Witness Statement Ref. No. WS-306/2

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Ian Carson

Title: Doctor

Present position and institution:

Retired

Non – Executive Chairman, Regulation and Quality Improvement Authority

Previous position and institution:

Medical Director Royal Group of Hospitals
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since the date of your last statement]

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:	
WS-306/1	13/12/2012	Inquiry Witness Statement

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. MEDICAL CERTIFICATES OF CAUSE OF DEATH AND CONSENT AUTOPSIES

(1) In answer to a question about why the Medical Certificate of Cause of Death in Lucy Crawford's case was completed after the autopsy, the Inquiry has been told by Dr Caroline Stewart that in her understanding (in the context of a consented autopsy) *"it is not normal practise (sic) to issue a death certificate before the preliminary autopsy results are known."*

Arising from this please answer the following questions:

(a) **Was it the practice in the Royal Group of Hospitals Trust, in 2000, in cases where a consent autopsy had been requested, for clinicians not to complete a Medical Certificate of Cause of Death until the preliminary autopsy results were known?**

It is a statutory legal duty, based on Births and Deaths Registration (Northern Ireland) Order 1976, for Registered Medical Practitioners to provide a Medical Certificate of Cause of Death (MCCD) without delay if, to the best of their knowledge, that person died of natural causes for which they had treated them in the last 28 days.
If a consented autopsy had been requested to provide additional information, or there was any uncertainty in regard to factors which may have contributed to a patient's death, it would have been common practice not to issue the Certificate until the preliminary autopsy results were known. This may have involved a discussion between the pathologist and the doctor prior to the certificate being signed.

(b) **If this was the practice, what were the reasons for the practice?**

As above.

(c) **Was there any written policy, protocol, or guidance, dealing with the issuing of a Medical Certificate of Cause of Death in circumstances where a consent autopsy was to be performed? If so, please provide a copy.**

I cannot recall whether the Trust had a written policy, protocol or guidance in place, in 2000.

This question would be better addressed to the Trust.

II. CLINICAL AUDIT

Describe the arrangements for clinical audit within the Royal Belfast Hospital for Sick Children by the year 2000. In particular what were those arrangements in relation to child mortalities?

Specific arrangements for clinical audit within the RBHSC, including child mortalities, was the responsibility of the Paediatric Directorate. They were led and co-ordinated by a consultant who would have been a member of the Trust Clinical Audit Committee.

Trust-wide arrangements for clinical audit by the year 2000 are described in the *'Trust Clinical Governance Report 1999/2000 and Clinical Governance Action Plan 2000/2001'* which was published in September 2000 I understand that copies of these documents have previously been furnished to the Inquiry by the Belfast Trust.

(2) **Were the arrangements for clinical audit documented? Please identify any relevant guidance, policy, protocol, or procedures, and make arrangements to ensure that the Inquiry is provided with a copy of any relevant documents.**

In addition to the information documented in *'Trust Clinical Governance Report 1999/2000 and Clinical Governance Action Plan 2000/2001'* the Trust published Annual Clinical Audit Reports, which were circulated within the Trust. I understand that copies of these documents have previously been furnished to the Inquiry by the Belfast Trust. My recollection also is that there would have been 'ad hoc' sharing of Trust audit reports between Audit Co-ordinators in different Trusts, and also with Area Board and Regional Audit committees.

The Inquiry may wish to refer this question to the Belfast Trust the Health & Social Care Board, and to the DHSSPS.

(3) **What, from your perspective as Medical Director, was the purpose(s) of clinical audit in the Royal Belfast Hospital for Sick Children in the year 2000? In particular what was the purpose(s) of clinical audit in relation to child mortalities?**

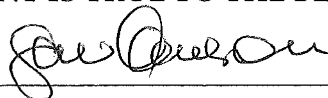
The arrangements for clinical audit in the RBHSC were no different from elsewhere in the Trust. It provided an opportunity for clinical staff on a multi-professional basis to reflect on current practice against agreed evidence-based standards. It was recognised as, and remains, an effective mechanism for improving the quality of care patients receive as a whole.

I refer to my witness statement WS-077-3 (paragraph 3.3 on page 7) in which I have also referred to the matter of clinical audit.

The National Institute for Clinical Excellence (NICE) have defined Clinical Audit as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."

Throughout the time period covered by this Inquiry there has been an assumption that clinical audit was the definitive instrument to be used when a critical incident or event occurred. Clinical audit can be used to look at outcomes, including mortality data, but the process is not capable of responding to each and every death whether expected or unexpected.

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

Signed:  **Dated:** 3 May 2013