before I did interject, but those of us  
3 who did clinical negligence in that period always put  
4 those terms in whether we were instructed to or not.  
5 I personally would never have allowed an admission of  
6 liability to go into a settlement for a professional  
7 man. I still do it for architects, for any professional  
8 man -- solicitors, anything like that. We do that as  
9 a matter of pure standard -- I doubt if the hospital was  
10 ever asked about it. It was done through the solicitors  
11 and counsel every single time. It was standard  
12 practice, sir, and it was not something that was  
13 adverted to in any particular way. The doctor's  
14 absolutely right: many times I was asked by plaintiff's  
15 counsel not to allow it to be anything other than  
16 confidential because they did not want the world to know  
17 what they took. So it was not articulated in the way  
18 that you are suggesting, sir, is what I want to get  
19 across.

20 THE CHAIRMAN: There are two points about that. First of  
21 all, you can have confidentiality about the amount of  
22 the payment as opposed to the fact that there was  
23 a settlement.

24 MR SIMPSON: You could, but that was not what was being done  
25 at the time. And I have to say in every case that I was

1           involved in -- and still am in cases which are not  
2           clinical negligence -- I still have confidentiality in  
3           there. I insist on that as a term when there's  
4           a professional person involved and never an admission of  
5           liability. You'll know that, sir, from your own  
6           practice, that that that was not done.

7 MS ANYADIKE-DANES: Dr Murnaghan, is the upshot of the thing  
8           that Adam's family was left with nobody, ostensibly,  
9           taking responsibility? No apology, nothing, until the  
10          first apology, I think, which may have come in these  
11          proceedings?

12 A. If one differentiates between sympathy, expression of  
13          sympathy and apology, I certainly remember that  
14          I offered sympathy on behalf of the Trust at the  
15          conclusion of the inquest because that was my standard  
16          practice.

17 Q. I understand that, Dr Murnaghan, I'm not suggesting that  
18          you wouldn't do that or that any clinician wouldn't do  
19          that. That is very different from an acceptance of  
20          responsibility for something having happened.

21                 I think there's just one --

22 THE CHAIRMAN: Sorry, let me reinforce that point.

23                 When you have a coroner's verdict, which is to the  
24          effect that it was the hospital's fault, do you see how  
25          it would aggravate the family that, despite that

1           verdict, the hospital doesn't accept responsibility and  
2           the hospital doesn't apologise?

3    A.   I know exactly what you're saying, chairman, but it  
4           wasn't within my gift.  I was the manager of the  
5           process.

6    THE CHAIRMAN:  Okay.

7    A.   And it was known that I had had no clinical input to  
8           Adam's care.

9    THE CHAIRMAN:  We'll move on.

10   MS ANYADIKE-DANES:  One last document, and the only reason  
11           I raise this with you, Dr Murnaghan, is because it is  
12           your document to all the clinicians who were involved,  
13           directly involved in the sense of having provided  
14           statements and so forth.  They have all been taken to  
15           it, so I think it's only fair that you, as the author,  
16           are asked about it.

17   A.   Thank you.

18   Q.   There is a series of them to Mr Crean, to Dr Taylor, to  
19           Dr Savage, Dr Webb, Mr Brown.  I think that's it.  We  
20           find they're all in the same format.  I pick one at  
21           060-010-018, which are happens to be the one to  
22           Dr Taylor.  There it is, 9 May:

23           "I am sure you will be pleased to be informed that  
24           this claim has been successfully concluded by payment of  
25           a sum which is not greater than the normal and statutory

1 scale, subject to the confidentiality clause binding on  
2 both parties. From a liability position, the case could  
3 not have been defended, particularly in the light of the  
4 information provided by one of the independent  
5 experts ... Additionally, it would have been unwise for  
6 the Trust to engage in litigation in a public forum  
7 given the tragic circumstances of the death. It would  
8 not have been helpful for an opportunity to be provided  
9 to lawyers to explore any differences of opinion, which  
10 might exist between various professional witnesses who  
11 would have been called to give evidence. I am grateful  
12 for your generous assistance in arriving at this  
13 successful conclusion."

14 What actually was the purpose of sending that letter  
15 to those clinicians?

16 A. It was winding-up the issue, a conclusion, informing  
17 them. They wouldn't have known otherwise that the claim  
18 had been settled. That is the purpose of it --

19 Q. It didn't have to --

20 A. -- and no other.

21 Q. It didn't have to provide the detail that you've  
22 provided in the second paragraph -- alert everybody to  
23 the fact there are those differences, alert everybody to  
24 the fact that the case could not be defended -- but  
25 nonetheless it's all going to be kept from publication,

1           those details, by virtue of the fact that the case is  
2           settled, so the evidence won't now be heard and there's  
3           a confidentiality clause so Adam's family aren't going  
4           to be in a position to tell anybody what happened. Why  
5           would you be providing that information to the  
6           clinicians?

7   A. With respect, chairman, that's a matter of opinion.

8   Q. Well, why would you be providing that information to the  
9           clinicians?

10  A. Because they were involved and they needed to know what  
11           had happened.

12  Q. What had happened?

13  A. It's a courtesy, if nothing else, to let them know the  
14           matter had been determined.

15  Q. When you say "winding-up", "a successful conclusion",  
16           that's the end of it, isn't it? There's going to be  
17           nothing like a seminar, nothing like an investigation to  
18           see how we got here and how we may perhaps avoid this  
19           in the future. That's the end of it.

20  A. I have already explained about what happened about the  
21           feedback session. I'm sorry again and again and again.  
22           This took longer to sort out and all I wanted to do was  
23           to ensure that each and everybody who had contributed to  
24           the information gathering and so forth was told that the  
25           file was now closed.

1 Q. Yes, that's exactly the point, Dr Murnaghan. The file  
2 is now closed. So irrespective of whether you had  
3 forgotten about the seminar or whatever it is, the  
4 opportunity to disseminate any lessons that might have  
5 been learned, that's going to be an end of it because  
6 we've now reached a successful conclusion. And one way  
7 of looking at it would be that the successful conclusion  
8 is we haven't had a coroner's recommendation.  
9 We haven't had a contested litigation and we have  
10 achieved a settlement with a confidentiality clause. So  
11 that is the end of it.

12 A. Chairman, how many times do I have to say sorry?  
13 Because that's the only way I can answer counsel.

14 THE CHAIRMAN: Okay, thank you very much. Thank you.

15 MS ANYADIKE-DANES: It is just one final point arising out  
16 of that because the coroner's been asked about it.

17 The coroner believed that something more would  
18 happen. In fact, if we can pull up the coroner's  
19 evidence to the inquiry. It's witness statement 091/1,  
20 at page 2, and could you please pull up page 3 alongside  
21 it?

22 It's a short statement:

23 "My understanding was that, so far as the Royal  
24 Belfast Hospital for Sick Children was concerned, the  
25 hospital would learn from what happened to Adam. As far



1 as I can recall, no specific commitment was given  
2 in relation to the future fluid management of children.  
3 I sensed that not everyone agreed with the views of  
4 Dr Sumner."

5 So that was an issue that had to be addressed. And  
6 then he was asked about dissemination in question 2 and  
7 he says:

8 "The consensus was that there was no effective means  
9 of doing so other than through the medical literature  
10 and Dr Sumner mentioned that else the editor and he  
11 undertook to arrange for Professor Arieff ..."

12 And he's not sure that there was anything that could  
13 be assisted through the Chief Medical Officer. And we  
14 know that Dr Armour took it upon herself to publish.  
15 Then if we look to the second page:

16 "Other points."

17 So this is volunteered by the coroner:

18 "I had assumed that the Royal Belfast Hospital for  
19 Sick Children would have circulated other hospitals in  
20 Northern Ireland with details of the evidence given  
21 at the inquest and, possibly, some best practice  
22 guidelines. Children are not always treated in  
23 a paediatric unit and, in the event of surgery, the  
24 anaesthetist may not be a paediatric anaesthetist."

25 And isn't that the point, that by not having some

1 sort of review, whether you call it your seminar or when  
2 you have concluded the settlement of the civil  
3 litigation, you didn't take up that possibility?

4 A. First of all, to take your last point, the medical  
5 negligence issue had no bearing whatsoever on the other  
6 file. That was dealt with on its own merits, pure and  
7 simple.

8 To come back to what the coroner believed and what  
9 our belief was and what I was lead to believe at that  
10 time was that this was an issue that had arisen within  
11 our knowledge in major surgery in sick children. And  
12 major surgery in sick children, only as far as I was  
13 advised, occurred on the Falls Road in the RBHSC.

14 Q. Dilutional hyponatraemia could occur in any surgery.

15 A. I accept that, but as I was advised at that time and, as  
16 this arose, in a complex procedure.

17 Q. I think the chairman has those points and I will just  
18 leave it with: if you had settled the litigation on  
19 terms of confidentiality, there was going to be no  
20 prospect of doing what the coroner has indicated there,  
21 the details of the evidence and so forth. That would  
22 never happen.

23 A. Of course it could. It could have been anonymised. No  
24 problem about that at all, chairman.

25 THE CHAIRMAN: Thank you. Are there any further questions?

1 No?

2 Doctor, thank you very much. It has been a long day  
3 and I'm grateful for you staying with us so late.

4 (The witness withdrew)

5 Ladies and gentlemen, we'll start at 10 o'clock  
6 tomorrow morning with Ms Duffin. Tomorrow will be  
7 a shorter day. On Wednesday, we have Dr Carson and  
8 Mr McKee. I mentioned on Friday last week that we'll  
9 try and get through their evidence in a single day.  
10 Some of the ground that we're going to go over with them  
11 has already been gone over, but we need their  
12 perspective on it. We'll do our best to finish on  
13 Wednesday, but if we don't, we'll finish on Thursday and  
14 that will be the end of this week. Thank you.

15 (5.30 pm)

16 (The hearing adjourned until 10.00 am the following day)

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I N D E X

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3 DR GEORGE MURNAGHAN (called) .....1  
4       Questions from MS ANYADIKE-DANES .....1  
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