Witness Statement Ref. No.	076/2

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: Paul Darragh

Title: Dr.

Present position and institution:

Public Health Agency - Consultant in Public Health, general duties

Previous position and institution (2000-02):

Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement of 29th June 2005]

Previous Statements, Depositions and Reports:
[Identify by date and title all those since your Witness Statement of 29th June 2005]

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	
WS-076/1	29.06.05	Witness Statement to the Inquiry

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

N.B. In answering the below questions, and where appropriate, please detail the circumstances throughout your appointment as Deputy Chief Medical Officer, including any changes that may have occurred during that period.

ROLE AS DEPUTY CHIEF MEDICAL OFFICER

(1) State the dates on which:

(a) You became Deputy Chief Medical Officer

Ans: Seconded to DHSS wef 5 June 2000.

(b) You ceased to hold that position.

Ans: 30 June 2002.

(2) Describe your career history prior to becoming Deputy Chief Medical Officer.

Ans: GP 1974/5 Asst NI and Canada.

1976 Principal GP East Belfast.

1977 Trainee Community Medicine EHSSB and Edinburgh.

1980-1996 Consultant/Lecturer Community Medicine.

Joint Appointment: QUB/EHSSB.

(3) Describe your career history since ceasing to be Deputy Chief Medical Officer.

Ans: 1996 - Present Consultant in Public Health EHSSB.

now Public Health Agency general duties.

(4) Please explain the Role of Deputy Chief Medical Officer and the responsibilities the role entailed.

Ans: Duties as prescribed by CMO through delegation and where CMO not available. Whatever necessary from time to time.

(a) If the duties/responsibilities changed while you were in the post, please give details of the changes and when they occurred.

Ans: n/a.

(5) Identify to whom you were accountable in carrying out the duties of Deputy Chief Medical Officer.

Ans: Accountable to CMO.

(6) In particular, please explain your responsibilities as Deputy Chief Medical Officer in regard to the quality of care provided to patients by hospitals, including any responsibilities to ensure that Trusts exercised their statutory duty to provide quality care.

(a) Please explain how those responsibilities were fulfilled.

Ans: Due to this being a secondment for a short period the specific duties were flexible at the behest of CMO.

FORMATION OF THE WORKING GROUP

(7) What was the system by which medical issues requiring guidelines came to the attention of the Department?

Ans: A variety of routes, via requests from service, from Directors of Public Health, nationally expressed concerns, Special Advisory Committees by specialty, the Hospital Services Committee, GMS Sub-Committee and Central Medical Advisory Committee and latterly CREST Clinical Resource Efficiency Support Team (Quality and Efficient Use of Resources).

(a) To what extent was the process by which the Hyponatraemia Guidelines were formulated an example of that system in practice?

Ans: The Guidelines were issued in response to Dr McConnell raising the issue first at a meeting of the Directors of Public Health on 2 July 2001.

(8) You stated at **Ref: WS-076/1, p.2** that you became aware of Raychel's death on 2nd July 2001 when it was discussed at the meeting of Directors of Public Health (**Ref: 075-081-323**)

(a) What, at this stage, did you consider needed to be done?

Ans: I was advised I would Chair a Working Group by CMO which would be tasked with producing a guideline.

(b) What options did you consider as a response of the Department to Raychel's death?

Ans: I did not consider other functions for this Committee, a restricted brief was handed to me.

(c) Were there any other reasons that the Department felt the need to intervene at this time?

Ans: I was not aware of any need to change the brief during my time in Chair.

(d) What did you do, at this stage, within the Department to address the issues arising from Raychel's death?

Ans: ***The issues were being addressed on a generic basis and the meeting of the Working Group with presentation from Dr Taylor indicated there was a more general issue to be addressed and not a response to a single case at that time.***

(e) Please explain when, where and by whom it was decided that guidelines for hyponatraemia would be provided by the Department.

Ans: ***CMO/DPH meeting on 2 July 2001 agreed a need for Guidelines to be provided to the Service.***

(f) What exactly led to the establishment of the working party which prepared the hyponatraemia guidelines? Was it only the report of Raychel's death or was there also significant information about other events?

Ans: ***The case raised by Dr McConnell at CMO/DPH meeting on 2 July 2001.***

(9) You stated at **Ref: WS-076/1, p.2** that Dr. Henrietta Campbell asked you to chair a working group to produce guidance on the prevention of hyponatraemia in children. As you are aware, this Group met for the first time on 26th September 2001 (**Ref: 007-048-094**).

(a) Please explain why you were asked to chair the Working Group, and what this role entailed.

Ans: ***This was simply an allocation of work, no particular significance. Chairing groups like that would be an expectation of the role of DCMO/SMO.***

The role entailed ensuring there was a representative group of knowledgeable clinicians involved to include consultants with experience of intensive care and anaesthetics. It would be important also that the group was drawn from across NI to ensure regional coverage.

(10) You stated at **Ref: WS-076/1, p.2** that *"the purpose of the working group was not to discover why the children had died or why the Department had not been made aware of the deaths earlier, but to produce Regional Guidance on the prevention of Hyponatraemia".*

(a) Please explain why one of the purposes of the working group was *"not to discover why the children had died"*

Ans: ***The reason for the death was known and it was involving Hyponatraemia. This had been established by post-mortem and at Coroner's Inquest.***

(i) Please explain whether any consideration was given to an investigation of *"why the children had died"*. If not, explain why.

Ans: ***As above.***

(ii) Please explain the assumption(s) the Working Group was working under as to *"why the children had died"*.

Ans: ***Because the brief we were given was to consider Hyponatraemia guidelines.***

(b) Please explain why one of the purposes of the working group was not to discover *"why the Department had not been made aware of the deaths earlier"*.

Ans: ***That did not fall within the remit of the brief we were given, which was to prepare guidelines on prevention of Hyponatraemia.***

(i) Please explain whether any consideration was given to an investigation of *"why the Department had not been made aware of the deaths earlier"*. If not, explain why.

Ans: ***Our task was to prepare guidelines only at that time.***

(11) What were the respective roles of yourself and Dr. Miriam McCarthy in regard to the Working Group that was to produce hyponatraemia guidance:

(a) Between 2001 and 2002

Ans: ***We worked together Dr McCarthy/Dr Mark and myself. I chaired the first meeting of the Working Group and the Working Group decided that they could most efficiently produce a guideline working as a drafting sub-group. That Group would develop a draft guideline which would be then circulated through the key specialty Special Advisory Committees on Anaesthetics, Paediatrics and Surgery for comment and revision. Dr McCathy chaired the sub-committee, the draft guidelines were prepared, circulated to SACs endorsed by all three, and then Hospital Services Sub-Committee and CREST.***

(b) After the expiry of your secondment to DHSSPS?

Ans: ***I had no further involvement after the end of my secondment in June 2002.***

(12) How did you / the Department identify the clinicians who would form the membership of the Working Group? For example, were they selected, did they volunteer etc.

Ans: ***I have no recollection how they were selected, usually a balance of people from various specialty positions, geographical locations.***

(a) Please explain why no nursing representatives were invited.

Ans: ***There was a senior paediatric nurse M/s E McElkerney.***

(13) What discussions (in person / by telephone / by letter / by e-mail) took place prior to 26th September 2001 as preparation for the inaugural meeting of the Working Group?

Ans: ***I have no recollection, though I assume there must have been some.***

(14) Materials prepared by Dr. Robert Taylor appears to have distributed to other Hospitals prior to the inaugural meeting in September 2001. For example, **Ref: 043-101-223** was received by Sperrin Lakeland Trust on 10th August 2001, and Craigavon Area Hospital had a copy of a similar document by 8th August 2001 - see **Ref: 329-014-004** and **Ref: 329-014-006.**

(a) Please state if you saw this document (**Ref: 043-101-223**) prior to 26th September 2001.

Ans: ***I have no recollection of this document prior to meeting of 26 September 2001.***

(b) Please state if you would have expected this information to have been made available to the Department. If so, state by what means you would have expected it to have been sent.

Ans: ***I would have had no problem with its circulation as this would have raised awareness of the issue.***

(c) Please explain the purpose of this document.

Ans: ***Generally helpful advice.***

(d) Please state if this document was discussed by the Working Group.

Ans: ***I have no recollection it could have been tabled.***

(15) Dr. Robert Taylor sent you a draft PowerPoint presentation by e-mail on 18th September 2001 *"for your consideration in advance of the meeting on the 26th Sep[tember]"*. **(Ref: 007-051-100)**

(a) Please state if the handwritten note *"Anne – Please copy to Miriam McCarthy"* was yours, and whether Dr. McCarthy received a copy of Dr. Taylor's draft PowerPoint presentation.

Ans: ***Yes that was my direction to Dr McCarthy on Dr Taylor's powerpoint presentation. I have no certainty if she did receive them, I can only assume she did because they were central to meeting of the Working Group.***

(b) Please state if you considered these, as requested by Dr. Taylor.

Ans: ***No recollection.***

(c) Please explain what use was made of these materials by the Working Group.

Ans: ***The powerpoint presentation helped set the issue of Hyponatraemia in context. It was showing an increasing upward trend in cases, which probably indicates a greater awareness of the problem.***

(d) At **Ref: 007-051-103**, there is a bar chart showing the incidence of hyponatraemia at the RBHSC from 1991 to 2001, including the number of admitted cases and deaths.

Ans: ***I have no recollection if this was discussed.***

(i) Please state if you saw this chart.

(ii) Please state if you recognised any significance in two deaths being recorded on the chart.

(iii) Please describe any investigations you / the Department carried out into the circumstances of the two deaths noted on the chart.

(16) Please explain what steps:

(a) You / the Department

took to discover how prevalent an issue hyponatraemia in children was in hospitals in Northern Ireland

Ans: ***Our task was to prepare guidelines in the first instance. These I believed would address the problem of hyponatraemia if widely disseminated and implemented.***

(b) The Working Group

took to discover how prevalent an issue hyponatraemia in children was in hospitals in Northern Ireland

Ans: ***I felt the Working Group had the same expectation. We did not seek to discover how prevalent the issue of hyponatraemia was across Northern Ireland hospitals. We had in our Working Group a collection of many of the most clinically aware doctors from across Northern Ireland who would be familiar with practice in this regard.***

(17) In the minutes of the inaugural meeting of the Working Group on 26th September 2001, it is stated that *"Fluid replacement in children is complex and while guidelines are in place for acute management, chronic management is not as well covered."* (**Ref: 007-048-094**).

(a) What guidelines were *"in place for acute management"*?

Ans: ***This was by way of a statement from Dr Taylor which was accepted by the Working Group - I was unaware of what specific guidelines if any were available in our hospitals prior to our meeting but it was our intention to ensure that there would henceforth be guidance available through our work.***

(b) What other guidelines were available in the area of fluid management?

Ans: ***I was not aware of any specifically.***

(18) It was also stated in the minutes that *"The Group felt there was a lack of a paediatrician's view, which it was decided was essential."* (**Ref: 007-048-095**).

(a) Why was it felt that there was *"a lack of a paediatrician's view"*?

Ans: ***Dr Jenkins was not present on the day of the meeting, but the role of paediatricians was specially high-lighted. I also was approached by Professor Savage and suggested to Dr McCarthy his involvement with the guideline drafting group, any guideline was going to have to be approved by Paediatric SAC.***

(b) Why was this considered *"essential"*?

Ans: ***It was considered essential because they are key members of staff dealing with children.***

(c) Were there no paediatricians present? If so, why not?

Ans: ***Dr Jenkins was not available on the day.***

(d) What action was taken to gain *"a paediatrician's view"*?

Ans: ***I do not know if either Professor Savage or Dr Jenkins were involved in drafting of guidelines. I note I spoke to Dr Jenkins about his involvement and also to Professor Savage.***

(19) Please explain fully the role of the sub-group as compared to the main Working Group.

Ans: ***The sub-group were to prepare a guideline which was to be endorsed by the various SACs/including Paediatrics SAC prior to issue and HSSCs.***

(20) Please identify the members of the "sub-group" responsible for drafting the guidance and how those members came to make up the sub-group - for example, were they selected, did they volunteer etc.

Ans: ***No recollection.***

(21) A second meeting of the Working Group took place on 10th October 2001. **(Ref: 007-038-072)**

Ans: ***I have no papers relating to a second meeting and can only recall attending one meeting of the Working Group. I do not believe I attended the second meeting on 10th October 2001.***

(a) Please state who attended this meeting.

(b) Please state why there is not an attendance sheet of this meeting.

(c) Please state who made the notes at **Ref: 007-038-072.**

(d) Please state why there is not a typed minute of this meeting.

(e) Please state why Professor Maurice Savage, as Professor of Paediatrics and President of the Ulster Paediatric Society, was not informed of, or invited to participate on, the original Working Group (**Ref: 007-042-087**).

(i) Please state if he did attend and participate in the second meeting of the Working Group.

(ii) Please state if you considered following Professor Savage's suggestion that the Royal College of Paediatrics and Child Health should scrutinise any guidelines prepared.

(f) Please state whether Dr. Jarlath McAloon, Consultant Paediatrician, Antrim Area Hospital was present at this meeting. If so,

(i) Why was he there?

(ii) Why was he not present at the inaugural meeting on 26th September 2001?

(22) Describe the steps you / the Department took to discuss the work of the Working Group and the issues arising with colleagues in the rest of the U.K.

Ans: ***I am unaware of any steps taken between DHSS and DOH, SHHD etc at CMO level.***

(23) Please state if you received a copy of Dr. Taylor's correspondence with the Medicines Control Agency (**Ref: 007-033-060**). As you are aware, Dr. Taylor filed a Yellow Card Report in respect of Solution No.18.

(a) Would you / the Department have expected a Yellow Card Report in relation to any of the other children's deaths given that hyponatraemia *"is a problem that had been present for many years"*? (**Ref: 007-048-094**).

Ans: ***I cannot recall receiving this report; reports do not necessarily go on to Committee on Safety of Medicine and do not always result in any further action in short term.***

RESPONSE TO THE GUIDANCE

(24) You stated at **Ref: WS-076/1**, p.2 that draft guidelines would be presented to the Special Advisory Committees (SACs) *"in the first instance for further comment"*. Please describe the respective responses of the Special Advisory Committees on:

(a) Paediatrics

Ans: ***Paediatrics SAC meeting - members welcomed the guidance. (Professor Savage attended no dissent).***

(b) General Surgery

Ans: ***General Surgery SAC - Guidelines commended by Group.***

(c) Anaesthetics

Ans: Anaesthetics SAC - any comments to be forwarded to Dr McCarthy.

to the draft guidance produced by the Working Group.

(25) Please describe any obstacles and/or difficulties the Working Group or sub-group faced in developing the guidelines that were published in March 2002. Please include any differences of opinion from individuals or specialties as to the content of the guidance, and any procedures/protocols that made development more difficult.

Ans: ***Apart from representations to be included by Professor Savage which were referred to Dr McCarthy - I was unaware of any dissensions and Professor Savage was present at subsequent SAC Paediatrics which endorsed the Guideline.***

No other problems were apparent to me during my period of involvement.

(26) Please describe the response in the initial period following publication of the Guidance in March 2002. In particular, please identify if you / the Department faced any difficulties / opposition to any element of the Guidance. If so, please identify the areas of difficulty / opposition.

Ans: ***I was unaware of any concerns following the publication of the Guidelines.***

(27) In the letter of Dr. Henrietta Campbell, Chief Medical Officer dated 25th March 2002 (**Ref: 007-001-001**), she states:

"The Guidance is designed to provide general advice and does not specify particular fluid choices. Fluid protocols should be developed locally to complement the Guidance and provide more specific direction to junior staff. [...]. It will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experiences."

Ans: ***I would interpret this as indicating general good practice principles regarding fluid administration but also stressing that this was to be subject to individual***

interpretation depending on the circumstances of each case. The document could not be an all encompassing guideline.

(a) How did the Department intend to ensure that the locally developed fluid protocols would reflect the Guidance?

Ans: I did not prepare this note and was not aware of the reasoning behind it.

(b) Who was intended to *"audit compliance with the guidance"*?

Ans: I did not prepare this note and was not aware of the reasoning behind it.

(i) The Department and Trusts together

(ii) The Department alone

(iii) The Trusts alone

(iv) Other organisations?

(c) Who was intended to *"audit compliance"* with the *"locally developed protocols"*?

Ans: I did not prepare this note and was not aware of the reasoning behind it.

(i) The Department and Trusts together

(ii) The Department alone

(iii) The Trusts alone

(iv) Other organisations?

(28) Dr. Jarleth McAloon conducted a Regional Audit in 2003-2004 to examine adherence to the DHSSPS hyponatraemia guidance (**Ref: 007-054-114**).

Ans: I was not involved in this after my departure in June 2002.

I cannot comment on a, b, c, d or e.

(a) Why was a Regional Audit conducted?

(b) What was its purpose / remit?

(c) In particular, why was Dr. McAloon asked to conduct the audit?

(d) What was he asked to do?

(e) What action was taken by you / the Department in relation to the results of this audit?

DEATHS OF ADAM, CLAIRE & LUCY

(29) In the minutes of the inaugural meeting of the Working Group on 26th September 2001, it is stated that *"Dr. Taylor informed the meeting about the background, incidence of cases seen in RBHSC and patients who are particularly at risk of hyponatraemia. This is a problem that had been present for many years."* (**Ref: 007-048-094**).

(a) Please explain what Dr. Taylor discussed at that time regarding the *"incidence of cases seen in RBHSC"*. In particular, state if he discussed the deaths of Adam, Claire or Lucy.

Ans: ***I have no recollection of reference to specific cases by Dr Taylor.***

(b) Please state if Adam, Claire or Lucy's cases were discussed at the meetings of:

Ans: ***I have no recollection that any specific case was discussed on 26 September 2001 and I have no recollection of a meeting on 10 October.***

(i) 26th September 2001

(ii) 10th October 2001.

(c) Please describe the knowledge of the Department in relation to the statement that *"This [hyponatraemia] is a problem that had been present for many years."*

Ans: ***I felt Dr Taylor was talking about a general concern about the overall management of IV fluids among children and not specifically about Hyponatraemia.***

(30) At **Ref: WS-076/1, p.2**, you state that you became aware of Adam Strain's death *"during the production of the Guidelines"*.

(a) Please specify:

(i) Whether you were aware of his case prior to the first meeting of the Working Group on 26th September 2001

Ans: ***I was unaware of any case by name but clearly Dr McConnell raised a case in Altnagelvin at the DPH/CMO meeting which led to the review.***

(ii) Whether you were aware of his case prior to the second meeting of the Working Group on 10th October 2001.

Ans: **I have no recollection of a meeting of the Working Group on 10 October 2001.**

(iii) Whether you were aware of his case prior to the publication of the draft guidelines in March 2002.

Ans: ***I had no further information about other specific cases other than the presentation from Dr Taylor at the meeting of 26 September of cases of Hyponatraemia in RBHSC. At some point I heard of Adam Strain not by name but my understanding was of a child with other complications and that it was not a straightforward case of hyponatraemia.***

(b) Please specify from whom you found out about his death.

Ans: ***I have no recollection who I heard this from.***

(c) Please state whether, because Adam *"suffered from other health problems"* (**Ref: WS-076/1, p.2**), you considered Adam's case to be similar or different to Raychel's case.

Ans: ***I assumed that his case was related to his other complications and was therefore different from Raychel.***

(d) Please describe your reaction to discovering another death in which hyponatraemia was identified as a cause of death, and what action you took as a response.

Ans: ***Given Dr Taylor's presentation at the Working Group there were clearly likely to be other cases emerging but the important step of producing guidelines was the appropriate step to be taking at regional level at that time. The DHSS was endorsing the need to be promoting the development of a regional Guideline.***

(31) Likewise, at **Ref: WS-076/1, p.2**, you state that you became aware of Lucy Crawford's death in *"early in 2004 through the media"*. Please describe your reaction to discovering another death in which hyponatraemia was identified as a cause of death, and what action you took as a response.

Ans: ***I was not involved in this after my departure in June 2002.***

(32) How and when did you first become aware of the death of Claire Roberts?

Ans: ***I was not involved in this after my departure in June 2002.***

(33) How and when did you first become aware of the death of Conor Mitchell?

Ans: ***I was not involved in this after my departure in June 2002.***

(a) What did you / the Department regard as the implications of Conor's death for the successful implementation of the guidelines?

(34) What discussions did you / the Department have with:

Ans: ***I had no involvement in any discussions out with the DHSSPS, regarding the deaths of Adam, Claire or Lucy's death and was unaware of these cases by names.***

(a) Colleagues in the DHSSPS

(b) Colleagues in other hospitals

regarding the failure to inform the Department of Adam / Claire / Lucy's deaths.

DISSEMINATION OF INFORMATION

(35) Please explain your role and responsibilities in the dissemination of information / guidelines / policies to Trusts and Hospitals. In particular:

Ans: ***Dissemination of new guidelines or information would generally occur under the signature of the CMO or the Permanent Secretaries office to the DHSS. In the absence of the CMO and usually with prior agreement I would sign letters or guidance for dissemination.***

(a) How were new guidelines / practices which were developed elsewhere in the U.K. considered and adapted for use in Northern Ireland?

Ans: ***A view would be taken on how appropriate it would be to endorse guidelines developed elsewhere. Depending on the topic, its relevance and the provenance of new guidelines, it could be issued without changes. In other situations a local working group could be formed and some tailoring or amendments would be made for local consideration.***

(b) How does new guidance find its way into medical training, at undergraduate and postgraduate level?

Ans: The Medical School and NIMDITA would be included in any distribution of new guidance.

(c) How were issues that required the production of guidelines / policies flagged up to you or the Department by Trusts and Hospitals?

Ans: The CMO would often be lobbied to become engaged in various medical issues. Trusts, professional groupings, the general public and special interest groups, individual practitioners and political representatives are always active in advising the medical department of problems. The deputy CMO would generally follow the work agenda of the CMO and not act other than by prior consultation unless in exceptional circumstances or during leave.

(i) The quality of care provided to patients

Ans: Quality of care issues would be generally the responsibility of Trusts with their own quality structures. Where there was involvement of the CMOs office, Trusts would generally be expected to provide a report on any follow up investigation.

(ii) Ensuring that Trusts exercised their statutory duty to provide quality care

Ans: I was not directly involved in this but I was aware of structures within DHSS to ensure compliance on care quality.

(iii) The implementation of guidelines / practices

Ans: Trusts were expected to implement guidances provided by the Department DHSSPS.

(36) How is it decided that an issue is one which can be handled by, or is limited to, a local hospital as opposed to something that is of regional significance?

Ans: The nature of the concern will determine the response but generally advice from DHSSPS was for general application to the whole HPSS.

(37) Were there communications between the Chief Medical Officer and her team and any other parts of the Department about the performance of trusts in any of the following matters:

(a) Patient safety and care

(b) Quality of care

(c) Clinical governance

(d) Clinical complaints

(e) Clinical audit?

Ans: During my time I was aware of many instances of commications across each of these topics though the details are now beyond recall. The CREST initiative was becoming

well established and this was especially aimed at enhancing quality, audit, care quality, clinical governance and safety.

(38) If there were communications of the kind mentioned:

(a) Identify those with whom the CMO's team communicated.

(b) Please give examples of the matters which were the subject of the communications

(c) Were there established systems/forums in the Department for such communications?

Ans: ***The CMO's office acts as a communication centre upwards and downwards linking every part of the HPSS together. At this moment I cannot recall individual actions each day saw a succession of issues old and new dealt with by staff.***

(39) What did you / the Department consider to be the role of the RBHSC in the dissemination of lessons learned / guidelines / protocols?

(a) What would you have liked the RBHSC's role to have been?

Ans: ***The RBHSC as the largest Paediatric facility with all regional services tended to exercise a leadership role. Since it was the main paediatric teaching hospital most doctors trained in Northern Ireland would have spent time working there. Hence the expectation that it would promote best practice across the Province. In developing good practice it would normally be represented or take a lead.***

(b) The 2002 Guidelines state at **Ref: 006-054-438**: *"In the event of problems that cannot be resolved locally, help should be sought from Consultant Paediatricians / Anaesthetists at the PICU, RBHSC"*

(i) How did the Department decide that the RBHSC was going to take that role?

(ii) What was the kind of role the Department expected the RBHSC to have generally?

Ans: ***The 2002 Guideline reflected the willingness of the PICU staff to provide support to colleagues across the Province. I was not party to the statement but recognise the spirit of generosity and support to be expected from professional staff.***

(40) Would you have expected the deaths of:

(a) Adam Strain

(b) Claire Roberts

(c) Lucy Crawford

to have been reported to you or the Department under the informal system? If so,

(i) To whom in the Department would it be reported?

(ii) What action, if any, would you have expected the Department to take?

Ans: ***I would not have expected individual reports to be made to the DHSSPS. This would occur through the system of all death certification.***

(41) Would you have expected the Department to have been informed of the statement produced by the RBHSC following the Inquest of Adam Strain? **(Ref: 011-014-107a)** If so,

(a) To whom in the Department would it be reported?

(b) What action, if any, would you have expected the Department to take?

Ans: I was not working in the DHSSPS at this time.

(42) Would you have expected:

(a) The death of Adam Strain

(b) The statement produced by the RBHSC at Adam's Inquest (Ref: **011-014-107a)**

(c) Claire Roberts

(d) Lucy Crawford

to have been raised at a Special Advisory Committee (particularly the SAC on Anaesthetics in relation to (b))?

Ans: I was not working in the DHSSPS at this time.

(43) You have told the Inquiry (**Ref: WS-076/1, p.2**) that you first became aware of the death of Lucy Crawford in early 2004. Arising from that;

(a) Please confirm whether you / the Department were made aware by the Sperrin Lakeland Trust during the period 2000-2002 of any untoward deaths occurring following treatment in the Trust's hospitals?

(b) Would you have expected the Sperrin Lakeland Trust to have made you or the Department aware of the untoward and unexplained death of a seventeen month old child following treatment at the Erne Hospital? Please give reasons for your answer.

Ans: I was unaware of any death in Sperrin Lakeland Trust during 2000-2002.

(44) What do you consider to have been the main impetus behind the creation of a formal adverse incident reporting system from 2002?

Ans: I was not involved in the establishment of the Adverse Reporting system from 2002 and left the DHSS in June 2002.

(45) Why was a formal approach not adopted for adverse incident reporting prior to 2002?

Ans: I have no idea

(46) Prior to 2002, what would you / the Department have expected Trusts / Hospitals to have done (if anything) in regard to informing you when cases involving deaths due to possible medical mismanagement were involved in:

(a) Formal complaint procedures

Ans: My expectation was if Trusts had information which derived from any of these sources which was likely to be of interest to the DHSSPS it should be forwarded to it.

At this time I do not recall the pathway or which branch of the civil service would receive what information or the means of ensuring its evaluation. Please note I arrived into the DHSSPS with very little appreciation of a very complex government department structure and function on a time - limited assignment.

(b) Coroner's Inquests

Ans: Information from Coroner's investigations if likely to be controversial or point to some significant concern this would normally be forwarded from Trust to DHSSPS.

(c) Medical negligence actions

Ans: Medical negligence cases would be unlikely to be advised at that time until the case had been resolved or at least fully evaluated.

(47) The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis Q.C. was published on Wednesday 6th February 2013. One of its key recommendations was that of 'openness and candour', namely that: *"Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful."*

(a) What were your/the Department's expectations of how the Trusts dealt with the deaths of Adam/Claire / Raychel / Lucy, and how did their actions meet or fail to meet your expectations?

Ans: I had no involvement with the Hyponotraemia cases after my departure from DHSSPS. Nor did I follow the cases in the media.

(b) What were your/the Department's expectations in situations where the Trust(s) withheld relevant documents on grounds of privilege?

Ans: I have no idea, I would, had I known, had to seek advice, if I had been aware of their existence.

(c) What were your/the Department's expectations in situations where the Trust(s) did not make public acceptance of liability in medical negligence actions?

Ans: I have no idea what the DHSSPS view was at that time of public acceptance of liability.

(48) In relation to the Specialty Advisory Committee (SACs):

(a) Please describe their purpose.

Ans: To provide advice to the DHSSPS.

To provide advice in specialty specific issues.

To advise on manpower planning in specialty.

To act as a two way channel of communication between specialists and DHSSPS.

(b) Please state when they were created

Ans: I have no idea when they were created.

(c) Please explain why they were created

Ans: ***I have no idea why they were created other than perception that the DHSSPS felt a need.***

(d) Please state whether you agree with the evidence of Dr. Elaine Hicks, Consultant Paediatric Neurologist, RBHSC at the Oral Hearings (**Transcript, 7th June 2013, p.22**) where she stated in relation to SACs:

"I think many of us were not convinced that it was as effective as it might have been."

Ans: ***Dr Hicks advice to the inquiry on the ability of SACs would need to be tested against a wide range of SACs - eventually, the DHSSPS discontinued SACs.***

(49) In relation to the "CMO update":

(a) Please describe its purpose.

Ans: ***Convey centrally collated information to the HPSS which was perceived to be useful.***

(b) Please state when it was started.

Ans: ***First edition August 1994.***

(c) Please explain why it was started

Ans: ***I have no knowledge of how it came to be initiated.***

(d) Please explain who produced it and who decided its contents

Ans: ***My recollection was that one of the medical staff in the DHSS collected and collated information which was intended to be widely distributed to the front line across the HPSS.***

(e) Please explain what preceded it in terms of provision of information.

Ans: ***I do not know exactly what preceded it but significant information was always disseminated by way of circular before and after and continues to to-day.***

(50) Provide any further points and comments that you wish to make, together with any relevant documents.

Ans: ***No further information.***

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Paul Dunay **Dated:** 26/9/13

SEC 1/00

Dr Paul Darragh

Department of Health, Social Services & Public Safety
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SECONDMENT OPPORTUNITY

DEPUTY CHIEF MEDICAL OFFICER CLOSING DATE
25 February 2000

2 YEAR SECONDMENT (with the possibility of extension for a third year)

Job Specification

The Department of Health, Social Services and Public Safety wishes to offer a secondment opportunity to the post of Deputy Chief Medical Officer (DCMO) within the Medical and Allied Group.

This memorandum provides information about the post, the job requirements, terms and conditions and selection process.

Background

The post is based at Castle Buildings, Stormont, Belfast. The responsibilities of the Medical and Allied Group within the Department of Health, Social Services and Public Safety (DHSSPS) are:-

(i) to monitor the state of health of the public in Northern Ireland and to advise Northern Ireland Government Departments on matters relating to the protection and improvement of public health;

(ii) to advise the DHSSPS on medical matters relating to the Health and Personal Social Services;

INVESTOR IN PEOPLE

(iii) to provide certain medical services for Northern Ireland Government Departments eg Prison Medical Service, Occupational Health Service to NICS, Employment Medical Advisory Service and Medical Referee Service.

DCMO DUTIES AND RESPONSIBILITIES

The main duties and responsibilities of the Deputy Chief Medical Officer, who will work in direct support of the Chief Medical Officer, will be:

(i) to monitor the state of the public health and to advise on action needed to protect and promote public health;

(ii) to ensure an effective medical contribution to the formulation and implementation of policy for the provision of health and personal social services in Northern Ireland;

(iii) to provide direct medical input to the work of the Department, advising on matters such as:-

- (i) management and policy issues within the Health Service;
- (ii) public health policy and practice;
- (iii) postgraduate training in medicine and continuing medical education;
- (iv) the Health Service support of undergraduate medical education;
- (v) health and the environment;
- (vi) health protection

(iv) to deputise for the Chief Medical Officer as required.

QUALIFICATIONS AND EXPERIENCE

Applicants must:-

1. hold or be entitled to hold full registration with the General Medical Council and currently be entitled to practice;

2. have at least 10 years' post full registration experience; and

3. have membership or fellowship of a faculty of public health medicine;

4. be able to demonstrate that they can meet the competence requirements of the Northern Ireland Senior Civil Service. A summary of these is set out in the Annex A attachment to this job specification.

Applicants should be aware that after an eligibility sift, should shortlisting be required, it may be necessary to apply one or more of the following criteria, in the following order:-

(i) have at least 5 years' experience, gained within the past 10 years, as a consultant in public health medicine; and

(ii) the experience gained as a consultant in public health medicine may be extended progressively up to a maximum of 8 years within the last 10 years.

The Department may decide to interview only those applicants who appear from the information available to be most suitable in terms of relevant experience and ability. It is therefore essential that applicants fully describe in the application form how they meet the experience and qualities sought. It is not appropriate to simply list the various posts held – the Department will not make assumptions from the title of the post as to the skills and experience gained.

As part of the selection process those candidates selected for interview will be required to give a pre-interview presentation of approximately 10 minutes, details of which will be provided on arrival prior to interview.

It is expected that interviews will take place in Castle Buildings during the latter part of March. Applicants should note that they will be tested at interview on the following:-

- Knowledge and understanding of
  - management and policy issues within the Health Service;
  - major public health issues.
- Senior Civil Service competences.

SECONDMENT TERMS

The position is offered as a 2 year secondment opportunity which may be extended for a further year. The secondment is offered on a full-time or less than full-time basis (but not less than 3 days per week). It is envisaged that the secondee will continue to be subject to health service terms and conditions appropriate to their current position.

All reasonable official travel and associated expenses incurred in connection with work for the Department will be paid by the Department at the normal Civil Service rates.

GENERAL INFORMATION

- Applicants wishing to find out more about the post before deciding to apply may telephone Dr McClements at Belfast (01232) 522709

- An application form and further information about Senior Civil Service competences may be obtained by telephoning DHSSPS Personnel Management Branch (01232) 522018. Applications will only be accepted by completing the application form provided.

- Anyone interested should submit an application form copied to their own Board/Trust personnel or Director of Public Health, to arrive no later than 25 February 2000 with Mrs J Young, Personnel Management Branch, Annex 3, Castle Buildings, Stormont.