Monday, 18 June 2012

(9.45 am)

(Hearing held in private)

(12.03 pm)

(A short break)

(12.22 pm)

THE CHAIRMAN: Sorry for keeping everybody waiting. I guess most of you know that an issue was raised, which had to be sorted out. It now has been ruled upon and we will now progress with Ms Anyadike-Danes' opening of this governance section. My intention is to sit until 1.30 in the hope that, by then, Ms Anyadike-Danes will be finished or very, very close to finishing so that we can then break and start Dr Gaston's evidence after lunch.

Opening submissions by MS ANYADIKE-DANES

MS ANYADIKE-DANES: Thank you very much indeed, Mr Chairman. I will certainly do my best.

Just for the benefit of those who may be new arrivals, just to confirm that everybody has received a copy of the opening on the governance issues. There should also be a list of persons, which is to be found, but not to be pulled up, at 306-081-001, and then a chronology.

The chronology is at 306-080-001. If you haven't had it, it's quite a lengthy document; it runs to

42 pages. Just to help you with the structure of it very briefly, the first part of the schedule -- maybe it is worth bringing this up. 306-080-001. The first part, schedule 1, is really to try and set the position as of Adam's admission on 27 November 1995. And by that, if one looks at the way that schedule is broken down, obviously you have the dates. But it's divided into two main sections, one is the protocols, guidance, circulars and practices that, so far as we are aware, were in force as at that date.

There may be others that are relevant and we just haven't been alerted to them, but that's what we know about. And then, on the far right-hand side, the final column, is the papers, publications and orders and down the middle are the references.

So that really starts with 1955, so far as we are aware, and it carries on -- and you will see the format of it -- right up until one gets to, in that section, 1995, to be found at 306-080-008, which is the HPSS management plan for 1995/1996. That, one sees, a short extract from. Some of these documents, we will be returning to in the course of this hearing, and that's the other reason why it might be helpful for you to have them all there, so far as we can do it, in chronological order, although we don't always know when documents were

released.

Then comes a second schedule, which is from Adam's death on 28 November until the inquest verdict on 21 June. You will already have had from us a chronology that deals with the intervening period, really, which is from his admission up until his death. That's because that formed, in large part, the basis of the investigation into the clinical matters, so I haven't sought to repeat that there, but if you want to refresh your memory, you can go back to that.

This picks up with the brainstem deaths and the announcement, the certifying that he has died. And you will see that along the date on the far left, it also has the times because we have more detail in relation to some of these matters. And then we go through, as I say, so far as we can do it, in chronological order, what was happening. To the extent that there should be any other developments by way of publication or anything of that sort, that would come in in the far right-hand side and there is an example of that on page 306-080-015.

There you see where the trust confirms independently that it was their belief that the protocols that Dr Gibson had referred to in her report in relation to the anaesthesia, that equipment [sic] didn't actually

exist in written form. So that's a relevant document. It goes in in that way.

That schedule continues on until actually the inquest, or at least the announcement of the verdict, and that you see at page 306-080-035. There's the verdict on inquest there. And then we start a schedule with another phase, which is really the developments on from that, and this would be the area where we start to look at what happened in terms of dissemination of any lessons that were learned or might have been learned. This is schedule 3; it takes us from 21 June up to November 1998.

You may wonder why it goes all the way to 1998. In fact, it goes a little bit further on from that, but in 1998 you had, if one looks at 306-080-041, you had the British Transplant Society issuing standards for organ and tissue transplantation in the United Kingdom, providing best practice. So one looks at that to see to what extent any of that fitted with what was happening and what the trust itself was developing.

These are all matters that we will develop later on in successive hearings, but for handy reference, certain matters to do with autopsy practice and people's publications in journals.

Claire died during this period -- and one sees that

at page 306-080-038 -- and you see her death features there on 23 October 1996.

That is also partly to put in context what was happening in the aftermath of Adam's death and to see how that may or may not be relevant to the fact that that was the date of Claire's death.

So that's that schedule and that's how it works. If anybody has any observations to make at any time, feels there's an inaccuracy or there's something that would be helpful that they can contribute to that, you know the inquiry is always open to receiving communications in relation to that. I'm not necessarily inviting it just for the sake of it, but if there is something that we have put there in error or something that could genuinely be of assistance to everybody, we are very happy to receive that.

Because the opening has been circulated to all the interested parties, I am not going to address it or present it in detail. You have had the opportunity, I hope, to look at it and it is rather lengthy. We did have some comments in relation to it and I have sought to address those. One of them, in particular, relates to a meeting that Dr Samuel Lyons participated in, who was a consultant anaesthetist, and you will see that this is now referred to in the version that, if

you haven't got a hard copy now, in due course it will be up on the website. It doesn't change the substance of things, but it's right to record when one's going into who attended meetings in relation to what, to try and see what the approach was following Adam's death. And it's right to record those people, so his name is there.

That meeting is in the chronology as is his participation in it. I had simply omitted to include it in the opening, so it's there, and that's a slight change from the one that would have been issued to you. I did have another comment that we received, which I will address when we get to the relevant part of it in the opening.

So Mr Chairman, the purpose now is to consider these wider implications of Adam's death and what I am trying to assist you with is to understand the organisation and the systems that were in place at the Children's Hospital, but also in the trust generally at that time, to answer the questions that we perceived have troubled so many people, which is what lessons could or should have been learned from the unexpected death of Adam and how should those lessons have been shared to improve the healthcare given to other children? And possibly to avoid the loss of further life. Those are the issues

that we are, at the heart of it, seeking to address in this section called governance.

We won't go overly into the clinical detail, Mr Chairman, because you already have that. But what we are looking at is the systems and mechanisms underpinning the delivery of the medical services and that governed the medical services given to Adam and that one can see reflected in the clinical evidence that we've heard, what those systems were. We can see how they operated and then, on his death, we can see how those systems dealt with his death and what could or might have been the result and consequences of it.

Mr Chairman, I am not going to go through all the evidence that we have received. Our approach to getting in the evidence for governance matters is very similar to that which we adopted in the clinical matters and any of it is all set out there in quite some detail. Nor am I going to deal with the revised terms of reference because, apart from anything else, they don't affect the governance issues in relation to Adam, save because Claire is involved, it might require us to think much more carefully about the fact that one had a death so closely after his death and, for that matter, so soon after the inquest into his death. That maybe does bring a heightened degree of scrutiny into what people did.

Of course nobody was to know at the time that that would happen, but one assumes it's in the contemplation of people that if you don't draw your lessons and make things public, then perhaps you are always having the risk that there will be another incident because people didn't know about your lessons.

Then if we go to the list of governance issues. I think, Mr Chairman, that's worth thinking about because those obviously are the issues that are going to govern what we actually deal with during this hearing. They are at paragraph 19, starting at page 11. I'm not going to read them out in detail, but just so that people have them there: investigation into the relevant governance issues that arise out of the care and treatment of Adam; the action of the statutory authorities and the other organisations; and the individuals who were responsible and concerned in the procedures; the quality of information on Adam that was provided to and received from his next of kin; and the procedures, protocols and practices governing paediatric renal transplant at the Children's Hospital and their adequacy; and an investigation into the experience of the transplant team.

I pause there. Some of these things will already have been addressed during the clinical hearing. I am

not proposing to go over that in detail, but simply to take that evidence and see what that leads to when one looks at it through the prism of governance, if I can put it that way.

Then the investigation into the extent to which the care and treatment provided to Adam and his family was consistent with the guidance that was being provided by the department and other professionals bodies. And other professional bodies being, for example, the GMC, or for nurses, the equivalent of the NMC at that time. An investigation into the teaching and training, particularly in relation to hyponatraemia, an investigation into the procedures and practices that existed at the time of Adam's death for the reporting and the dissemination of information to the department and the medical community in general of unexpected deaths in hospital and the outcomes of coroners' inquests. And then, coupled with that, is an investigation into the information that was actually provided in those respects.

Then an investigation into what action was taken by the hospital, or the department, following the communication on 25 April 1996 of a medical negligence claim and its settlement on 29 April 1997. So Mr Chairman, really looking at what difference did that

make. The fact that there was a claim, what was the effect of that? And then the fact that it was settled and what was the effect of that? So that's really what we are seeking to learn in that section.

If I may say just a little bit about the concept of governance because it doesn't admit, necessarily, of definitive definition, and certainly not in 1995. I'm taking you really to page 12 of the document and referring to clinical governance. One finds a definition or guidance as to what it might mean in a White Paper on health produced by the Department of Health, which is "The new NHS: modern and dependable". And there one sees at paragraph 3.6:

"Locally, there will be ... a new system of clinical governance in the NHS Trusts and primary care to ensure that clinical standards are met and that processes are in place to ensure continuous improvement, backed by a new statutory duty for quality in NHS Trusts."

Then one goes on:

"Clinical governance arrangements will be developed in every NHS Trust to guarantee an emphasis on quality."

And then:

"Public confidence will be rebuilt through openness, improved governance [there's that word, maybe one of the early times] and public commitment to the values and

aims of the NHS."

Then it goes on, which is something that has been well recognised that:

"Professional and statutory bodies have a vital role in setting and promoting standards and shifting the focus towards quality will also require the practitioners to accept responsibility for developing and maintaining standards within their NHS organisation, and for this reason, the government will require every NHS Trust to embrace the concept of clinical governance so that quality is at the core, both of their responsibilities as organisations and of each of their staff as individual professionals."

Although of course, Mr Chairman, that was 1997, what the paper made clear was that:

"These arrangements should build on and strengthen the existing systems of professional self-regulation and principles of corporate governance, but offer a framework for extending this more systematically into the local clinical community."

There you have it, Mr Chairman. That's a way of regarding governance and that is something that the paper recognised had been happening and trusts had to have a way of being able to be clear as to the standards that they were delivering. What was being sought here

was a recognition that one takes that into a more systematic way and one also emphasises the contribution of individual clinicians in doing that. It's not just about their organisation.

If I can then move on to look at how one seeks to deal with that. One element of it -- and certainly one that's of relevance in this inquiry -- is the question of incident reporting and risk management. Mr Chairman, as early as 1993 a book was produced called "Risk Management in the NHS", which was a manual, and it set out the requirements:

"A procedure should be devised and implemented covering the action to be taken by line managers in the event of an incident involving actual or potential loss, injury or damage and that all such incidents be reported immediately and that a designated individual should be responsible for initiating further communication or enquiries and ensuring that appropriate action is taken."

That is a book which pre-dates by a couple of years Adam's admission and it is something that we will be seeking to explore with the relevant persons. We actually have it. If anybody has any difficulty in obtaining it, we have a hard copy of it and you're welcome to have a look at it. If it's not already

clickable on the bibliography, we'll try and see what we can do about that to assist you.

Then, in 1994, came a report on the independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital. That was more commonly referred to as "The Allitt Inquiry". That stated that:

"There must be a quick route to ensure that serious matters [I'm contracting the quotation somewhat] are reported in writing to the chief executive of the hospital or District Health Authorities and NHS Trust boards should take steps immediately to ensure such arrangements are in place."

Of course, that inquiry, its report was published before Adam's admission.

So if one then goes to the organisational context or the framework in which all this might be happening, I think right at the outset, Mr Chairman, when I delivered the general opening, we had some organisational diagrams, which I have to say are diagrams that we produced from information that was given to us. We haven't had them corrected yet, so until that happens we're assuming we have got it about right. If I can go first to, just briefly, 303-039-505.

This is pre-2007, of course. After 2007, there was

major restructuring, but after 2007 isn't really relevant to Adam, or for that matter any of the other children. So you see the Secretary of State, Minister of Health, Department of Health and then you have the boards as they were then. Relevant to us in this part of the inquiry is the Eastern Health and Social Services Board, and then you see the Royal Group of Hospitals Trust within that, which is another relevant trust for us. And for Adam in particular, Belfast City Hospitals Trust is another one, and that's relevant in this particular case because, as you know from the clinical hearings, Mr Chairman, the transplant surgeons came from the Belfast City Hospitals Trust.

So that is an overall structure, if I can put it that way. Then there is another structure that might be helpful. One sees that at 303-040-506. This isn't ours. This is one trying to indicate the commissioning of services, and you see there the Northern Ireland government, the minister, Department of Health, Health & Social Care Board, five trusts and the five commissioning groups.

The relevance of raising commissioning at all is that -- and it may be that one will deal with these matters as we go slightly higher up the organisational chain, if I can put it that way. But if one is thinking

about the standards and the delivery of those standards, then healthcare is something that is commissioned and that has to be provided, and people have to be satisfied that what they have commissioned is actually being provided. That, at a very simplistic level, means some systems have to be in place to satisfy people as to that.

We may --

THE CHAIRMAN: Sorry, what is the timescale for this structure, which is on the screen at the moment? That's quite a recent one, isn't it? Because, for instance, the Eastern Health Board and Southern Health Board aren't there; you have a Health & Social Care Board, then filtering down into five trusts. That's the new total number of trusts in Northern Ireland, isn't it?

MS ANYADIKE-DANES: That, I believe, is new. I will check.

THE CHAIRMAN: Is this post-2007 then?

MS ANYADIKE-DANES: I think it might be, but I will check that.

If we then go to 303-043-510. There we are. That's the Royal Group of Hospitals Trusts. I don't have an equivalent for the Belfast City Hospitals Trust because we're not really going into their structure in quite the same way. This is the trust that we are mainly focused on. You will see the chairman and down to the

chief executive, then the non-execs on one side and the executive directors on the other. Cascading down, if one goes to the medical director, Dr Ian Carson, you see the various clinical directorates.

The ones which we will be primarily focusing on, although not exclusively, are anaesthetics, theatre and intensive care, ATICS as it is sometimes called, with Dr Joseph Gaston as its lead. Paediatrics, with Dr Conor Mulholland, who was acting at the relevant time. And then possibly surgery, Mr John Hood. There is an issue as to whether there was a surgical lead for the Children's Hospital, which doesn't appear to have an independent structure of its own, but nonetheless whether there was a paediatric surgical lead, if I can put it that way, and there is an issue as to whether, if there was, at the relevant time, if that person was Mr Brown, who, as you know, was a surgeon who assisted Mr Keane in Adam's renal transplant procedure. So that's on the medical directorate side.

If one then moves towards nursing, you see that the director there was Miss Duffin. We have recently received a witness statement from her and we'll be wanting to explore exactly what the structure of her directorate was. And then if one moves towards the left, you see groups who appear to report directly to

the chief executive, although that is an issue that we wish to explore, and in that group is the medical administration headed up by Dr George Murnaghan. Then we go to the non-executive directors and the only one that may feature at all in anything that we do could be Dr Ben Wilson in relation to information and records and so forth.

But that's the structure so far as we have it. There are some issues that we want to raise as to where, in all of that, lay the Children's Hospital, if it lay anywhere in particular, and also where in all of that came the Paediatric Renal Transplant Service, whether it came within one particular directorate or whether it straddled possibly the three that are highlighted there. Those are issues that we will want to take up and we certainly seem to have before us people who can help us with that.

So the picture that we suggest that emerges from that is the hospitals being held accountable by the Trust in accordance with proper governance standards, and the Trust, of course, being required to deliver in relation to the board.

If one thinks about what those standards might be, the inquiry's expert in these matters, Professor Mullan, has indicated that there was a code of conduct and

accountability, which is likely to have assisted in what those standards might be.

I have to say the code of conduct and code of accountability that we have received, the reference for which is 210-003-150, relates to the NHS. It's not coming up. Anyway, it's the wrong one. It relates to the NHS.

What we really want to see is the code of conduct that was applicable to healthcare in Northern Ireland, as it was delivered, and we are trying to obtain that. It's possible that they won't differ very much as to the sorts of standards and expectations that are required. The sort of thing is:

"To be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs, to provide active leadership of the organisation within a framework of prudent and effective controls, which enable risk to be assessed and managed, to set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives and review management performance and to set the organisation's values and standards and ensure that its obligations to patients, to the local community and the

Secretary of State are understood and met."

That is the sort of thing that the inquiry's expert says is likely to have been -- well, was covered in the equivalent for the NHS and we suggest may well be in that for Northern Ireland, but obviously we are going to seek it.

So the Trust's board of directors would, in turn, have been held accountable by the Eastern Health and Social Services Board, which commissioned health services from the Trust in order for it to fulfil the obligations placed on it by the Trust's board of directors, but would have had to maintain an effective system of internal control over its finances and financial management systems and provide suitable evidence that it had such systems of internal control. And we suggest that it would have had to go beyond just the financial side of things. It would have to talk about the values and standards to ensure that its obligations to patients in their healthcare were being met.

Then, Mr Chairman, I would suggest it's important to note that the responsibility of the trust board of directors was based on providing effective clinical services, and this necessitated the development of a clinically-based management structure and the result

was, as we are assisted with the inquiry expert, the devolution of decision-making to the front line clinical staff, giving leadership by the chief executive and empowered and supported by the clinical board. And it involved giving doctors, nurse, therapists and others direct responsibility for making decisions regarding not only patient treatment and care but also day-to-day running, planning and development of their service.

Not surprisingly, when one puts it like that, it was frequently described as a revolution in health management.

Mr Chairman, I am not going to go through all the directorates because when we had the -- well, as we see, I have identified those that I think we're most likely to be dealing with and that also sets out who their clinical leads are. I have also said that there is an issue as to the Paediatric Renal Transplant Service as to exactly where it sits in that structure and its management. There are some issues as to how the Paediatric Renal Transplant Service for the very young came over -- well, firstly, that Belfast decided that it was going to perform such procedures for the very young and, secondly, having decided that, how that service came over to be and was delivered at the Children's Hospital. There are some issues in relation to do with

that and we are not clear at present whether, prior to Adam's transplant surgery, the Trust had any processes or procedures whereby the analysis and/or recommendations and reports in relation to the delivery of that service was considered and, if appropriate, acted upon, how they dealt with the response. We simply aren't clear about that.

Nor are we entirely clear -- and as I said, how the decision was made and what processes were put in place when they moved that service over to the Children's Hospital. But I have to say, Mr Chairman, we do not consider it to be a function of this inquiry to investigate the operation of the paediatric renal transplant programme. That, in any event, has been the subject of independent review and you know, Mr Chairman, that there was a report out in 2011 which has commented upon that.

What, however, is of interest is the system that the Trust had established prior to Adam's surgery in relation to the Paediatric Renal Transplant Service being delivered and those who were charged with the responsibility to monitor its performance and investigate and report on adverse incidents in relation to its operations. Also of interest is the consideration that was given to the support services

that would be required. Having thought about that, then what is very much of interest is how all that structure, whatever it was that existed, was used or operated when Adam was admitted for his procedure and when he died and thereafter. So that's the particular aspect that we are interested in: the paediatric renal transplant for the very young, how is it monitored and governed once it gets into that trust?

In terms of internal control, having set out what the structures are, at the time of Adam's transplant surgery the mission statement of the Royal Hospitals and, therefore, the Children's Hospital was:

"To provide the highest quality, cost-effective healthcare as an outstanding acute general hospital and tertiary referral centre through exceptional service to our patients, staff and community in an environment of education, teaching and research."

And in order to achieve that purpose, one of its stated aims was:

"To provide training and education for healthcare professionals in association with Queen's University and the University of Ulster and to promote and support scientific and clinical research and foster an ethos of enquiry and innovation and make cost-effective use of all resources."

Mr Chairman, if you start with that as your mission statement, then that is one of the things -- and how that bears on and relates to the care that Adam got and what happened after his death, one's looking to see what the structures and procedures are that the trust had to deliver or the hospital had to deliver on that mission statement in relation to the matters that are relevant for Adam.

One of those might be medical and clinical audits. I mentioned something about that just earlier. And just to bear in mind that although, I think, Mr Chairman, I think you've expressed a view and, in any event have been addressed, on the fact that, in 1995, the amount of guidance that was there for these sort of things was perhaps not as prolific and maybe not as formal as now exists or certainly thereafter. But nonetheless there was guidance and that's one of the things we're going to be looking at: the guidance that did exist and what was done with it. So as far back as 1989, the Department of Health published its paper "Working for Patients" and "Working for Patients: Medical Audit Working Paper", and that set out plans -- so that's 1989 -- for a comprehensive system of medical audit. I won't go through all of that because it's set out in the opening, but one can see what the basic principles were that

should govern medical audit.

If I pick out just a few of them for illustrative purposes:

"The system should be medically led with a local medical audit advisory committee chaired by a senior clinician. The results of medical audit in respect of individual patients and doctors must remain confidential at all times. However, the general results need to be made available to local management so that they may be able to satisfy themselves that appropriate remedial action is taken where audit results reveal problems."

And so on. Then, Mr Chairman, apart from that system there was -- and this is something I had touched on a little earlier -- the role of the individual clinician. In some respects, the change might be said to have empowered the individual clinician.

The medical profession had given advice -- at least, the GMC gave advice to its members, clear advice. It circulated good medical practice guidelines for doctors and recommended that all doctors must work with colleagues to monitor and improve the quality of healthcare, and in particular:

"You should take part in regular and systematic clinical audit."

And then the Royal College of Surgeons, they came

out with guidelines for clinical audit and surgical practice. I believe the Royal College of Anaesthetists also produced clinical audit and quality of practice in anaesthesia, which they circulated in June 1994.

It is also possible, and we will be looking at it, to the extent to which the clinical performance was monitored. We note that the minutes of the paediatric directorate medical audit meeting for 15 March 1995 records a discussion relating to emergency surgery and the minutes of that meeting refer to the report of the confidential inquiry into perioperative deaths, and that is largely an inquiry concerned with the deaths of children aged 10 and under. There are a number of recommendations. The purpose of it, Mr Chairman, is to show you that from some of the documentation we've received, it seems clear that there were some systems and there was a level of investigation. What we're trying to find out is a fuller picture of that and how that might have worked and how it actually did work.

Though having said that, we are conscious that we don't have a full documentary picture and some of that is likely to be simply the passage of time. But we do note, for example, Dr Gaston, who as you know was the clinical lead in ATICS, he gave evidence to us in an inquiry witness statement to say that there was no

policy in place for the appraisal of anaesthetic staff after an unexpected death. And Mr McKee, who's the chief executive, says:

"There was no system of appraisal or process of assessing and developing the competence of doctors outside of the GMC."

So if you had an issue, it sounded like -- and this something we will be investigating -- you relied on the GMC.

And then Dr Carson has informed the inquiry:

"I am not aware of any system or systematic checklist whereby the trust would have assured itself that clinical directors/directorates had disseminated guidance, policy or procedures, let alone compliance by individual clinicians. A system of directorate accountability reviews was introduced much later as performance management was developed within the trust."

So that's what the clinicians say and if that proves to be the case, then the extent to which there is published material that could have assisted the Trust in developing those procedures, we will be seeking to take up why that didn't happen.

One of those sorts of helpful guidances out there is referred to by Professor Mullan. He refers to a letter dated 27 July 1994, sent by the divisional director,

Mr McConkey, of the Estate Services Directorate, a management executive to the Chief Executives of the Health and Social Services Board and the Health and Social Services Trust to update them on reporting adverse incidents, reactions and defective products relating to medical and non-medical equipment and supplies, food, buildings and plant, and medicinal products."

And that letter drew specific attention to the responsibility of chief executives for ensuring prompt reporting of adverse incidents and reactions. It also states:

"Adverse drug reactions to medicinal products should be reported to the Medicines Control Agency on specifically-designed yellow cards."

And, Mr Chairman, you'll be aware that that actually did happen later on. Dr Taylor did that and concludes:

"It is essential that all those who work in Health and Personal Social Services, including those in the private sector, are aware of the procedures for reporting occurrences, accidents, incidents and defects."

And the Trust had, we say, responsibility on occasions to report incidents to the board and Mr McKee points out that circular ET5/90 required:

"All unit general managers to ensure that appropriate reporting mechanisms were in place to ensure that the board received prompt notification of untoward incidents."

So some, certainly, were aware of requirements and what actually happened is something that we'll be looking at.

Then risk management. The manual that I referred to, the NHS management executive manual that was published in December 1993, describes that as:

"Risk management is generally thought of as a four-phase cycle: risk identification, risk analysis, risk control and risk funding."

So the issue will be: did the trust -- and, below them, the hospitals -- have in place something that will allow them to assess, manage and address risk in that way? And if they didn't have that, what did they have? It seems that there was something there from some of the information that we've obtained and, Mr Chairman, the fact that we don't have documentation on everything, I wouldn't like it to be suggested that means that documentation didn't exist.

THE CHAIRMAN: Of course.

MS ANYADIKE-DANES: It simply means we don't have it. It may have existed and it may have been mislaid over the

passage of time or been destroyed according to destruction policies. All I can point to is that which we do have and we have the benefits of the witnesses who can assist us with what else there might have been.

One document that we do have is the first Health and Safety report provided for the Trust board, which happens to cover a relevant period, 1995 to 1996, and the introduction says, apart from that --

THE CHAIRMAN: You're at paragraph 89?

MS ANYADIKE-DANES: I beg your pardon, I am. I'm at paragraph 89. It deals with how all aspects of health and safety, risk management and should form the basis for monitoring the trust's performance in future years:

"It is the first report presented to the trust and has been made possibly by significant advances in the collection, storage and analysis of information on accidents, untoward incidents and personal injury claims. The directorates of Occupational Health Services and Medical Administration have developed new computer systems to facilitate the process and are co-operating in the use of available information for more effective risk management."

So if that's what they were able to report in 1995/1996, then Mr Chairman, one suggests that in order to do that, they had at least thought about the

procedures they would have to put into place and that's the sort of thing that we would like to know about, what those were and how they actually operated in relation to Adam.

Then just finally, one point that's worth mentioning under that heading, that section, is the King's Fund Organisational Audit. That same report suggests that the Trust had embarked on an approach seeking systematic and continuous quality improvement and it had made an application in 1995 for accreditation to the King's Fund Organisational Unit, or KFOA, as it's sometimes called. That is a body that assists in developing systematic programmes. And, in fact, unless you do have appropriate programmes, you won't achieve accreditation.

THE CHAIRMAN: This is a Health Service equivalent of a BS in another office context?

MS ANYADIKE-DANES: In a way, yes, Mr Chairman.

That is actually a whole area that we have sought information on: exactly what the trust was doing about it. We know they didn't receive full accreditation at the first application, so there was obviously -- we can see it in various reports and some documents -- a process by which they developed their systems to the extent that they were ultimately able to achieve accreditation.

This is discussed in terms of its significance in a little more detail in Mr Ramsden's report for the inquiry on 22 July 2011. He is the inquiry's other expert dealing with these matters and he really approaches it from a slightly higher level, dealing with matters at really sort of board level and further. But he discusses it, as does Professor Mullan, and we will be seeking the assistance of some of the witnesses as to exactly what was happening and what they had to do in order to meet the level of systematic recording and reporting required by KFOA.

As I said, Mr Chairman, just recently we have received the witness statement from Miss Elizabeth Duffin, who was Director of Nursing, and it seems that Mr McKee, the Chief Executive, delegated the management of the whole application to her. We are very grateful that she's been able to respond and she is coming as a witness and we hope that she can assist us still further.

It is also worth noting that Dr Gaston, as one sees from his curriculum vitae, from 1992 to 2008, acted as a surveyor on behalf of KFOA and also its successor, the Health Quality Service. So we will be asking him to assist us in understanding what the process actually means.

It seems quite clear that some of the clinicians involved, certainly Dr Mulholland, who was the acting medical director for paediatrics, thought that there were changes brought about simply by the engagement with KFOA and he referred to, from his perspective, them relating to precision in drug prescription and clinical note-taking, in particular documenting what was said to the parents of children. And that may prove to be relevant because you'll be aware of the fact that from the clinical hearings, that is an issue: the extent to which those communications were well documented or adequately documented.

And Dr Carson felt that the process would have contributed in some way to the improvement of risk management arrangements, so clearly there is some further areas that we would like to explore with those witnesses.

That Health and Safety report that I mentioned, 1995/1996, does record some criticism in terms of the feedback that they were receiving and the criticism is reflected in that criteria, which is what I was just discussing:

"In acknowledgment of the recommendations received, the medical director is leading a review of risk management arrangements within the trust and the trust

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

It is just that sort of comment which we see there "close the loop". It's not entirely clear from the documentation what that meant, but certainly if there was an issue that there wasn't an appropriate line of communication in relation to matters, that is something that we would like to explore to the extent that it can be said to have affected the way in which Adam's death was investigated and the way in which the lessons were learned and disseminated or not, as the case may be.

I should just say that the DLS confirmed that the Trust received accreditation in 1997. Just for the sake of completion, it had received provisional accreditation in 1995/1996, although I don't think we as yet know precisely when.

Mr Chairman, there's a whole other issue to do with education and training. I have set it out in some detail, the areas that we're interested in, in the opening. I don't wish to go through them in any detail, but just to identify what the issue is that we are

concerned with. Certainly, we would like to know what, at an organisational level, the structures were that governed the relationship between, in particular, this trust and Queen's. As you know, Mr Chairman, and we will see as we go through, a number of the clinicians had teaching posts and obligations. Professor Savage, for example, he had contractual obligations in relation to Queen's University.

So one of the things to look at is how was that actually arranged, that relationship between the two organisations. And the reason why we want to know that is we want to look and see the extent to which any of that provided an opportunity to integrate into the teaching lessons the clinical lessons that were being learned on the ward, in the operating theatre and so forth. For example, the lessons that may have been being learned through Adam's case in relation to dilutional hyponatraemia or just hyponatraemia and fluid management and to what extent there was a way in which those lessons could have found themselves into the teaching for medical students.

So that's that area. We do have some documentation into what those structures might be and what the opportunities might be, but we don't have a very full picture, I think it's fair to say, and we are hoping

that with the assistance of Professor Johnson, and maybe the clinicians directly involved, we will be able to understand better what those opportunities were and to see to what extent there were missed opportunities in relation to Adam's case.

If I then move on to another area that is of specific concern and this also has had its grounding in the clinical hearing, and that's information and consent. It's a fundamental issue. It's referred to in the foreword to the Charter for Patients and Clients, and, just in ease of you and others, Mr Chairman, I am now at paragraph 140 at page 47.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: In the foreword to that charter, which is dated March 1992, the Minister of Health and Social Services states:

"As the minister responsible for health and personal social services in Northern Ireland, this charter is my personal pledge to all citizens that services in Northern Ireland will continue to match the very best available in the rest of the United Kingdom and the charter declares a patient's right to be given clear information about any treatment or care proposed, including any risks and any alternatives and to have your wishes taken into account as far as possible and to

be kept informed about your progress and, further, that relations and friends are also entitled to be informed."

Mr Chairman, that right is something that would be transferred in Adam's case to his mother because of his age. That right to be given sufficient information was, of course, established before the charter and the importance of the proper and valid consent was regarded as so important that, as you know, Mr Chairman, in 1990 the Department of Health published its "Guide to Consent for Examination or Treatment", which states that:

"A patient has the right under common law to give or withhold consent prior to examination or treatment, and this is one of the basic principles of healthcare."

And it further states:

"Patients are entitled to receive sufficient information in a way that they can understand about the proposed treatments, the possible alternatives and any substantial risks so that they can make a balanced judgment. Patients must be allowed to decide whether they will agree to the treatment and they may refuse treatment or withdraw consent to treatment at any time."

Mr Chairman, you will know that there is an issue as to the extent to which Adam's family, particularly his mother, was sufficiently appraised of the possible alternatives and maybe even the extent to which she was

appraised of the actual risks involved.

The concept of the choice of treatment is also addressed and it says:

"Where a choice of treatment may reasonably be offered, the health professional may always advise the patient of his/her recommendations together with reasons for selecting a particular course of action. Enough information must normally be given to ensure that they understand the nature, consequence and any substantial risks of the treatment proposed so that they are able to take a decision based on that information."

Pausing there, it may well be that, Mr Chairman, you will consider whether a decision as to whether or not the possibilities in relation to live donation were properly communicated to Adam's mother and the risks of it properly set out to her so that she could make a decision in relation to that. That, as you know, Mr Chairman, is a matter that was raised during the clinical hearing and something that we may at least invite you to consider, how this document cascaded down so that Professor Savage and others could appreciate, at least on that occasion, the significance of these matters.

Then, of course, it goes on to deal with written consent -- I won't go into that -- and that:

"The purpose of it is to provide documentary evidence of an explanation of the proposed procedure or treatment that was given and that consent was sought and obtained. Where written consent is obtained, it should be incorporated into the notes."

As, of course, it was.

But the guide proceeds to emphasise the importance of discussing treatment with the multidisciplinary team and other doctors and "these discussions", it's stated, "should be documented in the clinical case notes". And Mr Chairman, you have heard evidence in relation to that matter also.

The NHS Management Executive issued its "Risk Management in the NHS" manual in December 1993, so the first document I was taking you to was a Department of Health document, and there'll be an issue to the extent to which in Northern Ireland, the trusts, boards, departments for that matter, took cognisance of the documents that were released or issued by the Department of Health in the rest of the UK. But this is, at paragraph 46, a domestic document. The NHS Management Executive issue its "Risk Management in the NHS" manual, in December 1993, which notes:

"Obtaining content at treatment is an area almost entirely under the control of professional healthcare

staff and not one in which managers are generally involved, but managers have a responsibility to ensure that professionals are fully aware of their obligations and understand the legal framework in which they are operating."

And then if one goes over the page, Mr Chairman:

"The guidance was distributed by the Chief Executive with explicit instructions that Health and Social Services boards/HSS Trusts are asked to ensure that procedures are put in place to ensure that consent is obtained along the lines set out in the handbook and introduce revised documentation, preferably based on the new model consent forms described in it with adequate monitoring arrangements."

And the boards/HSS trusts were asked to confirm by 31 December 1995 that that had been done and they were told where they were to address their confirmation to.

So that is an area that we are going to explore, Mr Chairman: exactly what happened in relation to that. What, if any, confirmation was given? If it wasn't given, what was done about the fact that no confirmation was given, and, for that matter, what happened to the forms that were supposed to be being replaced by the revised documentation, the new model consent forms, and when, ultimately, did they get replaced. We are not

entirely sure when they were replaced. We have certainly seen, because of the cases that we are dealing with, when they changed, but that doesn't necessarily mean we know when they were actually replaced, but that's obviously something we're going to look at.

THE CHAIRMAN: The relevance of this is twofold. Firstly, it's relevant to the consent mechanism when Adam was admitted and, secondly, it's relevant to the general issue about how guidance, which is issued by the department or some other body, makes its way down and that ties in with Conor's case.

MS ANYADIKE-DANES: That's exactly right, Mr Chairman.

Then if we move on and come a little bit closer to the issues that directly bear on the governance points in terms of lessons learned and dissemination, we move really to paragraph 202 at page 71, which is the conduct of the autopsy.

I'm conscious it's a bit of a whistle-stop tour, Mr Chairman, but I know that people have it.

THE CHAIRMAN: It's the advantage of having issued it last week.

MS ANYADIKE-DANES: Exactly. So the conduct of the autopsy in many respects -- and I think Dr Armour agreed with it -- the autopsy really is the first step perhaps in the lessons that can be learned and dissemination.

Obviously, the Trust, the hospital, can carry out its own internal investigation and formulate its own lessons learned, but in terms of an outside agency, if one isn't called in, then the way that the autopsy is conducted, the report on autopsy provides a point where one can see the lessons that might be learned in a particular case and it also has an aspect of dissemination because, in this case, this autopsy report was going to the coroner for an inquest.

Mr Chairman, Dr Armour, and for that matter, actually, Dr Mirakhur and Dr Waney Squier all gave evidence in the latter part of the clinical hearing to do with how these matters are conducted and their potential significance. Dr Armour in particular sought to assist us with the structure of the State Pathology Department and how it interacts with the hospital and the coroner. We will seek to pursue from the hospital side a little bit more in that direction as to how it does. I would just give one example.

She gave evidence to say that, from the point of view of a pathologist, strictly from a pathologist's perspective, they would like the bodies to come to them in the mortuary with all the lines in situ. There is something that they can learn from that. And her view was that that had been communicated by the State

Pathology Department to the hospital. As it happens, in Adam's notes and records, one sees a clear record that the lines should be removed. We wish to explore how that happened, what is the communication that happened, what's the form of it between the State Pathology Department and why in that particular case did that happen. I just give that as an example. There are perhaps other examples as to how best the pathologists can be assisted with clinical information whilst maintaining her independence or his independence, for that matter.

So I don't propose to go very much more into that section. In fact, some of the matters that we identified there, Dr Armour went on to actually address. So with the assistance, we hope, of Professor Crane, if he can assist us, and the clinicians on the hospital side, we hope to get a little more information as to how that process works, given its significance for Adam and, very often in general, for lessons learned.

So if we then move on to the inquest into Adam's death. One finds that at paragraph 210. Mr John Leckey was the coroner for that, as I think everybody knows. He also was the coroner for all the inquests in the children who are the subject of this inquiry, which has its benefits in terms of him being able to see

a pattern -- sometimes not a pattern he wished to see -- as to what was happening, but it certainly gives a degree of continuity.

Adam's inquest opened on 18 June and the verdict on inquest was given on 21 June. One sees it there:

"1(A) Cerebral oedema due to (B) dilutional hyponatraemia and impaired cerebral perfusion during a renal transplant operation for chronic renal failure."

And then the findings reflected what was in Dr Sumner's report. Dr Sumner, of course, was the expert briefed by the coroner, the expert consultant paediatric anaesthetist. The finding included that:

"The onset of cerebral oedema was caused by the acute onset of hyponatraemia from the excess administration of fluids containing only very small amounts of sodium."

That view may prove to be -- at least the way it's described there may prove to be important when one looks to see the extent to which the clinicians' own views as to what had happened with Adam accorded with that, and if they didn't accord with that, what happened as a result of it.

But when we reach that stage in the investigation, what will be of particular interest is whether there were any policies or procedures to ensure that lessons

and information learned during that process were disseminated within the Trust hospitals and within the wider Health Service in Northern Ireland and if they weren't, why they weren't. I'm not going to go into all the recital of evidence in witness statements that I have put there from what various people say, but one has the benefit of evidence from Mr William McKee, who's the Chief Executive, right down to the individual clinicians as to what they thought was going to happen or what actually did happen.

If we just have Mr McKee:

"It is my understanding that the expert clinical opinion at the time was that the complication of hyponatraemia had occurred during specialised renal transplant surgery in a child with renal failure. I am not personally aware of wider dissemination of lessons learned from this inquest to the wider Health Service in Northern Ireland and elsewhere in the United Kingdom or that this was identified to be required at this time."

Mr Chairman, you will see that when we get to that part of the investigation, there's quite a bit of that, trying to see whether the lessons that were to be learned in relation to the development of hyponatraemia, dilutional hyponatraemia, in relation to the particular fluid management that Adam received, whether that is

something that very properly was confined to paediatric renal transplants or could reasonably have been supposed to have been confined to that at that time or whether the clinicians should have appreciated its wider significance, particularly in the light of the report of Dr Sumner and the paper from the study carried out by Arieff and others, whether they should have seen that it actually had a much wider significance, it was saying something of far greater application than just how you manage fluids during a paediatric renal transplant, and that is an issue to be taken up because, depending on what the management were entitled to understand about that, may explain what they did in relation to dissemination. Anyway, it's the substance of quite a bit of enquiry in our witness statement requests and we will be pursuing that to try and understand it better.

Certainly, Mr Chairman, it is the case that the documentation that was produced, the draft press release that went out, linked what they were going to do with the Arieff paper. That perhaps is a starting place for understanding how those two things co-exist.

Then, Mr Chairman, we move to the medical negligence litigation. I mentioned that right at the beginning. We won't see its effect, whether the fact that that was

happening at the time, at the same time as the inquest or at least the run-up to the inquest, did it have any effect on the actions that people took and, when it was settled, did that have any effect on people's actions?

Then, Mr Chairman, we conclude with a section that really starts at page 80, paragraph 237, which is -- we have titled the entire section "Aftermath Assessment: Investigation and dissemination" and this is really the heart of what followed Adam's death: what could have followed it, what might have been the implications for either what was done or what was not done in terms of successive cases.

By this, it's not just the fact that Claire was admitted to that same hospital shortly after that inquest and died there and we now know that hyponatraemia formed a part of the cause of her death. It's not just that, I would say, that the reason why the Trust should be -- and the hospitals -- concerned with lessons learned is along the way. You're treating children and one's wanting to make sure that just because no child has actually died, that you are nonetheless using the benefit of your lessons learned to ensure that they are having the best care that they could have. So it's not just about Claire; it's all the other children who don't feature in this inquiry.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: So Mr Chairman, we started there with investigation and we scrutinise -- at least we have on paper and will wish to do so in the examination of witnesses -- exactly what they did. It seems that there wasn't a full investigation in the sense that people would know it and therefore we wish to find out why there wasn't.

Then if we move on ...

THE CHAIRMAN: You move on to dissemination and what was disseminated.

MS ANYADIKE-DANES: Exactly. That's at pages 95 to 96. We start off there with Professor Mullan, whose view that this lack of corporate incident reporting and a formalised approach to investigation in 1995 suggested that there was also a lack of a formal approach to assessing and developing the competence of the staff involved in Adam's treatment, the internal dissemination of lessons learned, both before and after the inquest, and the external dissemination of lessons learned both before and after the inquest. Then we go on to deal with the whole question of dissemination and there you have the issues to do with the draft recommendations that were produced, a document that was signed by Dr Taylor and provided to the coroner and how that came

about, and the various meetings that were being had by any number of the consultant paediatric anaesthetists -- Gaston, Taylor, McKaigue, Crean, all of those senior anaesthetists -- and what those discussions were, what they were seeking to do, what they actually did do and how that bears scrutiny, the actual product of all those deliberations.

Then to note, of course, that so far as we are aware, during all this time, Dr Taylor is carrying on in his medical practice. He's carrying on teaching and we have not yet seen what consideration was given as to what could or should have been done, if anything, in relation to that. And if they decided they weren't going to do anything about it, then by what means did they reach that decision?

That leads on to the final point, really, Mr Chairman, at page 100, to make, which is that so far as we can tell, Dr Taylor's understanding as to the reasons for Adam's death don't appear actually to have changed at all until very, very recently. We don't know precisely when they changed, but we have been told in his recent witness statements and also in his evidence the process that led to it and it appears to have been prompted by release of documents from the inquiry's experts in November of last year. All of that

culminated in a witness statement that he volunteered on 1 February of this year, although there was a witness statement before that where nothing seems to have been stated.

But in any event, that's the witness statement where he appears to have recognised some of his errors. And the issue that we want to deal with is what was the effect of Dr Taylor's dissenting, as I've called it, opinion throughout all that period of time and his continued insistence on the validity of his position, despite the coroner's verdict? It wasn't just the matter that he didn't agree -- he actively didn't agree -- and what we want to know is what was the effect of that in terms of lessons that could have been learned and dissemination that might have taken place? And given that that was his position -- and it would appear, Mr Chairman, although it's not my place to say so, a genuinely held position -- Dr Armour was asked about it and despite the wealth of evidence, as she regarded it, he just couldn't seem to bring himself to accept the implications of that evidence.

So the question then becomes: well, if he couldn't, what should others have done about that? And that ends up, finally, at those last two questions, which we say are fundamental to the whole issue of investigation and

dissemination. What were the obligations at that time to report what was known or suspected and what was known or suspected from a raft of people, Mr Chairman? And you know that you have personally asked questions in relation to some of the clinicians about the statements they made to the coroner and about a letter that they received from Dr Murnaghan.

Then: what were the proper responses of the system if one can call it that, to Adam's death?

THE CHAIRMAN: Thank you very much. That brings an end to that summary of the very detailed and helpful submission. We will start at 2.30. Dr Gaston is available at 2.30? Thank you.

(1.38 pm)

(The Short Adjournment)

(2.30 pm)

MS ANYADIKE-DANES: Good afternoon, Dr Gaston.

Just before I ask you some questions, I wonder if I might deal with one matter which I overlooked before the break and I am very sorry for it. I had mentioned that there were a couple of comments made in relation to Adam's opening on governance. I had dealt with one in relation to Dr Lyons and the other I completely omitted to mention and I apologise for it. I do so now.

It arises at paragraph 244, going into 245, and

since it's an error, I think I should just read out the relevant part:

"Mr Keane stated during the oral hearing on the clinical issues that notwithstanding he had formed an early opinion as to the inappropriate administration of fluids in Adam's case, he did not draw this to the attention of Adam's mother or mention it in his early letter and statements, or tell the coroner about it. He told you, Mr Chairman ..."

And this is a quote:

"'The point was, from my perspective, as I looked at where I was, I had an issue, I had a serious concern about what was going on, but I thought it would be wrong of me, because I was actually the surgeon involved, to, if you like, try to influence something. I wanted an independent somebody to look and declare the cause of death. That was my thinking. Now I understand that as you look back on it now, you say, "How could you feel that way?" But you see, the Bristol governance thing came in six or seven years later. I was naive, scared, didn't know.'"

And then the paragraph that immediately follows it is:

"The nature of that 'Doctor's Dilemma' is a matter to be explored during the oral hearings. Was Mr Keane

caught between, on the one hand, not informing on a colleague for reasons of loyalty embedded in the culture of the system, and on the other, properly assisting in the coroner's inquiry and the medical issues arising in a manner consistent with professional probity and patient interest?"

It's fair to say that that is actually an issue to be explored with a number of the clinicians that were involved, not simply Mr Keane. But Mr Keane was dealt with in that particular way because of his statement of evidence, but it is an issue that we will be exploring with all the clinicians who were directly involved in Adam's care during that last admission to hospital.

THE CHAIRMAN: And you're making that point to remove any misunderstanding that somehow that section, those couple of paragraphs, were aimed at Mr Keane alone?

MS ANYADIKE-DANES: Yes, to suggest that only he gave rise to what has been described as the "Doctor's Dilemma". It may be something that applies to a number of others, but in any event we'll be looking at it.

THE CHAIRMAN: Thank you.

DR JOSEPH GASTON (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good afternoon.

A. Good afternoon.

Q. Dr Gaston, do you have a copy of your curriculum vitae?
A. Yes, I do. I must explain, this was sent off quite quickly because I got it quite late at the time of the inquiry. It was sent off by my wife and there are a couple of typo errors. It says:

"A situation --

THE CHAIRMAN: You're not blaming your wife, doctor, are you?

A. It's always useful to have them.

It should be "the simulation suite" and it was a simulation unit. And I think it's just it says "situation" when it should be "simulation".

MS ANYADIKE-DANES: We're going to go through it. And if, as we do, you can identify any of those points that I wish to correct, we can do it as we go.

For those who may not have it to hand, it's to be found at reference 306-067-001.

If we start literally on the first page, we see your education, a number of learned societies, and then, if we go over the page to 003, we see your appointments, 1977 to 1987, and then your clinical activities. Then you have the management and professional activities. 1984 to 1986, it says that you're the Chairman of the Department of Anaesthesia. Just so that we're clear, because I see also that it says you were Director of the

Fredericton medical clinic. The chairman of the department of anaesthesia, was that at Chalmers Hospital?

A. That's correct.

Q. Then you have a number of management and administrative positions. If we go on to 004 -- pausing there, does that reflect a particular interest of yours in management, because we note it starts in 1984? Or was that just because of the seniority of your position that that came with it, if I can put it that way?

A. It did actually because there was a sense in which it rotated as you became more senior. So at that point in time, I was actually delivering a high clinical workload and it was normal, unless someone said otherwise, for you to become Chairman of the Anaesthesia Division then. In my case, I then became involved in other aspects of management.

Q. I appreciate it's probably a different system, it's a Canadian system, but what did Chairman of the Department of Anaesthesia mean and entail?

A. Well, you were obviously responsible for the day-to-day issues with regard to the theatre distribution with regard to one -- one of the areas was covering emergency work. It would also have entailed providing cover for the intensive care unit and I was, for a period,

Chairman of the Department of Anaesthesia. It would have involved me in negotiations with surgeons and identifying things like how were we meeting and delivering emergency anaesthesia, both during the day and out of hours. And this was -- and this is fairly unique in the UK, there are a few. This was a consultant-delivered service. There was no junior staff involved. So it was a consultant-delivered service, so we provided the care during the day. We also delivered all the care at night.

Q. When you say that part of what it involved was how you were meeting those delivery standards -- I'm not sure you exactly used that word, but in any event, how you were meeting what you had to deliver -- what systems did you have at your disposal to assist you?

A. There was a Canadian accreditation system and I think -- certainly, when I was being Chairman of Anaesthesia, we had one of the accreditations -- I don't know if the word "accreditation" is quite right because it's going back a long way -- but we had a visit and we had very detailed standards, things like how you manage patients in the recovery room, what were the orders that were written, were these always in place. It's actually quite similar to the King's Fund, which I then followed, and quite similar to the Joint Committee for

Accreditation of Hospitals from the JCH in America.

Q. So these were written standards?

A. Yes.

Q. Did you help develop them?

A. No, those were up and running entirely. The system in Canada had been in place when I went there and I think we had two visitations during the time that I was there for 11 years, I think. It became every 3 years, 3 to 5 years, and then when I was in Saudi Arabia we had two quality assurance visits: one was by the American forces out of Heidelberg, which was in a preparatory to the hospital there getting JCH accreditation.

Q. If you pause there, we can take people to that place in your CV. It's 004, the end of that last paragraph:

"During my time, the hospital was the only accredited hospital outside the USA."

Is that what you're referring to?

A. Yes. It was the only JCH-accredited hospital.

Q. What did that mean?

A. It meant that they had to meet -- I mean, these were detailed standards which ... And those were detailed standards and they were very comprehensive in terms of patient care. Very similar, but possibly slightly more demanding than the King's Fund, and when the King's Fund initially was set up, they looked at JCH, they looked at

the Canadian -- there was an Australian system and they eventually used the Australian system for developing their standards.

Q. I see now that we're on that page and we're looking at the time when you were at the King Fahad National Guard Hospital in Riyadh, which is 1987 to 1990, under the management side of your work, we have you starting with, in 1988 to 1990, member of the hospital quality assurance committee. And then during that same period, you're the quality assurance coordinator for the anaesthesia department. And then during that period but going into the year after that, you acted as chief of anaesthesia on many occasions. If we can just stick to the quality assurance. How were you, if you were, involved in monitoring and ensuring quality?

A. Well, again, on the back of JCH, we had to agree that at the beginning of every year we sat down and agreed a number of triggers for an investigation. And one of the things -- "investigate" is not the word, but it would go to the audit department, who would then send back some information and say: you need to consider this case. And we would decide -- we had ... Post-operative chest infection would have been one. Unexplained problem in the recovery. Returned to theatre within X amount of -- so many hours. Unexplained management of

blood loss. Certainly we would have been -- also any deaths were ... So we actually agreed those among the anaesthetists.

I then submitted that to the audit department. It was a very big audit department because that was quite a key area. So those then, they would go through the charts and where they saw a word that indicated this might be a complication, they then would send us a request to consider that at our audit meeting. So we would meet as a group. Quality Assurance Group is what it's called. We met and we would have the details of that case.

We might also -- because that might also be sent to the surgeons. We might also have their [inaudible]. So sometimes they would come back to us, even though we didn't know, and say, "Can you consider this case?". So there was a cross-referencing.

Q. I was just about to ask you that. Did that mean that you had effectively, if not actually, multidisciplinary meetings?

A. Effectively. I mean, this was something that we discussed, actually, quite seriously -- and right through my time in the Royal -- how, with that experience, did we actually put in place a system that did that? And one of the big difficulties of course was

that we didn't have the same number of audit assistants, but I felt that this was a system that would start to identify --

Q. Once you had those triggers and those triggers might lead to a situation where you would discuss that at your audit meeting, either within your own directorate or department or with the benefit of input from another, if one was associated, for example surgery you have just mentioned, what were you trying to achieve --

A. At the end of the process, there were, if I remember, three categories of decision. One was standard of care met. One was standard of care met with variants, and the other was standard of care not met. If your colleagues, you as a peer group, considered that standard of care was not met, then you had to then take forward a detailed investigation at your own level.

Q. I understand.

A. And that might then require input from the surgeons. We also -- and I remember I was a member of that. We also had a Trust-wide quality assurance committee, so some of these would be brought to that committee and that would be multi-speciality.

Q. I beg your pardon. I don't want to confuse. At the moment, I was exploring what you were operating, if I can put it that way, in your hospital at Riyadh. I know

that you have said that some of that you wanted to bring to the Trust and see the extent to which that could be developed in the Trust. But so that people don't get confused about our time frames, if I can put it that way, if we can for the moment -- because obviously we're going to come to what happened at the Trust.

But if we can, for the moment, understand where you were getting your experience from, which is really having started something like that in Canada, you move to Riyadh, you're developing it, they have a system up and running. I was trying to get some sense of how that operated. I think you had got as far as telling me that you would have these agreed triggers, that might prompt an audit meeting, and that that audit meeting may be informed by information from another directorate or another department.

Can I ask you, at that stage, before you had actually formed a view as to how things had gone awry, or if they had indeed gone awry, what information did you have over and above perhaps the medical notes and records? If you can't remember, it's fine. It's obviously an awfully long time ago.

A. I can't remember in detail.

Q. Are you likely at that stage to have interviewed or invited a statement from the clinicians who were

involved?

A. Oh yes.

Q. Yes? That would have happened?

A. Yes.

Q. Could they --

A. Because they would have had input into the meeting.

Q. I understand. Could they actually be present --

A. Yes. It wasn't in any sense a disciplinary at that point in time. This was an investigation by a peer group into what was an incident. In many cases, it was standard of care met. And sometimes it was standard of care met with variants, in other words standard of care is met, but maybe you could have done something slightly different, you know.

Q. I think you said that if the standard of care was not met, then that might lead to a certain sort of investigation. If it was met with variants, I presume there might be lessons learned as to why there had been that variance and that would lead to other developments; is that right?

A. Yes. And you -- yes.

Q. Then if we come now to your period in the Royal. That's on that same page, 1990 to 2005, when you were consultant anaesthetist there. Leaving aside your clinical activities, if we go right down to the bottom

of the page, we have you as member of the team which developed a multi-professional care pathway and integrated health record for patients having dental surgery and an award was received for that.

Leaving aside the fact that it happens to be for dental surgery, which is one of the things we're not investigating in this inquiry, but nonetheless the process of the multi-professional care pathway and the integrated health records, was that something that you felt could be applied generally or was there something specific about the dental care that made it more appropriate there than in other areas?

A. It probably was slightly simpler there. But this was not just a -- and I think this is something that I wouldn't have the same wide experience, but this was done in other areas. There were other areas within the hospital. They may not have integrated the medical records to the same extent, but they developed care pathways and, in some cases, they did develop the integrated record. I would have been involved, I think, one other -- I can't really remember the detail.

Q. I understand. Roughly when was that happening, so far as you can recall?

A. I would guess that was probably after 2000. I mean, care pathway, as a concept, came in England, I think --

as quite a number of these things -- came in England and advanced, and then we took it forward, and I think it was largely nursing who took it forward and then I was involved in the quality committee, et cetera. So I actually got involved in this myself.

Q. So that was a development that happened after Adam's death?

A. I think so, yes.

Q. I understand. If we go over the page, 005, working one's way down, we get to 1993 to 2000 when you were clinical director of ATICS, and then you list a number of things that you were doing whilst you were a clinical director. If we go to the penultimate paragraph:

"During my time as clinical director, I was also chairman of the joint Royal Hospital/Belfast City Hospital Theatre Group tasked with the development and implementation of expanded anaesthetic and theatre services to facilitate [in this case it was the centralisation of fracture services] on the Royal site."

Leaving that aside, were you aware of other joint groups for development of mutual assistance to each other between the Royal and Belfast City Hospital?

A. Well, there were some -- centralisation was going on at that time and the other which went ahead was the centralisation of Royal maternity services with

the Jubilee services. I was remote to that one. That was managed by the Woman and Child -- I have forgotten, because these directorates changed names. But that was primarily taken forward by the maternity services. So I had a very remote involvement with that.

Q. One area that we're keen to explore, whether there was anything like that, is, for example, in relation to the renal transplant service, which, as you know, the actual transplant service -- the centre, was at the Belfast City Hospital, but there came a point where the transplants in relation to the very young children -- certainly of Adam's age and younger -- were being carried out at the Children's Hospital, obviously as part of the Royal Group of Hospitals. Were you aware of whether there was any equivalent sort of group as you've just described for fractures in relation to renal transplants?

A. I think the one thing that -- and I need to clarify the directorate structure in a sense --

Q. Yes.

A. -- which had come into place about, I think, 1992, maybe 1993. It was part of the Royal preparing for becoming a trust, which started a year later than in the UK mainland.

Q. Would you mind if we put that structure up and then

perhaps you can help us to the extent we may have got it incorrect?

A. Sure. Again, I'm thinking back.

Q. Of course. It's 303-043-510. There. Sorry.

I interrupted you.

A. That's okay. I think it's quite important to understand the structure of that directorate, which was set up. I became the Clinical Director of Anaesthesia, Theatres and Intensive Care --

Q. Yes.

A. -- and that incorporated the main Royal site, which was approximately 13 operating theatres -- I think it actually became 14 somewhere round about that time -- on three different sites within the main Royal area. So that was -- we managed that, those theatres. Secondly, I was the director of the intensive care on the main Royal site. Then thirdly, I was the director of anaesthetic services, which included anaesthetists in the Children's Hospital, in the cardiac directorate and also maternity.

I didn't have any involvement in the Children's Hospital. I didn't work there. I never had worked there. And so I -- we had ... The anaesthetists who worked there tended to be the people who interacted. So I would not have known the background to the setting up

of the paediatric -- of that transplant service and many aspects of the day-to-day running I had no knowledge of because I didn't work there and there was the paediatric anaesthetists and particularly Dr Peter Crean would have actually have interacted with the paediatric services.

So this -- and it's something that actually Dr Mulholland made(?). He found it frustrating that the anaesthetists weren't part of that directorate. I find it frustrating that I was managing an anaesthetic service when I was one hand behind my back, as he would say. So it was difficult.

Q. Sorry, just so that I get it clear: he's finding it frustrating that the paediatric anaesthetists weren't part of his paediatric directorate?

A. Yes.

Q. You're finding it frustrating that they were. In, a sense, because you were slightly removed from that service?

A. That's right. And I think that was an anomaly. And basically it was an anomaly and I suspect -- and I only came back to Northern [sic] after many, many years towards the end of 1990, and I would think that what happened was that the directorate structure at that initial stage was taken forward on the basis of the sort of old divisional elements that were there. And then

those started before I left. They started to address these structural issues so that you could integrate services in a better way.

Q. Now that you've mentioned that, maybe you might help us a little bit with this: so far as you were aware, what was the effect of the fact that you had such a large directorate which included -- because you were dealing with anaesthetics -- the paediatric anaesthetists, whereas the main paediatric service, if I can put it that way, was being provided through a specific paediatric directorate? So far as you can help us, what was the effect of that?

A. That meant actually that my primary role was in managing recruitment, retention and developing anaesthetic services within the Children's Hospital. That actually, during the time that I was clinical director, was my main preoccupation with the Children's Hospital because shortly after I became clinical director, one of the anaesthetists left, one of the most senior anaesthetists went off with long-term illness and that left just two experienced paediatric consultants.

So I had to put in place an immediate system, and I think, if I remember, from the transcripts, Dr Rosalie Campbell and Dr Rao were two locums that I put in so we had then got four anaesthetists. Over the next eight

years we then -- and this was largely taken forward by Dr Peter Crean because I didn't have a role within the paediatric directorate. I had to work through him. But to actually put in place a system that provided a comprehensive anaesthetic service for paediatrics was my preoccupation for a large part, if not all, of my time as clinical director with regard to the paediatric hospital. And we did, we actually put in place a system that actually allowed us to recruit and we were having difficulty recruiting anaesthetists, particularly for paediatrics.

So we put in place a system. I sent one anaesthetist off to train in Toronto. Another went to Vancouver. We got Dr McKaigue, who I think -- he moved. I think he came in. So eventually we ended up with the eight anaesthetists over the seven years I was clinical director and it allowed us then to provide a comprehensive theatre system as well as -- as a comprehensive cover of the intensive care unit.

Q. So would I be right in saying that when you first started, sort of 1993, you didn't have the system that you actually wanted to have, if I can put it that way, in terms of the breadth and depth of paediatric anaesthetic care? And that that's what you were working towards?

A. Absolutely.
Q. And can you help when you think you got there, if I can put it that way, between 1993 and 2000, which is -- yes, 2000.
A. I think it was 2000 or possibly even after, before we got our final eighth person in place. And I think it's quite important -- paediatric anaesthesia was not a popular specialty. Very, very few of the junior doctors wanted to go into paediatric anaesthesia. They were considered a high risk. They considered it stressful. Paediatrics are not small adults; they're a different specialty. So one had to come up with a system that made it attractive. You had to identify the people who you felt had an interest and then provide them with the opportunities to get the education. And so I could do that element, but the person who had to act on my behalf within the paediatric directorate -- and there was nobody against this, it was just that we had to find the money, we had to find the people. We were short of anaesthetists at that point. I was actually doing a full anaesthetic job. I was doing seven sessions as an anaesthetist when I was clinical director at that point in time.
So I relied on the structure that I put in place to take forward many of those things and Dr Peter Crean

really developed much of that on my behalf.

Q. Yes. I think you have described Dr Crean as having the day-to-day running --

A. Yes.

Q. So that we're clear what he's having the day-to-day running of, what was he having the day-to-day running of?

A. It would be ensuring that there was appropriate anaesthetic cover for the lists during the day, ensuring there was appropriate consultant cover and ensuring that we had appropriate out-of-hours cover and also that we actually provided the cover for the intensive care unit.

Q. And that was on the paediatric side?

A. Yes. There wasn't any interaction because -- and again, this is mentioned. A lot of discussion at that point in time, how many cases -- what should one's qualification be to be a paediatric anaesthetist? And that basically was one year of specialised paediatric care. What you also had was what was known as an anaesthetist with a paediatric interest, and I would have qualified as that. We had a number and that -- to do that in terms -- the Association of Anaesthetists and College of Anaesthetists had some guidelines. There had been much discussion about that, you know, and I think the Berkshire Royal Hospital was one where there was very

strong opinion that to limit the experience or the provision of paediatric anaesthesia only to paediatric anaesthetists meant that other anaesthetists, if they had to step in and do something, had no experience. Others said, "No, they should only do it if they have one year in paediatrics". And that was where we came from, but I had to work to get there.

Q. I see that. When you describe Dr Peter Crean as having the day-to-day running, does that mean that effectively -- well, was he effectively acting as a paediatric lead?

A. He was effectively doing that. I mean, I think the one thing is that when this set-up -- we didn't, to my knowledge -- I didn't have a job plan at that point in time.

Q. Yes.

A. And one of the reasons I got involved with the King's Fund at that point was England was probably at least a year ahead of us in terms of development. By working with the King's Fund and actually going over to England and being involved, I saw the structures. That assisted me in putting together a structure in terms of the management team and in terms of the committees that mirrored what I saw in the best situations in England. So that was how I was able to say, "Right, you are my

lead in this area, you're my lead in that area", and in most areas they were sub-directors.

Q. Sub-directors? You have just entered an area that I wanted really to ask you about, which is what was the structure that you created for ATICS?

A. It was built on the structure that was there.

Q. Yes.

A. We had -- I was the clinical director.

Q. So you're the clinical director.

A. Unlike England, we did not -- the decision I made in a consultation with the chief executive was not to go with the nurse/business manager model. We went with nurses who had either MBAs or MSc in health management. So we were actually very fortunate to recruit and we ended up with quite a number of -- and so we then had, at that level ... The nurse, initially called the manager, the directorate manager, eventually became a general manager for ATICS. We then had a sub-director for anaesthetic services. That was at that point Dr David Wilson. He basically ran the anaesthetic services, he chaired the Anaesthetic Services Committee, which had been the old Division of Anaesthesia in a way. So he chaired that, which was the consultants with maybe two representatives of the junior doctors. Consultant anaesthetist, two representative junior doctors, and he

chaired that.

He arranged with another nursing person, who I think was called the theatre coordinator. They actually had all the lists that had to be done, they looked at the number of doctors we had, they provided both the out-of-hour covers by the consultants, arranged the out-of-hours cover of consultants, the out-of-hours cover for the juniors, they also had -- and I have forgotten the number of lists we had to cover. It was -- every month, it was very large. And they actually provided the cover which was done -- we usually liked to have that up at least six weeks in advance of the start of the next month's rota. So they ran that and he would have had -- he would have actually been the person who, if there had been issues about covering lists, et cetera, it would have gone to Dr Wilson. He was in a better position for me than to be able to actually intervene at that level. I was doing seven sessions of anaesthesia in areas where I did not have a junior with me --

Q. Okay.

A. -- and so I couldn't -- my duty of care was to the patient I had. Dr Wilson was covering maternity, so he had periods when he wouldn't actually, say, be in the operating theatre and it made it slightly easier for him

to do that, and he was, from my point of view, just made -- made a huge difference, he did a fantastic job.

I had then a very experienced director of intensive care, sub-director of intensive care, so he basically ran that service.

Q. Do you know who that was?

A. At that time I think it was Dr Julian Johnson. I think was the person.

Q. Okay.

A. And then we had the theatre element of the [inaudible]. That had -- Dr Peter Farling was for some of the time, and I can't remember how long, sub-director, but this was an area which ATICS had just taken over before I became clinical director. This was an area where I devoted a great deal of my attention in terms of structures, in terms of -- and we actually decided that we needed a theatre management system that could actually put in place how you managed operating lists so that one piece of equipment wasn't needed at the same place -- in two separate places and we provided cover for as many lists as we could.

And the other area with regard to that -- and that covers something else that's in there, which is to do with critical incident reporting with regard to equipment. I felt that we needed to address the

equipment within the directorate. There had been difficulty finding the funding for that. We had, through the risk management of equipment, identified certain machines where we actually had seen quite a few incidents. I was able through the documentation of the incidents with regard to equipment to replace that machine.

And part of the private finance initiative that I worked on with Mr Norman Bennett and also Mr Jim Wilson, who was the chief technician, and again had been, for me, a right-hand man -- we, as part of the business case -- part of that was based on the record of critical incidents associated with a number of our anaesthetic machines. That became part of the business case that said: this is what it's going to cost us if we don't do something about this. Let's leave aside the lives, let's look at this -- this needs to be addressed.

And I wanted to standardise the equipment within the 13 theatres we had, but I also looked and had co-operation with Royal Maternity and with the School of Dentistry, so we standardised the equipment. That meant the juniors were not finding themselves suddenly doing a case with equipment they didn't know and we were able to put that in place, I think in 1998, but part of it

was due to the collection of data with regard to the incidents with equipment.

Q. That's what I was going to ask you. How did you manage that system? Because in order to be able to see that you have isolated pockets of equipment that is causing a disproportionate amount of difficulty, if I can put it that way, you have to be maintaining those records, somebody has to be looking at that data and forming a view of it. Did you have a committee, a subcommittee, how that was done?

A. Well, I also -- because of my background, I was very interested in risk. I had been in the RAF, I had the link between aircraft and anaesthesia risk had been clearly identified. I had been to a meeting in Basel, which was -- representatives of NASA following the disaster of one of the shuttles. There was also clinical psychologists who were pilots with SAS, who presented, and there was a Professor Jim Reisen, who was the expert in risk in the UK. He investigated the Piper Alpha disaster, he investigated the Townsend Torensen disaster. I invited him to Belfast to talk. So we had -- and then we -- and from about 1992 to 1993, with the audit department, I set up a risk management, a risk -- a critical incident reporting. Because again I had been experienced with critical incident reporting

under the --

Q. Do you know when you did that?

A. It's in here. I think it was either -- it could have been 1991 or 1992 ...

Q. Actually, if you look over the page, we see that you lead a joint study between ATICS and the Medical Defence Union in critical incident reporting and the results were presented to the Health Medical executive in June 1993.

A. Yes. That is actually the study. We had a software package that allowed us to analyse these and then we fed back to audit meetings and we fed back to that. The one element -- and it was -- was that those were anonymised.

Q. Yes.

A. At that time, that was pretty well standard.

Q. I understand. Just so that we're clear, Dr Taylor obviously was the anaesthetist who was directly involved in Adam's transplant surgery. Who would he have reported to?

A. That was part of the split situation. He would have reported to me, but I would not have known -- I would not have had his immediate -- been involved immediately. So if there was, say, a death in theatre, that, I think, would normally have gone to Dr Murnaghan.

Q. That would have gone to Dr Murnaghan?

A. I think so. And I would have been informed at some point fairly close to it. But because I didn't work in the Children's Hospital or in cardiac, I didn't automatically know about cases that were critical incidents or cases there. They would have been considered, for the most part, in the Children's Hospital, and most of them -- the audit activity that would have been involved in these cases would have been undertaken in the Children's Hospital rather than on the ATICS. In a way, that was sensible because that pulled together the disciplines. It was much more in keeping with multi-professional audit, but it did mean that from the ATICS point of view and our audit, we rarely had paediatric -- major paediatric cases presented.
It would be very rare because we did, I think, 2,500 children on the main Royal site -- mostly eyes, ENT, some dental -- but we weren't doing the big cases that were in the Children's Hospital.

Q. But just so that we get the lines right, does that mean that, leaving aside the fact that obviously reports are going to go to Dr Murnaghan, does that mean there's a report to Dr Mulholland as a paediatric lead and/or a report to Dr Peter Crean, who has the day-to-day running of the paediatric aspects of the anaesthesia and/or also report to you if one wanted to go, strictly

speaking, to the clinical lead of his directorate?
A. My feeling is -- and this actually was an area that was not clear.
Q. I see.
A. I think that the structure was in place to report a death associated with the operating theatre and that would, I think, have gone to Dr Murnaghan because Dr Murnaghan, due to the fact of illness that he had had, was not practising clinically, but he had a massive amount of clinical understanding. He was available. So he would have been the first port of call and he would have contacted me pretty regularly and said, "This case has come in, Joe, this is what's happening".
Q. Okay.
A. But there were quite a lot of cases in paediatrics and in cardiac that I wouldn't necessarily have known about.
Q. You mean that might have an anaesthetic element to it, but you wouldn't necessarily know about the case itself?
A. Yes. That wasn't -- I mean, that would happen because that might be considered, I think, as part of an investigation within the Children's Hospital.
Q. And could it happen the other way, that a paediatric case which had a heavy element of anaesthetic issue, if I can put it that way, involved in it might be looked at in your directorate and not in the paediatric

directorate?

A. That would very rarely have happened because the way the audit occurred was on a rolling basis, so that very often meant that paediatric audit and cardiac audit occurred at the same time as the ATICS audit, which meant that we very rarely would have had input from paediatrics. Dr Crean would have been very commonly at our audit, but it would have been rare for those cases to be considered at ours because they were running simultaneously. It was important that the paediatric anaesthetists were involved in the multi-professional audit that was there, and similar with cardiac. And in a sense, the anaesthetists on the main site were not dealing with those types of problems and therefore it was probably not the right forum. It was within the peer group that understood it.

Q. So does that mean if those sorts of cases were more naturally, if I can put it that way, being addressed within the paediatric directorate and subject to paediatric audit, that if there are lessons being learned, they're being developed as paediatric lessons to be learned?

A. They would be -- might be. And I think you have a copy of one audit. That was a case involving a child. At this point I can't remember -- I don't think I knew the

child, but I knew the circumstances. I can't remember if that was a child from the eyes and ENT set-up or if that was a child from Children's and it was presented at the ATICS directorate because we were managing airway and we needed to know about the airway aspects. That may have been why that case was discussed.

Q. Is it possible for a case to be discussed in more than one directorate?

A. Oh absolutely.

Q. Did that happen so far as you're aware?

A. I can't actually remember. I'm sure it did, but I can't remember.

Q. That's all right. Or could it be the case that when you saw a case like that, which is to do with intubation and so forth, and you think that's something that's directly relevant, we can see how we might develop some lessons out of that, but on the other hand it's a paediatric case, could there be a situation where you would invite the paediatric clinicians and so you could have a joint audit meeting?

A. We would have done that, I think, but I can't be specific. And we would have also at that stage, though very rarely, have had a joint meeting with the surgeons. It would not have been common.

Q. That was possible though?

A. Yes, it was, oh absolutely.

THE CHAIRMAN: In fact, anything was possible. You could have any combination you wanted, couldn't you?

A. Yes, there was nothing prescriptive with regard to this. There was no barrier. It was just actually the concept of clinical audit as opposed to -- medical audit was only really developing at that point and it became much more common, still not common, but towards the end of my career.

MS ANYADIKE-DANES: That's one of the differences between the two, isn't it, that the clinical audit is really more to do with building around a single discipline, looking at the lessons you might learn within that, whereas if you have a medical audit it's a much more multidisciplinary approach?

A. Well ...

Q. That's a simplistic way of looking at it --

A. I think medical audit would have tended to be that this is doctors considering doctors. Clinical audit would have included other people such as nurses and technicians and various people, so that this was looking at audit as it applied in the scene with everybody that could be involved in that. And clinical audit tended also to be a situation where surgeons might be involved in a case so that we had a learning experience with

regard to that. That did happen. It didn't happen all that commonly, but it did happen.

Q. Could it have been happening as early as 1995?

A. I think it possibly could have been, yes.

Q. There was one structural point that I wanted to ask you, only because I couldn't find the answer anywhere else. You were a member of the Hospital Council.

A. Yes.

Q. Where in the structure does that fit and what does the Hospital Council do? This is 1995, I should say. I should say, in your CV, you were a member of it between 1993 and 2000.

A. In a sense, it developed over that period of time. I think I probably conceived as the Hospital Council as the place where the activity that the trust senior management, the trust executives, were doing. We weren't necessarily part of that. But it would actually have implications for us as clinical directors, and implications for our staff. So that was a forum -- very often at that point in time of an information forum -- where Mr McKee would provide information. There was also an area for discussing finance and there would have been some things around activity in terms of theatre activity and, of course, at that stage I think we were having to make either 3 per cent or 5 per cent

efficiency savings as part of the drives. So a lot of time would have been taken up with that and where were we in terms of how we were managing that.

Q. Would it be a forum where you could discuss standards and meeting those sorts of targets, as opposed to just the financial issues?

A. At that point in time, I think that even though we talk about clinical governance and governance, I don't remember governance being a major talking point at that time. I don't remember that. And I think that was -- I think that's where, with my role within the King's Fund, I realised that this was more developed in England than it was in Northern Ireland. So I don't remember that. It might have been, but I just don't remember that.

Q. Who sat on it? I don't necessarily mean all the individuals.

A. I can give you roughly what it was. Obviously the chief executive was there and he was the chair. The deputy chair was Dr Ian Carson. I'm thinking back -- memory. There was the HR director. There was the finance director. There was, at that stage, what was called Facilities, which was the director. There was obviously the Nursing Director, the Director of Nursing Services was on it and then we had the clinical

directors: myself, dental, neurosciences, surgical, radiology, ophthalmology, cardiology, paediatrics, medical and laboratories. So there would have been representatives, usually the clinical directors --

Q. From the main directorates and nursing?

A. Just usually, as far as I remember, it was primarily Miss Duffin who was then Director of Patient Services.

THE CHAIRMAN: Sorry, what you have just described was the make-up of the King's Fund committee; is that right?

A. No, the only --

THE CHAIRMAN: What --

A. Miss Duffin and I would have been the two people because we were both surveyors who had taken through -- we would have led that. Miss Duffin led it, but not all of those people -- most of those would not have been on the King's Fund.

MS ANYADIKE-DANES: In answer to the Chairman, Dr Gaston was describing the membership of the Hospital Council.

A. That would not have been one and the same with the King's Fund Organisation.

Q. Maybe we can come to that now. You were a surveyor for the King's Fund.

A. Mm.

Q. And you were a member of the King's Fund Health Quality Services steering group from your CV.

A. Yes.
Q. And can you help with what that meant?
A. Yes. I mean, again, this was a developmental organisation. I think possibly that hasn't come through with the advice you've had to this point. And I know Stephen Ramsden well. I think what didn't come through was that this was a developmental process, it started, I think, initially in 1990 in the south-east of England and then they formalised that. And it was developmental: it set a set of standards, they were based on the Australian standards, that allowed trusts or hospitals to structure their -- to set their structures based around some of those standards. It allowed them to address things like medical records and the medical records centres, it allowed them to address nursing issues and policies and procedures.

My memory is that at the beginning, risk management wasn't as big an element of that. It also had some things -- and I would have always ... In every trust, I would have reviewed 20 charts and in some -- and in a big operation like the Royal, I'd have done ... If I had been doing the King's Fund in a hospital in England similar, I would have done 20 charts in say the main Royal site, I would have done 20 charts in paediatrics, I would have done 20 charts in maternity

and 20 charts in the other services.

Q. When you say that, what does that mean you are doing?

A. It meant that I had a set of standards to measure how -- the documentation that was in place, the policies, health and safety, risk management. They were just starting to develop. So those policies. And what happened then was that the organisation used this as a mechanism to actually bring their services up to an acceptable -- and then accreditation. So there was no accreditation awarded actually in the early days of the King's Fund. I think it was probably 1994, whenever the first accreditation -- there was a new manual came out in 1994 of standards and I think that was the first time whenever one then started to get accreditation.

I actually was on the -- eventually I was a member of the accreditation committee that assessed the trusts.

I think we still felt that even in -- towards the end of 2000, this was developmental.

Q. Yes.

A. And one of the things one saw in England was that sometimes chief executives -- it was nice to have the plaque, but it was how well was it ingrained? So part of our job as surveyors -- and we went in as a team. There would have been a chief executive, a medic -- of whom I would have been one -- a nursing person, there

would have been somebody with an HR background, there would have been somebody with a background in regard to facilities. And then as they got bigger and bigger, there would maybe have been two members from each sub-group in that area.

Q. Yes. Could I ask you this: you seem to have, for a lengthy period of time, have had an interest in this area.

A. Yes.

Q. Is that why you became a member of the King's Fund so that you could bring that, to the extent that you were able, to Belfast or did the Royal Hospital want that, you had that interest and between the two of you it was decided that you would become a member? Which came first?

A. I think -- I knew Dr Carson very well and Dr Carson knew that I had some of this background. And he had said to me when I was working abroad, "Are you interested in coming to the Royal and applying for a job?", and I said yes. So very shortly after I came, I became audit coordinator, I became involved in taking forward the concept of risk.

Q. So am I right in thinking this was the Trust wanting you to do that and encouraging and facilitating that?

A. The Trust certainly facilitated and encouraged me to do

that, absolutely.

Q. As a surveyor, you would go out with the rest of the team and see --

A. Spend about a week, three to five days, depending on the --

Q. In fact, the Royal had a team come to them to do that very sort of thing. Obviously, you wouldn't be on it, for conflict reasons, but because you knew what was involved, you were a surveyor yourself, to what extent were you able to use that to assist in the development of the Royal's own systems so that they could meet what you knew would be the requirements when the visiting review team came?

A. Oh, Miss Duffin actually probably -- because she was more -- would have -- we would together -- and we developed other people, somebody like Tony, Dr Stephens, who was the occupational health visitor and he was a member of the Hospital Council and he had an interest in risk. So he was brought on to the King's Fund. So we had a team of maybe about six and we would have done mock surveys. We would have gone into areas and looked at the medical records, looked at their policies and compared them to the standards that the King's Fund had at that point in time. So yes, we helped in preparing that and in putting in place -- and we also -- the other

element was that the King's Fund provided a client -- I'm trying to think what the name is ... It was like a coordinator that came out from the King's Fund. They would come out initially, maybe a year in advance, and work with the trust.

Q. For you to liaise with?

A. Yes. And that person then became very vital. The client manager, in a way, of the team. They had a very key role and whenever it came to accreditation, we would be considering accreditation, what we considered in regard to whether we accredited a hospital was based on the presentation that that client manager presented, usually in writing, to the accreditation committee.

Q. So far as we understand it, I think the Royal Hospitals got their accreditation in 1996/97, somewhere thereabouts.

A. Yes.

Q. How often would it be before a review team came again to see, you know, you were accredited then with your standards, let's see whether you're maintaining the appropriate standards. How often would that be?

A. I think it was about three-yearly, but quite a lot of trusts -- and I didn't necessarily follow up on that, and I have no knowledge -- I have no memory as to whether the Royal did. The Royal certainly had an

initial survey, which was done before accreditation, and then they had an accreditation survey and I think this is something that Liz Duffin will provide more clearly with you than I will. So there may well have been, during the development to going from zero to accreditation, there may well, I think, have been three processes. And I don't -- I think that was what it was.

Q. Miss Duffin -- the application was actually delegated to her, wasn't it?

A. She was the person as Head of Patient Services.

Q. Yes. And so far as you're aware, given your interest in it, was there any group at all who was tasked to ensure that you were maintaining the standards which had allowed you to achieve accreditation?

A. There would have been a group which I think would have been headed initially by Miss Duffin and then by her successor, Mrs Deirdre O'Brien. There would have been a group and they would have been regularly reviewing -- and I think, and this is something which I think Dr Mulholland mentions, or Dr Carson -- there was a ... You put together areas that needed to be addressed.

Q. Yes.

A. And Dr Carson in his statement says that he was addressing risk. So you had a series of things that you had to achieve, even after you had, say, had

accreditation. You needed to not just stand still, you needed to be actually -- and that, in a sense, is why I go back, that this, at the end of the day, at its best, was a developmental process.

Q. I understand. Then just perhaps two final points from your CV, but in the course of having answered this, you have actually answered some other things to do with organisational points that I would have otherwise asked you. If one goes to 010, if you look down under "presentations" you have, in 1997, "The role of the anaesthetic nurse". I have to say, the role of the anaesthetic nurse in this inquiry is something that we have been trying to identify, what that was in 1995, if I can put it that way.

I know that your presentation is 1997, but can you help us with whether there was a role of an anaesthetic nurse known in that way in 1995? And if so, what was it?

A. Right. Again, this is -- I think it was a developmental process. This was something again which I felt was an area that needed to be addressed. We did have anaesthetics -- an anaesthetic nurse. It'd be a nurse who had been attributed to the anaesthetist and they were very good. But they had limited training. And in many parts of the hospital theatres, we did not have the

equivalent of the English theatre -- um ... Operating theatre practitioner, we didn't have that. And I felt that was something that needed to be addressed. There were certain ways that one could have done it. We could have gone through the technician route. I felt that nurses had the clinical background and we had a number who were doing this, but without all the training. So I worked with developing this concept of anaesthetic nurse --

Q. Sorry, can I ask who you worked with to develop that?

A. I worked with the universities, both the -- to put in place a -- initially just an ordinary course. And Dr Julian Johnson had done some of this as well with a course and then we actually developed that as a Master's course.

Q. Roughly when would that have been?

A. Um ... I think.

Q. Could it have been in 1995?

A. It all started probably about 1993/94 as we started because I felt this was an area that we needed to address. We had anaesthetists ... Consultants working -- they wouldn't necessarily have had juniors in certain areas. And they needed trained support. There were a number of studies that suggested that two -- particularly, an anaesthetist and a nurse actually --

provided better safety care, safety of patients. There was a study came out from Denmark in regard to this. So that sort of was an area where I felt we needed to address.

So eventually, our anaesthetic nurses got to the point where they would put up intravenouses, some of them would be able to intubate patients, and they actually were developing some of the other areas.

Q. You may not be able to answer this because it's so long ago, but in 1995, if you had used the expression "anaesthetic nurse" in the Royal, is that something that would have meant something to someone?

A. I think that would just simply have meant that it was the nurse who had been designated that day to work with the anaesthetist and it wouldn't necessarily be the same one. But I would not have constituted that as an anaesthetic nurse as it eventually was.

Q. I understand.

A. They did provide support.

Q. That person would have been a theatre nurse effectively, who was, on that day, going to be assisting the anaesthetist --

A. That's right.

Q. -- as opposed to somebody who has gone through some particular training?

A. And had a particular interest in regard to anaesthesia.
Q. We may have to revisit that because there seems to be a reference to it in the annual report of 1995/1996 as to whether there were anaesthetic nurses.
A. Well --
Q. We may come back to that point, but it might be that it was on the cusp of change, if I can put it that way.
A. I think it was on the cusp of change, yes.
THE CHAIRMAN: Sorry, let me interrupt for one second.

Doctor, if you had a consultant anaesthetist with an anaesthetic nurse as you now know anaesthetic nurses who have been given specialist training, does that effectively dispense with the need for a junior doctor?
A. Well, in actual fact, because the Royal was a training centre, the training programme of the School of Anaesthesia, which developed -- and I can't remember when -- set out the specialties that they had to do with in the Royal and cardiac would have been one, intensive care would have been another, neurosurgery would have been another, paediatrics would have been another area.

It meant that there were large areas of that hospital where you would not have seen a junior very often. So there wouldn't have been the situation that you would have seen in England where you had a consultant and a junior together and probably would

have seen 10 years before, but because of the development, the concept of developing the training of the juniors -- and I think that was the right thing. I'm not sure the numbers were right, but the concept -- that was a North American concept which I actually felt was right, which was that the consultants delivered the care and juniors were being trained. And I always felt that that was a model which, to me, would offer the very best level of care.

MS ANYADIKE-DANES: I have it now. I'm hoping this will come up, but in any event I can give a reference for it. It's 061/2, page 101. Yes. If you see the last paragraph on the left-hand side:

"A fully comprehensive anaesthetic nurse service has been developed, providing skilled assistance to the anaesthetists, further strengthening the anaesthetic team and increasing the quality of care."

A. And --

Q. So it was up in 1995?

A. We actually have one of our very first anaesthetic nurses sitting here, or was, actually. It must have been up at that point. This was something which I felt very strongly was a safety issue that improved patient care and patient safety. It was something that I will say the College was -- and Association of Anaesthetists

didn't like the word "anaesthetic nurse" because of the concept of nurse anaesthetist from North America.

Q. I understand. I wonder if I can ask you this because some way back when you were explaining how clinical audit and medical audit -- and you explained when you were dealing with clinical audit you had an opportunity to involve a much broader range of specialisms and that would not just be the clinician who would be involved, but you could involve the nurses and other support staff if I can put it that way. If there'd been an issue as to whether there had been the appropriate level of nurses, whether it's the right number or whether it's an anaesthetic nurse or something of that sort in the theatre, and that was part of a case where, ultimately, there had been a death, is that something that would be discussed so far as your involvement with those sort of meetings?

A. Within the Royal hospitals group, many anaesthetists, if they didn't have an anaesthetic nurse at that point and soon after that, would have said, "I'm not going ahead with this case until I actually get an anaesthetic nurse to work with me", because there were, at that point, limited numbers and we had focused them on certain areas where we felt it was most appropriate. But the nurses at that stage -- I'm pretty sure were attending our

audit meetings. They mightn't have been there for the first hour, but the anaesthetic nurses would -- they were key people and actually our theatre nurses were. So we encouraged the nurses to come to our audit meetings and because some of the subjects from an educational point of view were across the spectrum of the profession, so that -- ATICS would have been one of the directorates, I think, that were -- brought that in fairly quickly. It was something I felt was important and I wasn't on my own. That was something that, I think, was very clear within the directorate.

Q. So the issue of cover is exactly the sort of thing that might be discussed at a meeting like that?

A. Well, actually, I suspect that one might have got critical incidents in those cases from the anaesthetists involved. I have a feeling that we did get some. They said: I didn't have an anaesthetic nurse in this case and I felt it was appropriate and a critical incident would have gone in and we would then have looked at the distribution, et cetera. But there were limited numbers and one of the issues was, again, was funding, persuading the Department of Health -- because we had actually to try to -- to make a case for funding.

Q. I understand.

THE CHAIRMAN: Did the Royal start this idea in

Northern Ireland of --

A. Of the nurse anaesthesia? The Ulster Hospital had, for many years, had anaesthetic technicians and there were anaesthetic technicians in cardiac surgery. There were anaesthetic technicians in neurosurgery and anaesthetic technicians in maternity and then the paediatrics had their own -- really, quite a developed, extensive technical service, who functioned within their own environment. But there were large areas in the main hospital, including the area where most of the major emergencies -- and the Royal being a trauma centre -- went through, where there wouldn't have been technicians, and these nurses then became very, very key members of the team.

MS ANYADIKE-DANES: How did those technicians that you have just described, which were being developed -- one in the Ulster Hospital and also in other directorates -- how did they compare with the medical technical officers?

A. I think, in Northern Ireland, they were one and the same thing to a large extent. I mean, Mr Jim Wilson, who I think you have a report from, Jim was the -- had started as an anaesthetic technician. They had very detailed knowledge of the equipment and the function. He then became a very key member to me, and he was on our -- on the ATICS management team. Jim was a standard

member along with the doctors of that team because he brought his ... But they were one and the same.

Q. I understand. Then, just finally on your CV, it post-dates Adam's death a little bit. I wonder if you could help us with it. It's 001/1. 306-067-011.

There we are. If one looks at 2006 to 2007, you were involved in assisting the Northern Ireland Office, the Forensic Department, to develop job plans and implement a new contract for the State Pathology consultants in Northern Ireland. What I wanted to ask you is: did you have any formal links or quasi-formal links when you were at the Royal with the State Pathologist Department?

A. There were links, yes, because they tended to operate, at least, out of the Royal site. They were in a separate unit and it was managed, obviously, through the Forensic Services Department of the Department in Stormont, but there would have been quite close links. You would have had frequent discussions, just even on a personal basis with them. I quite frequently would have had lunch with Professor Crane, so yes, there was quite a close -- they weren't remote.

Q. I understand that. Was there any suggestion that there may be cases in which you would seek to involve their pathologists in terms of discussing matters and making

sure you've extracted the lessons that were there to be learned?

A. There were cases which I think they would -- which would have been within the Royal where they would have actually been the people who would have done the case, but very often they would have been consulted and, from my memory, they would say, "No, we're happy to allow the Royal pathologists to do this", and then maybe feed some information back. They would have worked reasonably closely with the pathology services throughout the province, so they wouldn't have done all the post-mortems, even though they might have appeared like they should have been coroners' cases, they might well have said, "I'm quite happy to let the pathologist in, say, Craigavon to do that".

Q. I understand. Maybe it's a slightly different question that I'm asking you. We understood from Dr Armour's evidence and other material that we received that if it was a case of a death in hospital where there was a suggestion, not necessarily established -- it's one of the reasons I presume you want an autopsy, but where there was a suggestion that there might be medical negligence or something of that sort involved, then for independence reasons, if I can put it that way, the State Pathology Department would be involved and

it would be their pathologist who would do that.

What I was really asking is: if you had a situation like that, was there any opportunity or did you seek to -- once they had produced their reports, the inquests had happened and so forth, and you're really looking to see what are the lessons we take out of that, and you're having your meeting which you may be having in any event in your own directorate, was there any thought that you might invite the pathologist who has a slightly different perspective as to what they are able to see as the outcome of the clinical event, if I can put it that way?

A. I can't answer that. Certainly the forensic pathologist, I can never think of a situation where the forensic pathologist, but I certainly -- the history of the clinical pathological conferences, which started many years before, was a combination of pathologist and the clinicians.

Q. Mm-hm.

A. Those did happen from time to time over specific cases.

Q. They did happen?

A. They did happen. Even as a medical student, I remember attending those, where there would be what we call clinical pathological conferences, and this is something that happened throughout the UK as well.

Q. Did you seek to encourage that?
A. I don't -- I can't say that I either did or didn't. I have no recollection of it.
THE CHAIRMAN: I'm sorry, doctor, when you talk about a conference, is that -- that's a discussion about -- [OVERSPEAKING]?
A. That would have been more in terms of a clinical meeting, I think.
THE CHAIRMAN: This isn't some formal event, this is just a discussion. You're going to have a discussion about the death of a particular patient and you may bring in the hospital pathologist as part of the discussion of that?
A. Well, if you had a clinical pathological conference -- and I remember those more in the past than in the present because of the way the directorate structures were -- you would have actually ... That would have been something that would have been held in the operating theatre, you would have -- the lecture theatre and you would have had a pathologist, you'd have had maybe the physician if it was a patient, and they would have actually discussed the case with information coming from radiologists, pathologists, et cetera. That was probably more historical, but these things did happen and I can think of one case where we had -- where

a patient was shot -- very, very major gunshot wounds -- and that particular case brought -- the patient survived -- brought all of the services together to discuss: what did we learn from this? The fact that the patient survived didn't mean that you hadn't things to learn.

MS ANYADIKE-DANES: I understand that. You have said that they were literally on your site, on the site, and that I think you indicated, or at least we know, that you shared the same mortuary. Were there any sort of memoranda from the State Pathologist's Department in relation to how it would assist them to receive the body that you recall?

A. I wouldn't know.

Q. I will give you an example so it's just not a question in a vacuum. For example, we were told by Dr Armour during her evidence that if it could be done, the pathologists at the State Pathology Department would prefer the body to come with all the lines in, for example, because there are things they can learn from that.

A. Mm-hm.

Q. In fact, she said that that had been communicated to the Royal. We are not entirely sure because she can't remember -- I doubt she was responsible for doing it --

how that went, but in any event, that was her clear recollection. We know that that didn't happen with Adam, that in fact all his lines were removed. I'm talking about the catheter for the central venous pressure line and so forth, that was removed. His urinary catheters remained in place.

So what we were trying to discover is, if the State Pathology Department wished something like that to improve their investigation, how that might be communicated to the hospital. Are you aware of anything like that?

A. I certainly would have been aware, and I think Dr Murnaghan would have said that if there had been an unexpected death in theatre, no lines should come out, endotracheal tubes should not come out. The patient should be left as is so you can actually do a proper investigation. That would certainly have been -- and I think that was something that if Dr Murnaghan was contacted immediately, he would say, "Don't touch anything, leave things exactly as they are so that gives the pathologist the opportunity to do -- I think that was known. I can't say why it didn't happen in this case. As I say, I wasn't in the paediatric hospital.

Q. I understand. Is that on an ad hoc basis? That would be done case by case or was that something that

generally had been said and people should have appreciated that?

A. I think that would have probably been considered a standard of care with regard to what I had known in the past, actually.

Q. Thank you.

THE CHAIRMAN: When you say "Dr Murnaghan would have said so", does that mean that Dr Murnaghan would have said so at a meeting, for instance, with a number of directors who would have passed the word down or it would have been a note --

A. He would have been contacted in many of the cases at the time of the death and Dr Murnaghan will bring that -- and from my memory, he would have said, "Don't do anything, leave things as is, leave the tubes in place, leave everything in place". That would have been him personally as part of his role.

THE CHAIRMAN: What I'm trying to get at, doctor, is if this was a fairly standard approach, that the lines should be left in, and then they become, in essence, part of the autopsy, you seem to think that would have been a fairly standard arrangement?

A. I think this case that we're talking about was somewhat different from usual in that there was a great effort to resuscitate him at the end and that may have been --

I don't know because I didn't work there, I can't say why that didn't happen in this case.

MS ANYADIKE-DANES: I think what the chairman was exploring with you --

A. Would that have been brought up at a meeting?

Q. Does that become just part of the background knowledge, part of people's culture, they understood you didn't do that? Or was it -- well, is that how people learned about it?

A. No, I think that would -- I mean, I'm trying to ... I knew about this because of my background.

Q. Yes.

A. And I think Dr Murnaghan because of his element of risk management background and the investigation would have known --

Q. How would others know?

A. I don't know if they did know. I'm sure -- I mean, they would have known that if Dr Murnaghan would have said. Whether that was widely known, I can't answer.

Q. Thank you. Then just really dealing with these structures and your role in promoting auditing and so forth, right at the beginning when I was delivering the opening in this section of the case, I read out a bit from The Patients' Charter. We can pull it up now. It's 062/1, page 328. No, it's not going to come up.

I can read it out --

THE CHAIRMAN: Sorry, the witness statement you're reading from is?

MS ANYADIKE-DANES: I can think of a reason why it might not be coming up. I'm just trying to see if there is a ... I don't think we have an alternative way of pulling it up. I think we will get that individually paginated. If I just read the particular section that I'm interested in:

"The main standards of service each board has contracted for by type and location."

This is part of what The Patients' Charter says:

"And boards will be required to publish, each year, information about their achievements against these standards and to say what action they are taking to improve performance where necessary."

So that's part of what The Patients' Charter requires, that you publish the main standards of service, each board does, that is been contracted for by type and location, and that you publish each year information about the achievements against those standards. There might be another way of looking at it. 306-085-001.

There we are. That's it there. If we go into it. I'm just trying to ... If one goes in a little bit,

you will see" Right to information". Internal page 11.

THE CHAIRMAN: 012, please.

MS ANYADIKE-DANES: There we are. In the first column, you see:

"The local charters must include information about ..."

And that's the first bit I read out to you:

"The main standards of service each board has negotiated in its agreements."

And just across, next to that on the second column:

"The boards will be required to publish each year information about their achievements against these standard to say what action they are taking to improve performance where necessary."

So what I am going to ask you is: how did the Trust feed into that obligation of the board?

A. There would have been a publication -- my problem is that I don't remember the date. There would have been information that would have fed in as to how they had met standards and what they would have done. That would have been published. And it's possible now that you say it, as I think -- it is possible that the broad outline of that would have come to the Hospital Council before it was released.

Q. I understand that you're trying to remember this far

back and it may not entirely have been your area, but the board is going to have to comply with this and so the board presumably looks to the trusts within it and the trusts will look down to their hospitals who are delivering it to see the information that they can provide to enable it to be able to discharge this obligation.

Once it cascades down to the hospitals, if I can put it that way, do the clinical directorates -- are they required to provide the information to enable the hospital to send the information up?

A. I don't remember that. I don't know how that worked. I have no memory of -- I remember the Trust presenting figures, but I have no memory of the mechanism for that at all.

Q. You don't recall ever yourself having to --

A. I don't recall. No, I was never involved in a formal way, no.

Q. Did your directorate have to provide any figures, any performance figures, at all?

A. Oh, yes.

Q. And were those figures more than just how you had managed your budget, if I can put it that way?

A. Oh yes, there would have been a number of lists that were cancelled, when they were cancelled -- because

there were targets in terms of when you cancel patients. Patients who were cancelled at short notice had to be given an appointment within the next available -- so yes, there were, and we had to publish those. They may have fed in, I don't know. Those would have been -- the theatre coordinator and the directorate manager would have been the person who probably would have taken responsibility for that. I don't remember personally getting directly involved.

Q. I understand that. If we think about 1995 so we don't get too far ahead and into a different dispensation. In 1995, in addition to the matters you have just mentioned that your directorate would have been providing, would you have been providing information on adverse incidents, for example, deaths, unexpected deaths?

A. I suspect we were, but I can't absolutely confirm that. But I would suspect we did.

Q. I wonder, against that background, if we can now look at Adam's case in particular. We may have to revisit a bit of background as well, but if we may look at Adam's case in particular from the perspective of report and investigation.

If we look at your witness statements, you provided two witness statements for the inquiry; isn't that right?

A. Yes.
Q. Subject to anything that you have already said or anything that you may say in this oral hearing, are you standing over those as your evidence?
A. Yes.
Q. Thank you.
A. Yes, I am, absolutely. There may be things that I've had to -- I mean, I can think of one point that I need to clarify and that was when I said that I would have expected a report to be given to me to be -- when I said that yes -- did I receive a report? I said I don't remember receiving a report, but I would have expected to receive it. I was thinking actually of a report from the coroner rather than a report from another surgeon(?). I think that may actually have been the wrong understanding of that.
Q. Yes. Well, we can go to that. It's your second witness statement, so it's 013/2, and I think it's at page 17. Then if you go right down to the bottom it's the answer to question 49:

"Please confirm whether or not you received a report in writing of or into the death of Adam Strain in 1995."

And you say:

"I would have expected to receive a report, but cannot confirm this."

By that, you meant you would have expected to receive a report from the coroner?

A. I think that's what I thought. But I mean, I would have anticipated that I would have had a detailed report -- well, I would have had a report from the coroner and I don't remember ever -- not coming to me personally, but I would have seen a copy of what the coroner had said, and I think I did, probably.

Q. You mean over and above his verdict on inquest?

A. Not -- um, not expanding on that.

Q. So what you meant by that is you would have expected to receive his verdict on inquest?

A. Yes.

Q. Does that mean you don't think you did see that?

A. What I meant is at that point, I couldn't remember that.

Q. Right. Would you have expected to receive any other report in relation to that death?

A. No, I don't think so.

Q. Of any sort? Sorry, if I may be clear on this. It's a different matter whether you actually did receive one or whether you can remember whether you received one.

A. Sure.

Q. If we start with the first question. Would you have expected to receive one?

THE CHAIRMAN: Sorry, can I clarify what is meant by

"receiving a report" --

MS ANYADIKE-DANES: A report --

THE CHAIRMAN: -- because that can be formal or informal?

A. I find this a difficult question to answer. I think that's why I --

MS ANYADIKE-DANES: I understand that. In a way, I was going to ask Dr Gaston to deal with whether he would have expected to receive either a verbal report or something in writing. Basically, a report telling you that such a thing had happened and setting out the circumstances of it.

A. I certainly didn't receive a report like that.

Q. I understand. Would you have expected to?

A. Um ... I think I probably would have expected to, yes.

Q. Thank you. If --

THE CHAIRMAN: I'm sorry, let me develop that.

In what form or style or manner would you have expected to receive some form of report about Adam's death? Does that mean somebody ringing you or somebody coming to see you or somebody putting something in writing?

A. Um ... I think that that actually, in fairness, is something that would have ... I think that is -- I'm not still answering that question probably correctly. I think that I would -- I was part of the investigation

into Adam's death, so in fact that was -- that is seen in some of the documentation. I think that I wouldn't have expected to have had a report other than the feedback that we had in the group. No, I wouldn't.

MS ANYADIKE-DANES: Then perhaps I will start a little bit further back from that. How would you have expected to learn that Adam had died after surgery?

A. I didn't actually learn about Adam's death until some time after the surgery.

Q. No --

A. I'm not talking hours, I'm talking days. I think normally that would have been Dr Murnaghan and I think it was probably Dr Murnaghan who first spoke to me. I can't remember that, to be quite -- I can't remember how I found out and when I found out exactly.

Q. Sorry, Dr Gaston, it's a slightly different question I'm asking you. What actually happened is a different issue. What I'm asking you -- this is 1995, you're concerned about systems and procedures and all that sort of thing, and quality assurance and so on. How would you have expected to learn that there had been a paediatric death shortly after surgery, if not, medically speaking, during surgery?

A. Well, I wouldn't have known during surgery.

Q. No.

A. And I would rarely have known immediately after surgery.
Q. Okay.
A. And the person that I think normally -- and I would expect, in this case, was Dr Murnaghan because he was the person, the first person who would normally have heard about that. And he would have been the person who would have contacted me and said that there was such-and-such.
THE CHAIRMAN: Who would tell Dr Murnaghan in the first place?
A. Normally with a death, whoever was in the operating theatre, he would be informed, the coroner would have been informed. I can't remember who specifically did that because it would have been the people who were directly involved in the case. And being a big Royal site, there wasn't a formula as to who did it, I don't think.

It might have been that the anaesthetist or the surgeon who was involved in that case would have rung Dr Murnaghan and the coroner would have been informed that there had been an unexpected death in theatre.
MS ANYADIKE-DANES: Okay. You're ahead of the ATICS directorate.
A. Mm.
Q. The day-to-day management of that in relation to sort of

paediatric anaesthetic issues, you have delegated those to Dr Peter Crean.

A. Sure.

Q. Would you have expected Dr Peter Crean to have been told about it if there is any way in which a person might be concerned that it had anything to do with anaesthesia?

A. I would have expected him to have known about it, yes.

Q. Would you have expected somebody to have reported it to him as opposed to just learning about it?

A. I cannot say because I don't know what mechanisms were in place within the Children's Hospital for reporting things like that. I don't know how it was done.

Q. Then what were the mechanisms within ATICS for reporting something like that?

A. The person who was directly involved with that case -- whether it was the surgeon who had done it or the anaesthetist -- would have contacted either the -- probably both the coroner and Dr Murnaghan. It might be they contacted Dr Murnaghan, then it went to the coroner, but it was a duty that you had to report them to the coroner.

Q. Of course. Is there any reason why your systems couldn't have involved you as the clinical director of ATICS being notified of that directly?

A. There wasn't any system that said I couldn't be notified

directly, other than I wasn't in a position to actually investigate because I would very often be in an operating theatre and it wasn't appropriate to interrupt me with a complicated case when I was actually managing a patient.

Q. Yes.

A. So the system that was set up -- and again it comes back to the way the directorates were put together. The paediatric directorates and cardiac managed their own services, even though we managed the anaesthetists. I would very often -- I certainly wouldn't have known in cardiac surgery of deaths. That would have been quite rare for me to know about that.

Q. I'm just thinking about the critical incident reporting system you might have established.

A. Sure.

Q. And that being the case, does that mean that given that and given your interest in developing expertise in it, that really you had a system where somebody outside the clinical directorates -- leaving aside the coroner for the moment and the statutory obligations in relation to that -- was the first line of reporting? Is that what that means?

A. Certainly I was not the first line of reporting for paediatrics and cardiac surgery. I was not the first

line of reporting for that.

Q. On the clinical side, who would be the first line? Because if we just look at his actual specialism, Dr George Murnaghan was the director of medical administration?

A. Yes.

Q. That was his --

A. Mm-hm.

Q. If one recalls the organisational chart I put up, all the way to the right-hand side are the clinical directorates, all coming under the medical director, who is Dr Ian Carson?

A. That's correct.

Q. And there's any number of those that may or may not have had some sort of interest in the event that we had from paediatrics to ATICS to surgery.

A. Sure.

Q. What I'm trying to find out is, in your system that you were developing for critical incident reporting, did you actually have a system where, leaving aside the coroner, the first line of reporting was nothing to do with a clinical directorate?

A. The critical incident reporting that we had in place was entirely within the ATICS directorate; it didn't apply to paediatrics and it didn't apply to cardiac, it was

entirely within the ATICS, the main ATICS theatres and the main ATICS service. We weren't getting reports from the other areas.

Q. I understand that.

A. In other words, the anaesthetists in those areas may have been putting reports in within their own -- say within the paediatric directorate there may have been a mechanism for identifying critical incidents, there may have been there, but I wouldn't have known about it.

Q. Yes, but, strictly speaking, although you have described it as being a bit of an anomaly, Dr Taylor was within your directorate?

A. He was within my directorate.

Q. Yes, so your critical incident reporting in relation to a paediatric anaesthetist who was within your directorate, albeit oddly, but your critical incident reporting, are we to understand, didn't involve that person notifying you or anybody else that you should have delegated that to in your directorate?

A. The critical incident reporting at that point was still quite informal. I mean, I think that's quite important. Even though we had -- it was an informal system and it was an anonymised system and it wasn't a very comprehensive system, but it was where we started from in terms of -- in 1992 we started with this. And it

wasn't perfect with regard to identifying when -- and it wasn't perfect in identifying who was the person who would investigate it, and I think they would have gone centrally within that particular hospital. I would have known about the case, but I didn't necessarily know it in the immediacy.

THE CHAIRMAN: Sorry, when you say that the system you had was still quite informal, I understand that. You say it wasn't very comprehensive, I understand that. You say it was anonymised?

A. I said that earlier, that it was anonymised. Not with regard to this, no.

THE CHAIRMAN: Okay.

A. There was a system in place for reporting deaths and sudden deaths in theatre. It wouldn't necessarily -- in the directorates outside my control, I wouldn't automatically have been copied into that critical incident report.

MS ANYADIKE-DANES: We'll come to that point in a minute. Let's see if we can help by putting up what we have on critical incidents reporting. I think it's 306-067-006. Sorry, that's just where -- I beg your pardon, I thought that was going to be a reference to something else.

In your system, where did deaths of patients involving clinicians who were within your directorate --

leaving aside the coroner if that was an involvement -- in your system where did they get reported to?

A. They would have been -- well, they would have come to me at some -- in the point of time within the ATICS directorate, they would have come to me very quickly. It wouldn't necessarily have come to me immediately because I was not -- it might be that Dr David Wilson as the director of anaesthetic services would have been the first port of call. But the person who would normally have been certain to have been called was Dr Murnaghan.

Q. Yes, I have appreciated that. I'm just really dealing with the people who are within your directorate.

A. Well, within my directorate they would have been -- the person who would be available would have been one of the three directors. If it was ICU, it would have been Dr Julian Johnson. If it was anaesthetic services, it probably would have been David Wilson. And then I would have been involved very quickly if it was within the ATICS directorate. Outside the ATICS directorate, it was not a quick response as far as I was concerned.

Q. I understand that. So within the ATICS directorate, which -- let's deal with Dr Taylor, an anaesthetist. The death happens either in the theatre or shortly after the operation. So are you saying that from a clinical point of view, the systems you had within your

directorate, that would have been reported to Dr Wilson?
A. Not in Dr Taylor's case. That was not happening --
THE CHAIRMAN: Because it was a paediatric case?
A. Exactly. And the same with cardiac, exactly the same with cardiac.
MS ANYADIKE-DANES: So even though he's an anaesthetist and you're ultimately his clinical lead, he would not be reporting that to you?
A. Not routinely, no. He would be routinely reporting it, but it would have gone up through the paediatric director to Dr Murnaghan, it would have gone through the cardiac director to Dr Murnaghan. It would probably in many cases have gone through -- the maternity would have gone directly and I would not have been -- that would have been directly involved [sic]. That was part of the developmental process in terms of the structures. They weren't ideally structured and a very large directorate -- it wasn't ideal.
THE CHAIRMAN: And then, Dr Gaston, is it then really for Dr Murnaghan to decide what actions are to be taken, who's to be involved in investigating or reviewing what happened?
A. I think that would be what happened, yes, and I think it happened in this case.
MS ANYADIKE-DANES: You have described that as a not

entirely satisfactory arrangement.

A. I think it was very satisfactory that Dr Murnaghan was -- yes. I think the other system, I agree with you, yes, it wasn't ideal at all.

Q. Is that something that you might have discussed coming out of Adam's case, that you actually had an instance of that?

A. One of the things that came out of Adam's case was that I felt there were broader issues in this case. I felt that to consider this case just within the ATICS directorate would actually fail to address the issues. I felt quite strongly there were broad issues that needed to be addressed. It wasn't just about hyponatraemia, it was about structures, it was about all sorts of thing that contributed. I felt that could be best done -- and I know Dr Murnaghan felt that, that that could be best done with a multi-specialty team. That, in part, was why he set up that symposium, which I don't remember going ahead. But that was the reason for it, was an initial -- and then I sort of felt that once that had met [sic] and we had sorted out quite a few -- then that should have cascaded down and that was the way we would have gone. Because I felt quite strongly this was a multi-professional issue, you couldn't actually leave one service out of it, you

needed to bring it all together.

Q. I understand. In fact, I'm going to ask you to develop that a little bit as we go on, but I'm very grateful for that early indication that that was your thinking at the time.

In any event, actually, Dr Taylor does come to speak to you, doesn't he? If we go to your first inquiry witness statement, 013/1, page 3. It's the second paragraph:

"Shortly after the death of Adam Strain, though I do not know when, hours or days, Dr Taylor came to speak to me about the case and how upset he was about the case. We talked through the circumstances and I assured him of my support and understanding of what had been a very complex and challenging anaesthetic."

Can I ask you a number of questions about that? Firstly, at the time he came to see you, did you know anything about the circumstances of the death?

A. I would have known something, but --

Q. Sorry?

A. I think I might have known a little bit, but not very much. And part of what -- I mean, this was a devastating death. It was a devastating death and I think it's important that -- it was devastating for the family, for Adam's mother, for his grandparents.

This was devastating, but it was devastating for the staff who took part. To have a four-year-old child die in those circumstances is absolutely devastating.

So when Dr Taylor came to me, he was a very upset anaesthetist. I had been doing renal transplants, not paediatric renal transplants, up to 1990, so I knew something about them. And what I did with Dr Taylor, I said, tell me what -- and I can't put the words here because I can't remember. Basically, I asked him to go through the case. Because I had been involved in transplants, I wanted to know about the complexity. This was a child who'd had multiple procedures. There were issues around whether there had been adhesions, there were issues around the complexity of his high output renal failure. Bob had anaesthetised that patient quite a few times before. There were issues around the length of the surgery, there were issues around things like the irrigation that had to be done. These were not unexpected, given that this was a very complex case. This was a major challenge for the surgeon and a major challenge for Dr Taylor. So what we did --

Q. Sorry, can I just pause you there? Did you regard this as being a complex case from an anaesthetic point of view?

A. Yes.
Q. Or a complex case from a surgical point of view?
A. Every point of view.
Q. Every point of view. And did you reach that view from what Dr Taylor told you or simply by knowing that we are dealing with a paediatric renal transplant in a child of about 4 years old and that's going to be complex?
A. If this had been an adult, which would have been the area I was working with, having had all the operative procedures he'd had, the access and everything would have been difficult. To have that in a four-year-old child made that so much more difficult. So this was a complex anaesthetic, it was a complex -- in terms of calculating fluid balance, it was -- and so we talked through how Bob had worked that out. We would have spent time on that. It was --
Q. Sorry, did he provide you with the anaesthetic record?
A. Not at that time, no.
Q. But he talked you through what he did and his calculations?
A. Yes, he talked through what had been the difficulties. I felt that he needed -- we needed to talk it through.
Q. Sure.
A. And he did. And because I had been involved in renal transplants, there were areas where I said, "What

happened here? And where was it there?" and we did -- and then the one thing that I do remember very clearly saying to him, I said, "Bob, if you would like to talk, then it might be good to talk to some other of the senior anaesthetists in our department who might have been more senior than I was in terms of -- I would suggest that you do that", because I felt that that was important, he needed to talk through various things.

So whenever I said --

Q. Sorry, pause there. Why did you think that was important?

A. Because I felt that he needed to actually -- from the fact that he was so upset, he needed one of the really senior people to be able for him to talk it through with them as well as having talked it through with me.

Q. Did you have anybody in mind, who that might be?

A. I think I would have had a couple of people in mind, yes.

Q. Who might they be?

A. I think one might have been Dr Morrell(?) Lyons, who was a very senior anaesthetist; he'd been president of the Association of Anaesthetists. I think probably Dr Coppell, who had been director of -- those were people who had experience of managing. And those -- I may well have said those people, I just can't

remember.

Q. I understand.

A. But those are the sort of people I felt that he could actually talk to. And when I said I would support him, what I was saying was: as I would have supported a patient with a serious illness, I would have supported him through it. I was saying to him, basically, "I can support you", but he was going through it, he was deciding what he did. And to the best of my knowledge and recollection, I never had a one-to-one meeting with Dr Taylor after that again; I think that was the only one I had.

Q. I think you said that you took notes of that meeting?

A. What I said was it would have been my usual practice to have taken notes. I cannot remember now if I did or not and, if I did, I have no recollection of where they are. I would usually -- and it would have been a very short note: I have spoken to Dr Taylor today, we have discussed through what were the issues that he had to face in this, I've talked to him and I have provided him with a couple of names of other people he may want to talk to and I'm available if he feels he needs to talk.

That's what I would have expected I would have written. I cannot -- I apologise, and I live in England, I don't live in Northern Ireland any more, so

I don't have access to it and I can't confirm that, but that would have been normal practice for me to have done that.

Q. Dr Gaston, this is many years removed, you may not be able to understand [sic] this, but, on the other hand, it's not the sort of thing that happens all the time and you did have before you a colleague who was incredibly distraught. Are you able to recall the key things that he communicated to you, if I can put it that way, during that exchange or during his discussion with you?

A. I think it was the challenges that he met, and I would have partly been the prompt to some of those because I had experience.

Q. And do you recollect what they were? I'm not asking you to recollect the terms he used or even all of them, but do you recollect what they were?

A. I do recollect them because I think I would have made those points, some of the discussions that we had in a group, and I just can't remember them exactly.
I mean, the areas that I felt was a high output renal failure -- a high output renal failure in a small child in my experience -- and I had been anaesthetising children but I didn't actually -- I had been anaesthetising children with renal failure who would have been in the renal failure unit, but I didn't

actually anaesthetise the children for transplant; we had two very experienced paediatric anaesthetists.

Q. Do you mean the fact that Adam was polyuric?

A. Yes.

Q. That was one key issue?

A. That was one key issue. The other was the issue around the central venous pressure. That was something which was an issue for Bob, it was something that would have been diverting his attention.

Q. Do you know what that issue was for him?

A. It was the fact that he was concerned that it wasn't an accurate reading.

Q. Okay.

A. The other was that it was longer surgery than he had anticipated, so that made the calculation of the fluid, his fluid balance, more difficult. He felt that -- and this is a hard thing to assess in a renal transplant sometimes, how much blood he had lost. He felt he had lost a bit more blood than he would have expected and he felt that was partly due to the fact that this was difficult surgery. There was nothing wrong, it was just difficult surgery. There would have been adhesions in many places. Actually, if you work your way through that, you tend to get a little bit more bleeding. So he felt that was an issue. And, because of the bleeding,

to allow the surgeon to see -- because in a small child when you're anastomosing arteries, veins and ureter, et cetera, that is actually very fine work and if you have any sort of -- it's very important for the surgeon to keep his vascular field, or his field, clear of blood.

Q. Yes.

A. So he would have been irrigating and he felt that there was actually quite a lot of irrigation of fluid in this case. And as I say, I said, "Well, that wouldn't be surprising really". So he felt that was ...

The other issue that he raised at some point -- and I think it was then -- was that this was a long operation. He was concerned about this child becoming hypoglycaemic. So one of the things he was considering was: did he need to provide some sugar for this kid to actually ... So this wasn't -- I mean, I was doing renal transplants where, once I got the patient asleep and everything stable, I could sit down and fill in the notes and have time. And once you had got the anastomosis and you had got them -- and it's such a long time ago now -- you had got them stabilised -- this wasn't like that, this was a case that required concentration. It required a great deal of work, it was difficult and this, I think, is quite important.

It would have been difficult for him to keep the note

just absolutely perfect. The one thing I do know because it's the one thing that became very, very clear and I mentioned that in the -- was that the quality of Bob's documentation of the fluid he provided was of the very highest standard. And that's the one thing that I remember very clearly. I hadn't seen the record at that time, but I did see -- and that was very clear.

Q. If we pause there, actually, because at that stage, from what I understood you to say, you wouldn't have actually seen it at that stage?

A. No.

Q. You're really dealing with Dr Taylor --

A. That's right.

Q. -- explaining what has happened and so forth. And you're trying to tease out, if you like, what the main issues are?

A. That's what I think was what I primarily talked about.

Q. Okay. Now that you've mentioned that --

THE CHAIRMAN: When you get to a convenient point, we'll break.

MS ANYADIKE-DANES: Probably this is it.

THE CHAIRMAN: Okay.

Doctor, we're going to break there for this afternoon and we will resume at 10 o'clock tomorrow morning. Thank you very much.

(4.35 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X