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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

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

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

16                 So that really starts with 1955, so far as we are  
17          aware, and it carries on -- and you will see the format  
18          of it -- right up until one gets to, in that section,  
19          1995, to be found at 306-080-008, which is the HPSS  
20          management plan for 1995/1996. That, one sees, a short  
21          extract from. Some of these documents, we will be  
22          returning to in the course of this hearing, and that's  
23          the other reason why it might be helpful for you to have  
24          them all there, so far as we can do it, in chronological  
25          order, although we don't always know when documents were

1 released.

2 Then comes a second schedule, which is from Adam's  
3 death on 28 November until the inquest verdict on  
4 21 June. You will already have had from us a chronology  
5 that deals with the intervening period, really, which is  
6 from his admission up until his death. That's because  
7 that formed, in large part, the basis of the  
8 investigation into the clinical matters, so I haven't  
9 sought to repeat that there, but if you want to refresh  
10 your memory, you can go back to that.

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

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

1           exist in written form. So that's a relevant document.

2           It goes in in that way.

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

13          You may wonder why it goes all the way to 1998. In  
14          fact, it goes a little bit further on from that, but in  
15          1998 you had, if one looks at 306-080-041, you had the  
16          British Transplant Society issuing standards for organ  
17          and tissue transplantation in the United Kingdom,  
18          providing best practice. So one looks at that to see to  
19          what extent any of that fitted with what was happening  
20          and what the trust itself was developing.

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

25          Claire died during this period -- and one sees that

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

19 Then one goes on:

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

22 And then:

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

1 aims of the NHS."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 We may --

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

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

17 THE CHAIRMAN: Is this post-2007 then?

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

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

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

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

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



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

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

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

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

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

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

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

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

1 Secretary of State are understood and met."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 should govern medical audit.

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

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

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

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

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

25 And then the Royal College of Surgeons, they came



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

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

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

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

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

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

10 And then Dr Carson has informed the inquiry:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23           THE CHAIRMAN: Of course.

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

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

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

9 THE CHAIRMAN: You're at paragraph 89?

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

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

23 So if that's what they were able to report in  
24 1995/1996, then Mr Chairman, one suggests that in order  
25 to do that, they had at least thought about the

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

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

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

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

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

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

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

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

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

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

18          That Health and Safety report that I mentioned,  
19          1995/1996, does record some criticism in terms of the  
20          feedback that they were receiving and the criticism is  
21          reflected in that criteria, which is what I was just  
22          discussing:

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



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

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

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

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

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

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

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

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

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

13   THE CHAIRMAN: Thank you.

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

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

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

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

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

14 And it further states:

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

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

1           appraised of the actual risks involved.

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

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

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

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

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

6           As, of course, it was.

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

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

24          "Obtaining consent at treatment is an area almost  
25          entirely under the control of professional healthcare

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

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

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

15 And the boards/HSS trusts were asked to confirm by  
16 31 December 1995 that that had been done and they were  
17 told where they were to address their confirmation to.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

6 "1(A) Cerebral oedema due to (B) dilutional  
7 hyponatraemia and impaired cerebral perfusion during  
8 a renal transplant operation for chronic renal failure."

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

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

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

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

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

11 If we just have Mr McKee:

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

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

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

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

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

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

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

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

1 THE CHAIRMAN: Yes.

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

9 Then if we move on ...

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

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

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

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

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



1 culminated in a witness statement that he volunteered on  
2 1 February of this year, although there was a witness  
3 statement before that where nothing seems to have been  
4 stated.

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

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

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

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

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

14 (1.38 pm)

15 (The Short Adjournment)

16 (2.30 pm)

17 MS ANYADIKE-DANES: Good afternoon, Dr Gaston.

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

25 It arises at paragraph 244, going into 245, and

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

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

10          And this is a quote:

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

22          And then the paragraph that immediately follows  
23          it is:

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

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

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

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

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

21 THE CHAIRMAN: Thank you.

22 DR JOSEPH GASTON (called)

23 Questions from MS ANYADIKE-DANES

24 MS ANYADIKE-DANES: Good afternoon.

25 A. Good afternoon.

1 Q. Dr Gaston, do you have a copy of your curriculum vitae?

2 A. Yes, I do. I must explain, this was sent off quite  
3 quickly because I got it quite late at the time of the  
4 inquiry. It was sent off by my wife and there are  
5 a couple of typo errors. It says:

6 "A situation --

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

9 A. It's always useful to have them.

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

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

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

18 If we start literally on the first page, we see your  
19 education, a number of learned societies, and then, if  
20 we go over the page to 003, we see your appointments,  
21 1977 to 1987, and then your clinical activities. Then  
22 you have the management and professional activities.  
23 1984 to 1986, it says that you're the Chairman of the  
24 Department of Anaesthesia. Just so that we're clear,  
25 because I see also that it says you were Director of the

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

4    A. That's correct.

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

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

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

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

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

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

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

1 Accreditation of Hospitals from the JCH in America.

2 Q. So these were written standards?

3 A. Yes.

4 Q. Did you help develop them?

5 A. No, those were up and running entirely. The system in  
6 Canada had been in place when I went there and I think  
7 we had two visitations during the time that I was there  
8 for 11 years, I think. It became every 3 years, 3 to  
9 5 years, and then when I was in Saudi Arabia we had two  
10 quality assurance visits: one was by the American forces  
11 out of Heidelberg, which was in a preparatory to the  
12 hospital there getting JCH accreditation.

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

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

17 Is that what you're referring to?

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

19 Q. What did that mean?

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



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

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

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

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

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

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

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

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

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

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

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

17   Q.   I understand.

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

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

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

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

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

23    A. I can't remember in detail.

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

1           involved?

2    A.   Oh yes.

3    Q.   Yes?  That would have happened?

4    A.   Yes.

5    Q.   Could they --

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

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

8    A.   Yes.  It wasn't in any sense a disciplinary at that

9           point in time.  This was an investigation by a peer

10           group into what was an incident.  In many cases, it was

11           standard of care met.  And sometimes it was standard of

12           care met with variants, in other words standard of care

13           is met, but maybe you could have done something slightly

14           different, you know.

15   Q.   I think you said that if the standard of care was not

16           met, then that might lead to a certain sort of

17           investigation.  If it was met with variants, I presume

18           there might be lessons learned as to why there had been

19           that variance and that would lead to other developments;

20           is that right?

21   A.   Yes.  And you -- yes.

22   Q.   Then if we come now to your period in the Royal.  That's

23           on that same page, 1990 to 2005, when you were

24           consultant anaesthetist there.  Leaving aside your

25           clinical activities, if we go right down to the bottom

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

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

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

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

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

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

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

8 A. I think so, yes.

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

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

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

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

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

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

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

20 Q. Yes.

21 A. -- which had come into place about, I think, 1992, maybe  
22 1993. It was part of the Royal preparing for becoming  
23 a trust, which started a year later than in the UK  
24 mainland.

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



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

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

4 Q. Of course. It's 303-043-510. There. Sorry.  
5 I interrupted you.

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

10 Q. Yes.

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

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

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

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

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

15 A. Yes.

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

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

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

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

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

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

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

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

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

1 A. Absolutely.

2 Q. And can you help when you think you got there, if I can  
3 put it that way, between 1993 and 2000, which is -- yes,  
4 2000.

5 A. I think it was 2000 or possibly even after, before we  
6 got our final eighth person in place. And I think it's  
7 quite important -- paediatric anaesthesia was not  
8 a popular specialty. Very, very few of the junior  
9 doctors wanted to go into paediatric anaesthesia. They  
10 were considered a high risk. They considered it  
11 stressful. Paediatrics are not small adults; they're  
12 a different specialty. So one had to come up with  
13 a system that made it attractive. You had to identify  
14 the people who you felt had an interest and then provide  
15 them with the opportunities to get the education. And  
16 so I could do that element, but the person who had to  
17 act on my behalf within the paediatric directorate --  
18 and there was nobody against this, it was just that we  
19 had to find the money, we had to find the people.  
20 We were short of anaesthetists at that point. I was  
21 actually doing a full anaesthetic job. I was doing  
22 seven sessions as an anaesthetist when I was clinical  
23 director at that point in time.

24 So I relied on the structure that I put in place to  
25 take forward many of those things and Dr Peter Crean

1 really developed much of that on my behalf.

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

4 A. Yes.

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

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

13 Q. And that was on the paediatric side?

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

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

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

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

16 Q. Yes.

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

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

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

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

7   Q.   Yes.

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

9   Q.   So you're the clinical director.

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



1           chaired that.

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

21        Q.   Okay.

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

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

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

6 Q. Do you know who that was?

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

9 Q. Okay.

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

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

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

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

19 And I wanted to standardise the equipment within the  
20 13 theatres we had, but I also looked and had  
21 co-operation with Royal Maternity and with the School of  
22 Dentistry, so we standardised the equipment. That meant  
23 the juniors were not finding themselves suddenly doing  
24 a case with equipment they didn't know and we were able  
25 to put that in place, I think in 1998, but part of it

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

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

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

1 under the --

2 Q. Do you know when you did that?

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

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

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

14 Q. Yes.

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

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

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

25 Q. That would have gone to Dr Murnaghan?

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

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

1 speaking, to the clinical lead of his directorate?

2 A. My feeling is -- and this actually was an area that was  
3 not clear.

4 Q. I see.

5 A. I think that the structure was in place to report  
6 a death associated with the operating theatre and that  
7 would, I think, have gone to Dr Murnaghan because  
8 Dr Murnaghan, due to the fact of illness that he had  
9 had, was not practising clinically, but he had a massive  
10 amount of clinical understanding. He was available. So  
11 he would have been the first port of call and he would  
12 have contacted me pretty regularly and said, "This case  
13 has come in, Joe, this is what's happening".

14 Q. Okay.

15 A. But there were quite a lot of cases in paediatrics and  
16 in cardiac that I wouldn't necessarily have known about.

17 Q. You mean that might have an anaesthetic element to it,  
18 but you wouldn't necessarily know about the case itself?

19 A. Yes. That wasn't -- I mean, that would happen because  
20 that might be considered, I think, as part of an  
21 investigation within the Children's Hospital.

22 Q. And could it happen the other way, that a paediatric  
23 case which had a heavy element of anaesthetic issue, if  
24 I can put it that way, involved in it might be looked at  
25 in your directorate and not in the paediatric

1           directorate?

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

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

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



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

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

9 A. Oh absolutely.

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

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

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

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

25 Q. That was possible though?

1 A. Yes, it was, oh absolutely.

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

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

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

16 A. Well ...

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

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

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

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

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

5 Q. There was one structural point that I wanted to ask you,  
6 only because I couldn't find the answer anywhere else.

7 You were a member of the Hospital Council.

8 A. Yes.

9 Q. Where in the structure does that fit and what does the  
10 Hospital Council do? This is 1995, I should say.

11 I should say, in your CV, you were a member of it  
12 between 1993 and 2000.

13 A. In a sense, it developed over that period of time.

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

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

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

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

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

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

1 directors: myself, dental, neurosciences, surgical,  
2 radiology, ophthalmology, cardiology, paediatrics,  
3 medical and laboratories. So there would have been  
4 representatives, usually the clinical directors --  
5 Q. From the main directorates and nursing?  
6 A. Just usually, as far as I remember, it was primarily  
7 Miss Duffin who was then Director of Patient Services.  
8 THE CHAIRMAN: Sorry, what you have just described was the  
9 make-up of the King's Fund committee; is that right?  
10 A. No, the only --  
11 THE CHAIRMAN: What --  
12 A. Miss Duffin and I would have been the two people because  
13 we were both surveyors who had taken through -- we would  
14 have led that. Miss Duffin led it, but not all of those  
15 people -- most of those would not have been on the  
16 King's Fund.  
17 MS ANYADIKE-DANES: In answer to the Chairman, Dr Gaston was  
18 describing the membership of the Hospital Council.  
19 A. That would not have been one and the same with the  
20 King's Fund Organisation.  
21 Q. Maybe we can come to that now. You were a surveyor for  
22 the King's Fund.  
23 A. Mm.  
24 Q. And you were a member of the King's Fund Health Quality  
25 Services steering group from your CV.

1 A. Yes.

2 Q. And can you help with what that meant?

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

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

1 and 20 charts in the other services.

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

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

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

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

19 Q. Yes.

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

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

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

9 A. Yes.

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

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

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

25 A. The Trust certainly facilitated and encouraged me to do



1           that, absolutely.

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

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

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

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

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

6 Q. For you to liaise with?

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

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

17 A. Yes.

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

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

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

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

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

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

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

22 Q. Yes.

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

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

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

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

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

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

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

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

16 Q. Roughly when would that have been?

17 A. Um ... I think.

18 Q. Could it have been in 1995?

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

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

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

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

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

18 Q. I understand.

19 A. They did provide support.

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

23 A. That's right.

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

1 A. And had a particular interest in regard to anaesthesia.

2 Q. We may have to revisit that because there seems to be  
3 a reference to it in the annual report of 1995/1996 as  
4 to whether there were anaesthetic nurses.

5 A. Well --

6 Q. We may come back to that point, but it might be that it  
7 was on the cusp of change, if I can put it that way.

8 A. I think it was on the cusp of change, yes.

9 THE CHAIRMAN: Sorry, let me interrupt for one second.

10 Doctor, if you had a consultant anaesthetist with an  
11 anaesthetic nurse as you now know anaesthetic nurses who  
12 have been given specialist training, does that  
13 effectively dispense with the need for a junior doctor?

14 A. Well, in actual fact, because the Royal was a training  
15 centre, the training programme of the School of  
16 Anaesthesia, which developed -- and I can't remember  
17 when -- set out the specialties that they had to do with  
18 in the Royal and cardiac would have been one, intensive  
19 care would have been another, neurosurgery would have  
20 been another, paediatrics would have been another area.

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

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

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

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

18 A. And --

19 Q. So it was up in 1995?

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



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

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

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

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

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

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

24        Q. I understand.

25        THE CHAIRMAN: Did the Royal start this idea in

1 Northern Ireland of --

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

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

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

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

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

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

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

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

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

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

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

1 it would be their pathologist who would do that.

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

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

19 Q. Mm-hm.

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

21 Q. They did happen?

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

1 Q. Did you seek to encourage that?

2 A. I don't -- I can't say that I either did or didn't.

3 I have no recollection of it.

4 THE CHAIRMAN: I'm sorry, doctor, when you talk about

5 a conference, is that -- that's a discussion about --

6 [OVERSPEAKING]?

7 A. That would have been more in terms of a clinical

8 meeting, I think.

9 THE CHAIRMAN: This isn't some formal event, this is just

10 a discussion. You're going to have a discussion about

11 the death of a particular patient and you may bring

12 in the hospital pathologist as part of the discussion of

13 that?

14 A. Well, if you had a clinical pathological conference --

15 and I remember those more in the past than in the

16 present because of the way the directorate structures

17 were -- you would have actually ... That would have

18 been something that would have been held in the

19 operating theatre, you would have -- the lecture theatre

20 and you would have had a pathologist, you'd have had

21 maybe the physician if it was a patient, and they would

22 have actually discussed the case with information coming

23 from radiologists, pathologists, et cetera. That was

24 probably more historical, but these things did happen

25 and I can think of one case where we had -- where

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

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

14 A. I wouldn't know.

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

22 A. Mm-hm.

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



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

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

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

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

1 generally had been said and people should have  
2 appreciated that?

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

6 Q. Thank you.

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

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

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

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

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

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

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

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

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

12 Q. Yes.

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

16 Q. How would others know?

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

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

1 I can read it out --

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

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

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

12 This is part of what The Patients' Charter says:

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

17 So that's part of what The Patients' Charter  
18 requires, that you publish the main standards of  
19 service, each board does, that is been contracted for by  
20 type and location, and that you publish each year  
21 information about the achievements against those  
22 standards. There might be another way of looking at it.  
23 306-085-001.

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

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

2   THE CHAIRMAN: 012, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 A. Oh, yes.

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

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

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

10        Q. I understand that. If we think about 1995 so we don't  
11        get too far ahead and into a different dispensation. In  
12        1995, in addition to the matters you have just mentioned  
13        that your directorate would have been providing, would  
14        you have been providing information on adverse  
15        incidents, for example, deaths, unexpected deaths?

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

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

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

1 A. Yes.

2 Q. Subject to anything that you have already said or  
3 anything that you may say in this oral hearing, are you  
4 standing over those as your evidence?

5 A. Yes.

6 Q. Thank you.

7 A. Yes, I am, absolutely. There may be things that I've  
8 had to -- I mean, I can think of one point that I need  
9 to clarify and that was when I said that I would have  
10 expected a report to be given to me to be -- when I said  
11 that yes -- did I receive a report? I said I don't  
12 remember receiving a report, but I would have expected  
13 to receive it. I was thinking actually of a report from  
14 the coroner rather than a report from another  
15 surgeon(?). I think that may actually have been the  
16 wrong understanding of that.

17 Q. Yes. Well, we can go to that. It's your second witness  
18 statement, so it's 013/2, and I think it's at page 17.  
19 Then if you go right down to the bottom it's the answer  
20 to question 49:

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

23 And you say:

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



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

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

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

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

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

13  A.   Yes.

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

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

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

18  A.   No, I don't think so.

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

22  A.   Sure.

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

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

1 "receiving a report" --

2 MS ANYADIKE-DANES: A report --

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

4 A. I find this a difficult question to answer. I think

5 that's why I --

6 MS ANYADIKE-DANES: I understand that. In a way, I was

7 going to ask Dr Gaston to deal with whether he would

8 have expected to receive either a verbal report or

9 something in writing. Basically, a report telling you

10 that such a thing had happened and setting out the

11 circumstances of it.

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

13 Q. I understand. Would you have expected to?

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

15 Q. Thank you. If --

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

17 In what form or style or manner would you have

18 expected to receive some form of report about Adam's

19 death? Does that mean somebody ringing you or somebody

20 coming to see you or somebody putting something in

21 writing?

22 A. Um ... I think that that actually, in fairness, is

23 something that would have ... I think that is -- I'm

24 not still answering that question probably correctly.

25 I think that I would -- I was part of the investigation

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

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

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

10 Q. No --

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

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

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

25 Q. No.

1 A. And I would rarely have known immediately after surgery.

2 Q. Okay.

3 A. And the person that I think normally -- and I would  
4 expect, in this case, was Dr Murnaghan because he was  
5 the person, the first person who would normally have  
6 heard about that. And he would have been the person who  
7 would have contacted me and said that there was  
8 such-and-such.

9 THE CHAIRMAN: Who would tell Dr Murnaghan in the first  
10 place?

11 A. Normally with a death, whoever was in the operating  
12 theatre, he would be informed, the coroner would have  
13 been informed. I can't remember who specifically did  
14 that because it would have been the people who were  
15 directly involved in the case. And being a big Royal  
16 site, there wasn't a formula as to who did it, I don't  
17 think.

18 It might have been that the anaesthetist or the  
19 surgeon who was involved in that case would have rung  
20 Dr Murnaghan and the coroner would have been informed  
21 that there had been an unexpected death in theatre.

22 MS ANYADIKE-DANES: Okay. You're ahead of the ATICS  
23 directorate.

24 A. Mm.

25 Q. The day-to-day management of that in relation to sort of

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

3    A.    Sure.

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

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

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

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

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

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

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

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

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

6 Q. Yes.

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

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

16 A. Sure.

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

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

1 line of reporting for that.

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

6 A. Yes.

7 Q. That was his --

8 A. Mm-hm.

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

13 A. That's correct.

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

17 A. Sure.

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

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

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

4 Q. I understand that.

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

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

13 A. He was within my directorate.

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

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



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

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

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

13   THE CHAIRMAN: Okay.

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

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

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

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

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

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

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

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

1           directorate, that would have been reported to Dr Wilson?

2    A.   Not in Dr Taylor's case.  That was not happening --

3    THE CHAIRMAN:  Because it was a paediatric case?

4    A.   Exactly.  And the same with cardiac, exactly the same

5           with cardiac.

6    MS ANYADIKE-DANES:  So even though he's an anaesthetist and

7           you're ultimately his clinical lead, he would not be

8           reporting that to you?

9    A.   Not routinely, no.  He would be routinely reporting it,

10           but it would have gone up through the paediatric

11           director to Dr Murnaghan, it would have gone through the

12           cardiac director to Dr Murnaghan.  It would probably in

13           many cases have gone through -- the maternity would have

14           gone directly and I would not have been -- that would

15           have been directly involved [sic].  That was part of the

16           developmental process in terms of the structures.

17           They weren't ideally structured and a very large

18           directorate -- it wasn't ideal.

19    THE CHAIRMAN:  And then, Dr Gaston, is it then really for

20           Dr Murnaghan to decide what actions are to be taken,

21           who's to be involved in investigating or reviewing what

22           happened?

23    A.   I think that would be what happened, yes, and I think it

24           happened in this case.

25    MS ANYADIKE-DANES:  You have described that as a not

1 entirely satisfactory arrangement.

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

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

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

1           needed to bring it all together.

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

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

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

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

19    A.   I would have known something, but --

20    Q.   Sorry?

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

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

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

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

1 A. Yes.

2 Q. Or a complex case from a surgical point of view?

3 A. Every point of view.

4 Q. Every point of view. And did you reach that view from  
5 what Dr Taylor told you or simply by knowing that we are  
6 dealing with a paediatric renal transplant in a child of  
7 about 4 years old and that's going to be complex?

8 A. If this had been an adult, which would have been the  
9 area I was working with, having had all the operative  
10 procedures he'd had, the access and everything would  
11 have been difficult. To have that in a four-year-old  
12 child made that so much more difficult. So this was  
13 a complex anaesthetic, it was a complex -- in terms of  
14 calculating fluid balance, it was -- and so we talked  
15 through how Bob had worked that out. We would have  
16 spent time on that. It was --

17 Q. Sorry, did he provide you with the anaesthetic record?

18 A. Not at that time, no.

19 Q. But he talked you through what he did and his  
20 calculations?

21 A. Yes, he talked through what had been the difficulties.  
22 I felt that he needed -- we needed to talk it through.

23 Q. Sure.

24 A. And he did. And because I had been involved in renal  
25 transplants, there were areas where I said, "What

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

9           So whenever I said --

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

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

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

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

19          Q. Who might they be?

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



1 remember.

2 Q. I understand.

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

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

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

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

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

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

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

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

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

1           actually anaesthetise the children for transplant; we

2           had two very experienced paediatric anaesthetists.

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

4   A.   Yes.

5   Q.   That was one key issue?

6   A.   That was one key issue.   The other was the issue around

7           the central venous pressure.   That was something which

8           was an issue for Bob, it was something that would have

9           been diverting his attention.

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

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

12           accurate reading.

13   Q.   Okay.

14   A.   The other was that it was longer surgery than he had

15           anticipated, so that made the calculation of the fluid,

16           his fluid balance, more difficult.   He felt that -- and

17           this is a hard thing to assess in a renal transplant

18           sometimes, how much blood he had lost.   He felt he had

19           lost a bit more blood than he would have expected and he

20           felt that was partly due to the fact that this was

21           difficult surgery.   There was nothing wrong, it was just

22           difficult surgery.   There would have been adhesions in

23           many places.   Actually, if you work your way through

24           that, you tend to get a little bit more bleeding.   So he

25           felt that was an issue.   And, because of the bleeding,

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

6 Q. Yes.

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

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

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

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

11   A. No.

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

13   A. That's right.

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

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

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

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

21   MS ANYADIKE-DANES: Probably this is it.

22   THE CHAIRMAN: Okay.

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

1 (4.35 pm)

2 (The hearing adjourned until 10.00 am the following day)

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