

Dr Murray Quinn
(Doorstep at home in Claudy, Saturday September 25)

TB: (48:12) Dr Quinn?

MQ: Ah, what are you doing here?

TB: Dr Quinn. My name is Trevor Birney. I'm from UTV, sir.

MQ: I just wonder why you have the camera going?

TB: Well, I have. I just want to ask you some questions about this report.

MQ: What report?

TB: This report you completed into the death of Lucy Crawford for Sperrin and Lakeland Trust.

MQ: What I would like to say is, I had nothing to do with the treatment of Lucy Crawford. I'm very sorry that she died. The death of a child is an absolute tragedy ...

TB: So why did you not reach any conclusions about her death?

MQ: (48:40) Because this is a ... I did a case-notes report for the, um, Director, no the Medical Director of Sperrin Lakeland, the Director of Patient treatment, the Chief Executive and I said that what they should do when I did the case report was - the case review, the notes review, was that they should get an independent person from outside our board to give an opinion as I had no intention of ... (49:14)

TB: But why does it not say that in your report?

MQ: ... as I had no intention of being involved in any formal complaints procedure ...

TB: That wasn't a complaints procedure at that stage.

MQ: ... or any ...

TB: The family hadn't asked ...

MQ: I said ... no ... excuse me!

TB: But it ... none of that is ...

MQ: Sorry, are you ... do you allow me to speak ...

TB: Yes, I can.

MQ: ... or are you not going to?

TB: But I'd like to ask you the question. None of ...

MQ: I, I ...

TB: ... that is contained in your report.

MQ: I, I've a few things that I want to say.

TB: OK

MQ: I've come out. I'm speaking to you. There you are. You've doorstepped me on a Saturday afternoon to come, you know ...

TB: Well, I ...

MQ: ... I've plenty of work to do. So maybe you want me to speak ...

TB: I would like you to speak. Yip.

MQ: The first thing I would say is, the people that you've been dealing with through the hospital have said you've been pretty rude with them. OK? That's the first thing I'd like to say (49:54). I did a case notes report. I told the people down in Sperrin Lakeland that I'd no intention of being involved in either formal complaints procedures – and I have in the past been involved with other boards in that ... I had no intention of being involved in any legal case if that was what was happening and that they should get an independent person to represent them if they wanted to take it further ...

TB: So why did you ... just ... The question that we want to ask is, in this report which had nothing to do with legal actions, when this was just part of the chairman, the chief Executive's review into the case that you completed on 26th June ... (50:29)

MQ: No, no, this wasn't a review. This was my case-notes review ...

TB: This is your medical report, yes.

MQ: ... so that they could discuss with me where they should go ...

TB: Well, why did you not ...

MQ: What I said was, what I said was ...

TB: How did you ... Could I ask you a question, sir?

MQ: No you can't. What ...

TB: Well, I would like to ask you a question. Why did you not come to the conclusion that she died of hyponatraemia. How did you fail to do that?

MQ: Because ^{so it's} this is not a medical report.

TB: It is. It says 'medical report' right there.

MQ: No ^{so} This is a case note review.

TB: Well, it says 'medical report', sir.

MQ: That's not what it is.

TB: OK. So it's ... that's wrong. That's not .. So you got that wrong as well? *50:59*

MQ: No, no, no. It's a case notes review ...

TB: Well, why did you not say 'case notes review'?

MQ: It doesn't matter what's written there. *51:04*

TB: Well, it ... whether it is or not, why did you fail to come to the conclusion that she died of hyponatraemia ...

MQ: Because I wasn't ...

TB: ... when everyone else did?

MQ: Because I was not asked to come to a conclusion.

TB: Sorry, you came to the conclusion that you couldn't find a conclusion.

MQ: What I was asked was to review the notes and see where they should go next. I told them where they should go next.

TB: But you didn't say that.

MQ: They should go to an independent person outside the Western Board. What aspect of the, what aspect of this do you want to ...

TB: I would like to ask you, first of all, how, unlike every other expert, you decided Lucy started receiving ...

MQ: Which, which ...

TB: ... liquid ...

MQ: ... which expert?

TB: Well, Dr Sumner or Dr Evans who gave evidence at ...

MQ: Ah, so, Dr Sumner.

TB: ... at her inquest. Dr Jenkins, Dr Auterson ...

MQ: Dr Sumner is?

TB: All these people said she got too much fluid and the wrong fluid.

MQ: Well, I ...

TB: You say that nowhere in your ...

MQ: I calculated, I calculated what you would expect to give her for a ...

TB: No but you miscalculated completely ...

MQ: No, I didn't ...

TB: You said from 7pm in the evening ...

MQ: No, no, I didn't miscalulate ...

TB: ... when Lucy never ... yes you did. You said Lucy had a volume of fluids over seven hours between admission and 3am. Lucy only started receiving fluids at 11pm.

MQ: No, no no. If you actually look at the chart ...

TB: No. Yes ...

MQ: ... if you actually look at the chart, she had ...

TB: She had 150ml of water ...

MQ: No, no, no ...

TB: ... between nine o'clock ...

MQ: No, no, no ... not water. She received oral rehydration solution.

TB: ... so ... Do you think that contributed towards her death?

MQ: I think she had received ... I took ... I said how much oral, how much fluid ...

TB: 150 ml ... But she didn't receive it . She only started receiving the oral rehydration at 9pm.

MQ: Anyway ...

TB: 9pm, not 7pm.

MQ: Anyway, what's ...

TB: so ... no, no, no, no, Sir. You haven't answered that question.

MQ: No, well I (52:32)

TB: How did you calculate that? No-one calculated that over a seven-hour period. Everyone calculated from the moment she started receiving Solution 18 through a drip at 11pm ...

MQ: So, yeah, so ...

TB: How did you, how did you miscalculate that so badly?

MQ: No. I didn't miscalculate.

TB: You did!

MQ: No, I did not.

TB: You did!

MQ: I put exactly the calculations that I did there.

TB: Yes. Which are completely wrong.

MQ: No, they're not.

TB: And it's now ...

MQ: ... no they're not.

TB: This report is now completely discredited. Do you understand that?

MQ: It's not a report.

TB: It is! It's a medical report.

MQ: It's a case note review. It's a case note review.

TB: Did you write that?

MQ: Which part?

TB: Did you write ...

MQ: Case note review.

TB: ...medical report? Did you write that? 53:01

MQ: It may have been typed.

TB: And that is your hand. But that is your ... You do recognize, this is your document?

MQ: What I would like to say is ...

TB: This is your document?

MQ: It may be.

TB: Is it your document? Well it says your name on it. Is it your document?

MQ: It may be.

TB: It is your document. Well, I'm saying it is your document and it says 'medical report', not 'case note review'. 53:22

MQ: A point I'd like to make is that back in 2000, the commonest fluid used for children who were deemed to be unwell, dehydrated, the initial fluid that was given to hundreds of children all throughout the UK was fifth normal saline. Now you'll see that ... (Trevor flicking through pages) you've probably got someone to look at that, who said that I said that fluids were ...

TB: Well, the Coroner has expressed real concern and, I mean, you say here, 'I find it difficult to be totally certain as to what occurred to Lucy in or around 3am'. A doctor of your experience, a consultant ...

MQ: The only ...

TB: ... a paediatrician of your experience ...

MQ: The only, no, this is ...

TB: No-one, no-one, everyong is now totally certain what happened.

MQ: Anybody ...

TB: Everybody is totally certain who has given evidence in the ...

MQ: Anybody who wrote anything without the full information, which I did not have ...

TB: Why did you not?

MQ: ... because I did not want to talk to the parents; I did not want to talk ...

TB: No, no, no. Neither ...

MQ: ...to the medical staff; I did not want to

TB: No, but neither did Dr Sumner ...

MQ: ... to talk to the nursing staff.

TB: ... nor Dr Evans.

MQ: Well, how did they come to a conclusion?

TB: Well, they've come to their conclusion because they say it's simple: ^{Bark} whenever you give a child 400ml of the wrong fluid over a four-hour period, she will suffer from hyponatraemia and cerebral oedema. You don't even understand that.

MQ: Oh, actually, I do.

TB: Well, why did you not put that in your report?

MQ: Because it's not a report ...

TB: Do you not accept she died of hyponatraemia?

MQ: That's what the coroner said.

TB: Do you accept that?

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MQ: It may be. I mean, there are a lot of explanations ... 56:41

TB: So you disagree with the Coroner?

MQ: No, I don't disagree. I'm not saying that at all ...

TB: Look, I'll read you the coroner's findings ...

MQ: No, it's fine. It's OK.

TB: The coroner said it was the wrong fluid and too much of it. (54:50)

MQ: Fine. I think I'm going to make no more comments. OK? I've said my piece. The commonest fluid used for rehydrating children back in 2000 was fifth normal saline. That has changed. It actually changed after a case in Alt...

TB: A death in Altnagelvin Hospital. Did you warn Altnagelvin Hospital when you read Lucy Crawford's notes? Did you say anything about the dangers of rehydrating children who used dangerous ...

MQ: Eh...

TB: Did you accept ...

MQ: So that's the commonest fluid that was used.

TB: Did you say anything to Altnagelvin? (55:14) 55:15

MQ: That was the commonest fluid was used at that time. I'm very sorry that Lucy Crawford died and I hope that her parents are allowed to grieve in private, not in public. Thank you.

TB: But do you think they deserve the truth?

MQ: Thank you.

TB: Do you think they deserved the truth of what happened?

MQ: They've been through the formal complaints procedure. They've been through a court case where I understand they got financial compensation for, for whatever reason. They've been through ... and there's been another TV programme. There've been paper reports, none of which ... the Coroner's court. So they're got the answers (shrugs).

TB: They don't. They say they don't.

MQ: Well, they've got the answers. // out 55:56

TB: They say they don't. I mean, they say that this report actually compounded their problems because of your failure ...

MQ: No, no, no. compounds the problems?

TB: Yes. Because you failed. You ignored the evidence.

MQ: No, I didn't ignore the evidence. This is ...

TB: Well, explain to me, Dr Quinn.

MQ: ... from limited evidence.

TB: The same evidence that Dr Evans and Dr Sumner came to. (Dr Quinn puts his hands up and starts to walk away) No, just explain to me something ...

MQ: No, no, that's fine. Thank you very much.

TB: How did you? How ... How did you ...

MQ: That's it. That's it. No that's finished.

TB: Did you ...

MQ: Finished.

TB: Do you ...

MQ: Finished.

TB: Do you admit that Lucy Crawford died of hyponatraemia?

MQ: That's what the Coroner ...

TB: Do you in your expert ...

MQ: I have no comment to make on anything because I did not talk to the parents. I did not talk to the medical representatives and I did not talk to the nursing staff.

TB: So, did you ...

MQ: (Shrugging, hands up) Finish.

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TB: ... feel you could do a report like this without talking to these people.

MQ: I did a case note review (56:36)

TB: It doesn't say that. It says 'medical report'.

MQ: and ^{56:39} **I said to Dr Kelly and to Mr ... ah ... what's his name ...**

TB: Fee.

MQ: ... Mr Fee that I would discuss it with them. I was sweet-talked into writing a summary which is not the complete amount of discussion that I had at that time, so anyone who make a ...

56:58

TB: You were sweet-talked?

MQ: ... if I were ...

TB: You were sweet-talked?

MQ: ... if I were ... if I were ...

TB: Sweet-talked by whom?

MQ: If I were to write a medical report, I would talk to all the people involved. I did not so ...

TB: Sorry it says ...

MQ: ... the information that I had was ...

TB: It says ...

MQ: Excuse me!

TB: It says 'medical report'.

MQ: No. The information that I had was limited and I think that anybody who comes to any conclusions there, they ...

TB: So you're prepared to put yourself, name to a document of a medical review ...

MQ: Anyone, anyone ...

TB: ... with limited information?

MQ: anyone who comes to a conclusion without speaking to all these people, I think would have to go back and look at their evidence.

TB: I ...

MQ: Thank you very much.

TB: Did you do that?

MQ: (Shrugging). I've no ...I wasn't involved with this. Thank you (walks down path and into house).

TB: And did you say anything to Altnagelvin about your concerns of hyponatraemia? Have you raised fluid management at Altnagelvin? (door clicks shut and Dr Quinn disappears inside) (57:45)