

Discussions with Clinicians

23. I now turn to the second of the three sets of specific questions set out in the letter from the Inquiry to me of 5 August 1999.
24. As stated in "Postmortem Audit in a paediatric cardiology unit", flaws in surgical technique were "uncommon". However, when possible diagnostic, surgical or other errors were identified at postmortem then these were routinely and invariably recorded in the postmortem report. I did not make entries in the medical records, but a copy of the postmortem report was routinely sent to the surgeon or other clinician concerned. This then gave the clinician the opportunity to discuss the postmortem findings with us. Occasionally, I did seek out and speak directly to a clinician about a discrepancy in the diagnosis or a possible surgical imperfection, but I do not remember this happening very often. It was anticipated that in any event significant postmortem findings would be discussed at one of the regular clinico-pathology meetings.
25. I attended a number of clinico-pathology meetings when I was in the Department of Paediatric Pathology, but I cannot now recall how many. Nor can I recall whether all deaths in the Cardiology Unit were discussed at those meetings. The purpose of the meetings was, as far as I was concerned, educational. I did not look on those meetings as a general audit of clinical standards. The meetings were a case by case study of deaths which had occurred, with the purpose of trying to identify any lessons to be learned from those deaths, and with the overriding objective of improving and developing further clinical practice. The postmortem findings were of course only a limited part of this process.