Witness Statement Ref. No. 243/1

NAME OF CHILD: ADAM STRAIN

Name: Connor Mulholland

Title: Dr.

Present position and institution: Retired 2003

Previous position and institution:
[As at the time of the child's death]
Clinical Director, Paediatrics (Acting) - Royal Belfast Hospital for Sick Children ("RBHSC").
Clinical Director , Cardiology & Cardiac Surgery Royal Hospitals

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 - April 2012]
Hospital Council 1991-97 & 1999-03
Chair Hospital Clinical Audit Committee1997-2003
Chair Clinical Care Pathways Committee1997-2002
Member of EHSSB Audit Committee1997-2001

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

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

Ref:	Date:	

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.

I. QUERIES IN RELATION TO YOUR MEDICAL QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) Please provide the following information:

(a) State your medical qualifications as of 1995; *MB BCh BAO (QUB 1962) , FRCP Edin. 1979*

(b) State the date you qualified as a medical doctor; *1962*

(c) Describe your career history before you were appointed Clinical Director, Paediatrics (Acting)- RBHSC;

1962 - 1963	*House Physician/Surgeon, Royal Victoria Hospital, Belfast*
1963 - 1965	*Junior Tutor/Senior House Officer* *Department of Medicine, Queens University, Belfast* *Royal Victoria Hospital, Belfast*
1966 - 1968	*Royal Victoria Hospital, Research Fellow (Registrar)*
1968	*Senior Registrar, General Medicine, Northern Ireland Hospitals Authority*
1969 - 1971	*Assistant Professor, Department of Medicine, Christian Medical College Ludhiana, Punjab, India*
1972 - 1974	*Research Fellow (Senior Registrar, Cardiology)*
1974 - 1976	*Ontario Heart Foundation, Research Fellow, Division of Cardiology Hospital for Sick Children, Toronto*
1976 - 2003	*Consultant Paediatric Cardiologist, Belfast, Northern Ireland*

1983 - 1993	*Co-Chairman (formerly Co-Director), Regional Medical Cardiology Centre*
1991 - 1997	*Clinical Director, Cardiology Directorate, Royal Hospital Trust*
1995 - 1996	*Clinical Director, Paediatric Directorate, Royal Hospital Trust*

(d)Describe your work commitments at the RBHSC from the date of your appointment to November 1995;
Develop a multidisciplinary consultant based Regional Paediatric Cardiology Service & team, centred in the Royal Hospitals but with outreach clinics to the Ulster Hospital, Northern ,Southern & Western Boards. Ensure communication with parents & support of parents & siblings of affected children. Supervise the work & develop the experience of trainees. Ensure close communication & collaboration with Cardiac Surgeons. Promote & engage in research into aspects of Congenital Heart Disease. I had a full-time NHS contract. As Clinical Director Cardiology and Cardiac Surgery(1991-1997) I had responsibility for leading, and through clinical & managerial colleagues managing the activities of the Service to the best advantage of patients. This included the care of children and adolescents transferred to the Royal Victoria Hospital for cardiac investigations & surgery.

(e)Was there a written job description for your post in 1995? If so please provide copy of the same. If not, what were the functions and responsibilities of the post? *Not that I recall. If there was one it was very generic. My appointment arose out of a need to address the issues of financial & clinical management structures in the Directorate & improve liaison with all staff. Prior to my appointment a Support (? Supervisory) Group was set up to work with the then Clinical Director (Mr Stephen Brown). It included myself ,the Director of Nursing& a couple of other Clinical Directors.*

(f) Describe the accountability of the Clinical Director, Paediatrics- RBHSC at that time. *To the Chief Executive of the Trust.*

(g) What is your view of the role of a Director of Paediatrics in 1995? *To oversee & manage the functioning of the Directorate through the Nurse Manager, Business Manager & Clinical leads .To that end I set up regular (initially weekly) meetings with the above & appointed Clinical sub-Directors. <u>However one critical feature</u> was that the Anaesthetic & Intensive care consultants were part of the ATICS directorate , not Paediatric Directorate, for professional & clinical matters, although inevitably a close working arrangement was needed & initially Dr Peter Crean attended sub-Directors meetings.*

(h) What was your experience of renal paediatric transplant surgery in 1995?

I had none.

II. INTERNAL CONTROL

(2) What progress had the RBHSC made in 1995 in achieving compliance with extant guidance on both general and specialist children's services in RBHSC?
I don't remember

(3) Were professional Codes of Conduct incorporated into the contracts of those healthcare professionals involved in the care and treatment of Adam Strain in 1995?
I have no information on that.

III. HEALTH AND SAFETY

(4) In its **Health and Safety Report for 1995/96,** the Trust reported that *"a full internal investigation"* had been conducted into an incident in which a patient had died in November 1995 (DLS letter to the Inquiry dated 22nd December 2011). If this patient died in the RBHSC please address the following:

(a) Why was a full internal investigation conducted in relation to this death?
I *was not aware of this death.*

(b) In what circumstances had the patient died?

(c) Who was responsible for conducting the investigation? *Within the Trust Dr Murnaghan as Medical Administrator would have coordinated such an investigation*

(d) Under what procedures was the investigation conducted?

(e) What particular steps were carried out as part of the investigation?

(f) Who was the report presented to, and circulated to?

(5) Had the RBHSC taken any steps to implement guidance for children, including that in:

(a) **Welfare of Children and Young People in Hospital'**, Department of Health (1991), HMSO IBSN 0113213581?

(b) **'Children First - A Study of Hospital Services'**, Audit Commission (1993) HMSO IBSN 0118860968?

I do not recall and was not Clinical Director at that time.

If so:

(i) What were those steps?

(ii) When were they instituted?

(iii) Was their implementation monitored and if so please provide record of the same?

(iv) Who was responsible in the RBHSC for implementing such guidance for children?

(6) From a 1995 risk management perspective, what should have been expected in respect of:

(a) The composition of a paediatric operating theatre team;

(b) The minimum staffing requirements thereof;

(c) The experience of anaesthetist and surgeon in paediatrics;

(d) The appraisal of anaesthetic staff after an unexpected death;

(e) The monitoring of anaesthetic set up and drug administration;

(f) The documentation and record keeping in respect of anaesthetic equipment;

(g) The content of operation notes.

I did not work in theatres so could not answer authoritatively

IV. KINGS FUND ORGANISATIONAL AUDIT

(7) What knowledge do you have of the King's Fund accreditation process? *I do not recall, almost nine years after retirement.*

(8) If you participated in that process, specify the steps that you took? *In the trial period I answered questions about Pediatric cardiology & later was a member of an 'shadow'assessing team.*

(9) Identify any changes in practice which occurred as a result of engaging with the Kings Fund process, both in respect of improving systems of risk management at a clinical and corporate level, and in any other respect? *The main ones I recall related to precision in drug prescription & clinical note taking,in particular documenting what was said to the parents of children .*

(10) Where these steps considered sufficient to obtain full accreditation and if not, why not? *Other changes were also required over at least one other assesment but I do not recall details or dates.*

V. CLINICAL/MEDICAL AUDITS

(11) In 1995, what arrangements did the RBHSC have in place for ensuring that regular and systematic medical and/or clinical audits took place? *I do not have a clear memory of this I have no data to confirm the situation in 1995 other than believing that there were Morbidity & Mortality meetings usually held on a monthly basis & attended mainly by surgeons. In non-surgical units they may have been less organised.*

If the RBHSC did have a system in place for conducting medical and/or clinical audits, please address the following:-

(a) Was there a Clinical Audit Committee? If so, what was its remit? *It would have been developing as formal part of Directorates in the mid 90's*

(b) What were the rules that regulated the operation of the Clinical Audit Committee? *I do not recall.*

(c) Who formed the Clinical Audit Committee? *Representatives of clinical staff*

(d) Did you play a role in connection with the Clinical Audit Committee, and if so what? *Not that I can recall*

(e) Who was responsible for ensuring that medical and/or clinical audits were carried out? *Audit leads in directorates*

(f) Who was responsible for carrying out medical and/or clinical audits? *Clinical staffs in different disciplines with help from the Audit Dept.*

(g) Under what procedures were medical and/or clinical audits carried out? *Some variation on : Accepted standards, Compare against standards, Change practice , Review outcome and if necessary repeat the cycle.*

(h) To whom were the results of medical and/or clinical audits sent? *Ideally to the Audit Dept & relevant clinicians.*

(i) What kinds of action could be taken on foot of the results of medical and/or clinical audits? *Changes in practice & in roles of staff.*

(12) Please particularise all steps taken by the RBHSC to investigate the unexpected death of Adam Strain. *I was not involved*

(13) Was there any procedure or system in place in 1995 to audit the quality, clarity and completeness of clinical case notes? *If Clinical audit was firmly established in '95 it was often a part of individual discipline's half-day audit but this may not have been until later.*

(14) If there was no system in place for conducting medical and/or clinical audits in 1995, please clarify whether there was any other system in place for quality assuring the safe

provision of clinical care? *I am not aware that there was save from Morbidity & Mortality meetings.*

(15) Was there a system of independent external scrutiny in place to review patterns of performance in the RBHSC, and if so please provide details of the same? *The King's Fund Organisational Audit – I am uncertain of the date of the initial visit.*

(16) What steps were taken to achieve the objectives outlined in **HPSS Management Plan 1995/96- 1997/98** with particular reference to paragraph 4.4.11 and the adoption of a policy of clinical audit as part of a program to improve service quality and state when each such step was taken? *I cannot provide specific dates but Clinical Audit moved from being a special interest of some, to individual units regularly meeting on days which were suitable to their staff,to Hospitals selecting a day for all clinical units to meet,to the Eastern HSSB setting a rolling Audit date for all staff within the Board area to meet. A register of attendees was kept for each Subdirectorate or Directorate. There were variations in the degree to which such audit meetings were multidisciplinary.*

VI. CONSENT

(17) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of patient 'consent'? *Beyond the standand 'Consent form ' & medico-legal guidence that consent should be taken by a senior doctor who was familiar with the proceedure & its outcomes including possible complications I do not recall other matters.*

In paediatric cardiology it was always taken by a Consultant ,& fully explained with the aid of standard diagrams & leaflets which we designed.

If so,

(a) Provide a copy of the guidance, policy or procedure;

(b) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) Describe its main features;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the guidance, policy or procedures were monitored for compliance.

(18) With respect to the recommendations deriving from:

(a) **Guide HC (90) 22, a Guide to Consent for Examination or Treatment;**

(b) **Circular HSS (GHS) 2/95.**

Please state what steps the Trust took to:

(i) Disseminate this guidance and to whom;

(ii) Monitor and record compliance with the same;

(iii) Enforce compliance.
I do not have a clear recollection of issues around this in 1995

(19) What arrangements were in place in order to notify the Trust that Circular HSS (GHS) 2/95 had been disseminated, and that there was a system in place to monitor compliance with the Circular?
I do not have a clear recollection of issues around this in 1995

(20) If it is correct that the RBHSC did not commence using the new model consent forms recommended in **HSS (GHS) 2/95** until early in 2000, please state the reasons for this delay. If not, please advise date of introduction of new consent forms. *I do not have a clear recollection of issues around this in 1995*

VII. RECORD KEEPING

(21) In 1995 did the RBHSC have guidance, policy or procedures in place which governed the issue of clinical record keeping?
I have no clear recall of the above in 1995/6.My memory is that engaging in the King's Fund Organisational Audit process was the main stimulus to improving record keeping.

If so,

(a) Provide a copy of the guidance, policy or procedures;

(b) Describe its main features;

(c) Was the guidance, policy or procedure adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the Trust satisfied itself that the guidance, policy or procedure was being complied with by members of clinical teams;

(f) State whether there was/ is any protocol or procedure governing the destruction of any clinical records created in 1995, and if so please identify the same;

Medico legal advice was that records should be kept until three years after the patient reached their 18th birthday

(g) Whether there is/ was any protocol or procedure governing the identity of those individuals permitted to sign for and signify safe receipt of transplant organs;

(h) In respect of the composition and documentation of clinical and surgical teams engaged in specific operations.

(22) In 1995, had the RBHSC established a Medical Records Committee? *Yes*

If so, please address the following:

(a) Who formed the membership of this committee?

(b) Did you play a role in connection with the committee? No

(c) What rules regulated the operation of this committee?

(d) What was the purpose of the committee?

(e) Was its operation governed by any policy/procedure?

I have no information on any of the above questions.

(23) With respect to the recommendations deriving from:

(a) **Department of Health Circular HC (89)20;**

(b) **Department of Health Circular HSG (94)11;**

(c) **HSC 1999/053- 'For the Record-Managing Records in NHS Trusts and Health Authorities;**

(d) **The 1995 Audit Commission study 'Setting the Records Straight, a study of hospital health records';**

(e) **The Royal College of Surgeons of England Guidelines for Clinicians on Medical Records and Notes (1990, revised 1994).**

Please state what steps the Trust took to: *I do not remember*

(i) Disseminate this guidance and to whom;

(ii) Monitor and record compliance with the same;

(iii) Enforce compliance.

(24) What guidance was provided to medical/ nursing staff in respect of:

(a) The monitoring and recording of intra-operative fluid balance?

(b) Recording weights in children?

(c) Monitoring effectiveness of peritoneal dialysis?

(d) The completion of patient records?

Not my field of work

(25) What procedures or protocols were in place in 1995 for monitoring compliance with professional standards for record keeping?
I do not remember

VIII. COMMUNICATION

(26) In 1995 did the RBHSC have guidance, policy or procedures in place governing the issue of communication with next of kin and the provision of information during, before and after surgery; and after an unexpected death?
I do not know.My personal practice & that of my Paediatric Cardiology colleagues was to speak to parents before surgery & after they left surgical theatre to go to the Cardiac surgical Intensive Care unit or if a death occurred.

(27) If so please provide:

(a) A copy of the guidance, policy or procedures;

(b) Describe its main features;

(c) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so please identify this guidance;

(d) State how the guidance, policy or procedures were distributed to clinical staff;

(e) State how the Trust satisfied itself that the guidance, policy or procedures were being complied with by members of clinical teams.

(28) Were there any procedures in place in 1995 for communication with next of kin when aspects of care had not gone to plan and had resulted in harm to the patient?
I do not know of a proceedure document.

IX. DISSEMINATION AND INSTITUTIONAL LINKS

(29) In 1995 did the RBHSC have guidance, policy or procedures in place governing issues arising out of a serious untoward incident or an adverse incident such as the death of a patient following surgery?
I'm not sure if there were any in 1995.

If so, please address the following:

(a) Provide a copy of the relevant guidance, policy or procedures.

(b) Was the guidance, policy or procedures adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures were distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures was being complied with by members of clinical teams;

(e) How was the guidance, policy or procedures applied in Adam's case?

(30) Did the RBHSC take any steps, whether by way of an internal investigation or otherwise, to establish whether lessons could be learned from the death of Adam Strain? *I have no knowledge other than as set out in Dr Murnaghan's(093-025) & Dr Gaston's(060-0180-035,036) statements*

If no such steps were taken, please explain why not?

If steps were taken, please address the following:

(a) What steps were taken to learn lessons from the death of Adam?

(b) Under what policy or procedures were these steps taken?

(c) Identify the person(s) who took steps to establish whether lessons could be learned from Adam's death?

(d) When were those steps taken?

(e) What lessons were learned from the death of Adam?

(f) What lessons were learned from the Inquest into the death of Adam?

(g) What measures were taken to review matters arising from the Inquest?

(h) What steps, if any, were taken to disseminate outcomes and lessons internally (within the RBHSC/ Trust)?

(i) What steps, if any, were taken to disseminate outcomes and lessons externally (outside the RBHSC/ Trust)?

(j) What steps, if any, were taken to assess and develop the competence of staff involved in the treatment that preceded Adam's death?

(31) Following the Inquest into Adam's death it was agreed that the *"other issues identified"* at the Inquest would be dealt with and that a seminar would be arranged for that purpose and would involve the following clinicians: Doctors Mulholland, O'Connor, Hicks, Gaston, Savage, Taylor, and Mr. Keane (Ref: 059-001-001).

Please address the following:

(a) Did that seminar take place? If it did not take place, please explain why it didn't take place?

It may have taken place but I have no memory of being there & I think I would have remembered such a seminar.

Upon the assumption that it did take, place please provide any record associated with the meeting or its conclusions and address the following:

(i) When did it take place?

(ii) Who attended?

(iii) What was discussed?

(iv) What conclusions were reached?

(v) Did you make any contribution to the seminar? If so what?

(vi) Were these conclusions disseminated, and if so, when and to whom?

(32) Dr. Taylor indicated his disagreement with the cause of death indicated on Adam's death certificate. State whether any steps were taken by the RBHSC to address Dr. Taylor's views? *Unknown to me.*

If so, please address the following:

(a) What steps were taken to address Dr. Taylor's views?

(b) When were those steps taken?

(c) Who took those steps?

(d) What conclusions emerged from this process?

(33) Please state your view on whether it would have been easier to use Adam Strain's case history as a vehicle for learning had there been agreement as to the role dilutional hyponatraemia played in Adam's death?
Possibly yes

(34) Please confirm whether or not you received a report in writing of or into the death of Adam Strain in 1995?
I do not remember receiving any .

(35) Please state whether there existed, a formal approach to:

(a) Assessing and developing the competence of the staff involved in the treatment that led to Adam's death;

(b) Disseminating outcomes and lessons learned internally both before and after the Inquest;

(c) Disseminating outcomes and lessons learned externally both before and after the Inquest?

I am unsure how formal & standardized it would have been but for (a) & (b)there would have been a process ; for (c) this was less likely to always happen.

X. INTERNAL REVIEW

(36) Did the RBHSC conduct an internal review in respect of any of the following matters after Adam's death:

(a) The procedures governing consent, and whether they were complied with in Adam's case;

(b) The records kept/made relating to the pre, intra and post-operative care of Adam;

(c) The records kept/ made of communications with Adam's parents;

(d) The use of equipment before and during Adam's surgery;

(e) Lessons to be learned from the treatment which preceded his death;

(f) The competence and training needs of those who cared for Adam.

I do not know more than is contained in Dr Murnaghan's & Dr Gaston's statements

If so, please address the following:

(i) What steps were taken in respect of each matter?

(ii) When were those steps taken?

(iii) Who took those steps?

(iv) What policies or procedures were used when taking those steps?

(v) What conclusions emerged in respect of any of these matters?

(37) Did the RBHSC have a policy for investigating adverse incidents in 1995?

(38) With reference to:

(a) **'Reporting of Accidents in hospitals' (1955)** guidance;

(b) **'Risk Management in the NHS' (1993)** guidance;

(c) **'EL (94) Report 'The Allitt Inquiry' (1994)** recommendations;

Please particularise how the above were taken into consideration when formulating the RBHSC response to the unexpected death of Adam Strain?

I was not involved.

XI. OTHER

(39) In respect of the clinical negligence action commenced 25th April 1996 and settled 29th April 1997 please state:

(a) Why was a confidentiality clause was made a term of settlement?

(b) Did the litigation restrict the scope of explanation offered to Adam's parents?

(c) Did the litigation restrict the scope of dissemination of information in respect of learning both internally and externally?

(d) Were the clinical staff involved in Adam's case kept informed of all aspects of the outcome of the clinical negligence case

I am unable to comment as I was unaware of any details of the litigation

(40) Has any consideration been given to the viability of the RBHSC renal transplant facility and if so:

(a) When?

(b) Why?

(c) By whom?

(d) What was considered?

(e) With what outcome?

(f) In the light of the publication of the *'Provision of Services for Children and Adolescents with Renal Disease'* (Working Party Report in March 1995)

Unknown to me

(41) Were any child patients transferred from the RBHSC to any other hospital in the UK for surgery before Adam's death, and if so please state: *Unknown to me*

(a) Date of transfer;

(b) Hospital to which child was transferred;

(c) Age of child when transferred;

(d) Identity of Consultant in charge of child prior to transfer;

(e) Reason for the transfer;

(f) Whether there existed any policy, protocol, procedure or guidelines in relation to the transfer of children to hospitals outside of Northern Ireland for surgery.

(42) Were there any procedures, protocols or practices in 1995 governing paediatric renal transplant surgery? If so, please address the following:

Not within my field of work

(a) Provide a copy of the relevant guidance, policy or procedure;

(b) Was the guidance, policy or procedure adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(c) State how the RBHSC's guidance, policy or procedures were distributed to clinical staff;

(d) State how the Trust satisfied itself that the guidance, policy, or procedures were being complied with by members of clinical teams;

(e) Was there a system for periodic review and updating of any such policy, protocol or guidance?

(43) Please describe and particularise the experience gained by the RBHSC by 1995 as a paediatric renal transplant centre in relation to other UK centres? *I don't have the information*

(44) In respect of the UTV Insight documentary *('When Hospitals Kill'-* 21st October 2004) please state: *I retired in 2003 & had no involvement*

(a) What requests for information and comment were received from UTV;

(b) What information and comment were given to UTV, specifying by whom, to whom and when;

(c) Please identify those individuals engaged in this process;

(d) Who bore responsibility for this process;

(e) What internal responses were generated by any such requests;

(f) What internal responses were generated by the broadcast of the documentary;

(g) Whether any record or documentation of this process was made, and if so please provide the same;

(h) If same was created, but is now no longer available please state what became of it.

(45) Please identify those procedures and protocols governing the reporting and dissemination of information to the DHSSPS and the wider medical community in 1995 and now relating to:

I don't have the information

(a) Unexpected/ unexplained deaths in RBHSC;

(b) Outcomes of Coroner's Inquests

and further please address the following:

(i) Identify those individuals responsible for the implementation of the same;

(ii) Was the procedure/ protocol as adopted by the RBHSC, modeled on or informed by any published guidance, and if so, identify this guidance;

(iii) State how the Trust satisfied itself that the procedures and protocols were complied with;

(iv) To what extent were the procedures and protocols followed in Adam's case?

(v) What information was supplied in Adam's case?

(vi) Whether the procedures and protocols were consistent with guidance in both Northern Ireland and the UK in 1995.

(46) Please indicate what teaching and/ or training was provided to nursing and/ or medical teams in and before 1995 in respect of: *Unknown to me*

(a) Fluid management (with particular reference to hyponatraemia);

(b) Record keeping.

(47) Please state what steps had been taken by November 1995 to implement the recommendations of the NCPOD report in respect of out of hours paediatric surgery. *I don't know*

(48) Please state what action you took following the Inquest into Adam's death. If you took no action please explain why. *I was not involved in procedures before or during the Inquest and was not Clinical Director for Anaesthetics and Intensive Care.*

(49) Explain why no contact was made by the RBHSC with other hospitals to inform them of the amendment of the renal transplant guidelines by the anaesthetic, theatre and intensive care directorate.
I do not know as I was not involved in the internal review. The ATICS directorate produced the guidelines (060-018-036)-Dr Gaston's draft 19/6/96 . Please also see Dr Murnaghan's statement (093-025) on 2/5/06 as to why no contact was made.

XII. EDUCATION, TRAINING AND EXPERIENCE.

(50) Describe in detail the education and training you received in fluid management (with particular reference to hyponatraemia) and record keeping through the following, providing dates and names of institutions/ bodies: *None*

(a) Undergraduate level;

(b) Postgraduate level;

(c) Hospital induction programs;

(d) Continuous Professional Development;

(51) Prior to 26th November 1995, describe in detail your experience of dealing with children with hyponatraemia, including:
I had no experience of this condition

(a) The estimated total of such cases, together with the dates and where they took place;

(b) The number of children who were aged under 6 years;

(c) The nature of your involvement;

(d) The outcome for the children.

XIII. GENERAL

(52) Please provide any further comments you may wish to make.

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

Signed: [signature] **Dated:** 16/5/12

Hyponatraemia Inquiry 2012

Director (Acting) Context

I wish to provide some context to my role, for eighteen months, as Clinical Director (Acting) Paediatrics in 1995-96 in the Royal Belfast Hospital for Sick Children(RBHSC)

In 1976 I was appointed as the first full-time Paediatric Cardiologist in N.Ireland During the succeeding years as the service based in Clark Clinic at the RBHSC was built up I remained as a member of the Cardiology Division but attended meetings of the Paediatric Division.

In the 90's with the coming of Resource Management the Cardiology Directorate (Medical & Surgical) was formed. I still attended meetings of the Paediatric Directorate & was a member of the RBHSC Medical Staff Committee. I was consulted by colleagues about children under their care with possible cardiac problems & often consulted them about patients under my care who had additional problems-neurological, endocrine, orthopaedic & others. Hence although not involved in the central management of the Paediatric Directorate I knew the staff, facilities & buildings well.

I became Clinical Director of Cardiology in 1991 & remained in that post until 1997

In **1995** with increasing emphasis on keeping within budget, improving services & clinical management I was asked to take over temporarily as Director of the Paediatric Directorate which had been developing an increasing financial deficit. My primary focus was to be on finance & on management structures, ensuring that all staff worked together towards a solutions.

Significantly the Anaesthetists, who also ran the Intensive Care Unit, were professionally & to a degree clinically, within the Anaesthetic, Theatres & Intensive Care Services Directorate. As a consequence although I had heard in1995 that a child had died following a kidney transplant, I knew the Medico-legal aspects were in the hands of Dr George Murnaghan as Medical Administrator & that Anaesthetic issues, questions, review & subsequent recommendations were with Dr Gaston who was Clinical Director of ATICS. As both men were highly competent & experienced in their roles I did not see a need for my involvement. I was not asked for any opinion or comment at that time nor after I had handed over the post to Dr Hicks.

I reached retiring age in 2003 & now live mostly in England .Having cleared my office at retirement & then moved subsequently to a smaller house in England I have very little documentation from those years & have had to rely on my memory for most of my answers.

H. Connor Mulholland

18.4.2012