IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS IN NORTHERN IRELAND

CLOSING SUBMISSIONS ON BEHALF OF DR KELLY

Key
References beginning with T refer to the transcript of the oral hearings. They are followed by the date of the oral hearing referred to, followed by the page number, then the line number. So, for example, T12/6/13 P1 L3 is the transcript for 12th June 2013, page 1, line 3.
References to documents used by the Inquiry adopt the Inquiry's own referencing method.

THE APPROACH ADOPTED IN THESE SUBMISSIONS

1. Many issues have been explored with Dr Kelly during the Raychel Ferguson (Lucy Crawford aftermath) segment of the Inquiry. Closing submissions dealing with all those issues would inevitably run to very many pages which might, in turn, be apt to lose sight of the critical points. It is therefore proposed to select the most important issues that have been raised with Dr Kelly, both in correspondence and in evidence, and to make focussed submissions on those issues[1].

2. The remainder of these submissions are accordingly arranged under the following headings:

    a) Overview analysis of, and submission on, Dr Kelly's involvement in the aftermath of Lucy Crawford's death.

[1] In the event that there are any particular issues not covered by these submissions about which the Chairman would like further written assistance from those representing Dr Kelly, then the Chairman can read this footnote as extending a standing invitation to ask for it.

b) The extent to which Dr Kelly is open to fair criticism for failing to ensure that the review of Lucy Crawford's treatment and death was better carried out and the recommendations actioned.

c) The impression Dr Kelly was left with following his meeting with Dr Quinn on 21st June 2000.

d) Should Dr Kelly have done more to establish a bespoke external review of Lucy Crawford's treatment and death to obtain a clearer explanation for how her death was caused? If so, what should be read into the fact he did not?

e) The impression Dr Kelly was left with following his meeting with Dr Stewart on 1st June 2001.

f) When did Dr Kelly first learn that no inquest into the death of Lucy Crawford was planned?

g) Upon discovering no inquest was planned was Dr Kelly under any statutory or common law duty to inform the Coroner of the findings of either RCPCH report?

h) Conclusion the Chairman is invited to reach.

OVERVIEW ANALYSIS OF, AND SUBMISSION ON DR KELLY'S INVOLVEMENT IN THE AFTERMATH OF LUCY CRAWFORD'S DEATH

3. As is now clear to all, at the time of Lucy Crawford's death, Dr Kelly was Medical Director at the Sperrin Lakeland HSS Trust. Self-evidently, this role included requiring him to provide leadership and advice within the

Trust. And, as with all those in a senior managerial position within a substantial organisation, his work involved the need to delegate tasks to others, whom he had no reason to think would require intrusive oversight, or micro-management to ensure that they performed their duties diligently and competently.

4. On 13th April 2000, Dr Jarlath O'Donohoe phoned Dr Kelly. He informed Dr Kelly that Lucy Crawford had suffered an unexplained collapse requiring resuscitation and incubation, and that he (Dr O'Donohoe) was not sure what had happened, but that he considered there may have been a misdiagnosis, the wrong drug prescribed, or the child had had an adverse drug reaction. He also said there had been some confusion over fluids.

5. Dr Kelly's response was to inform Hugh Mills, the Trust Chief Executive, and request that a senior review team be established to investigate and review Lucy Crawford's case. The next day – 14th April 2000 – Dr Kelly agreed with Mr Mills that the Acute Services Manager, Mr Eugene Fee, should lead the review supported by the Clinical Director for Women and Children's Directorate, Mr Trevor Anderson. Dr Kelly requested that all Lucy Crawford's medical records be photocopied to assist in the review. Mr Fee spoke with Dr Kelly and confirmed that he would lead the review. Dr Kelly also checked with Mr Fee that Lucy Crawford's family were being supported and informed. Dr Kelly also asked the review team, and Dr

O'Donohoe, for any initial results from the post mortem examination performed the same day.

6. From 15th April 2000 to 2nd May 2000, Dr Kelly was on holiday. This did not stop the review team from getting on with its task, because it was during this period of Dr Kelly's absence that the review team selected Dr Murray Quinn to provide an external and independent expert opinion. There has been some criticism of this selection. Dr Kelly makes three points on this criticism:

    a) Dr Quinn was a very experienced paediatrician. When Mr Fee and Dr Anderson wanted specialist expert input into the review, they could hardly be blamed for going to such a paediatrician.

    b) As to the identity of that paediatrician, the criticism has been that because Dr Quinn had provided visiting support and outpatient work at the Erne from time-to-time during the early nineties, there might be an appearance of bias. But as is well known – perhaps trite – the test to be applied for determining the existence of apparent bias was whether a fair minded and informed observer would conclude that there was a real possibility of bias (see *Porter v Magill* [2002] 2 AC 357). It is difficult to see how an observer who was genuinely fair minded and informed could really think there was a possibility that Dr Quinn's independence was somehow qualified because of the mere fact he had worked from time-to-time at the

Erne. (In any event, see *R (Factortame Ltd) v Transport Secretary (No.8)* [2003] QB 381 at [70], in which Lord Phillips MR deprecated the application to an expert the same test that would be applicable to a tribunal).

c) For the avoidance of doubt, whilst he submits for the reasons set out above that there was absolutely nothing wrong with the instruction of Dr Quinn in the circumstances, Dr Kelly reminds the Inquiry that as a matter of fact he played no part whatsoever in the selection of Dr Quinn as the prospective source of expert opinion. By the time Dr Kelly returned from Annual Leave, Dr Quinn had already been contacted and agreed to provide a report.

7. Shortly after Lucy Crawford's death, a staff grade paediatrician named Dr Ashgar made a complaint about Dr O'Donohoe to Dr Kelly. That complaint, predominantly about bullying and harassment included criticism of Dr O'Donohoe's treatment of four patients, one of whom was Lucy Crawford. It was decided to keep this complaint separate from the review team's work, so Dr Kelly decided to deal personally with Dr Ashgar's complaint. So he sought, and obtained, an external report from Dr Moira Stewart, as representative of the Royal College of Paediatrics and Child Health. Dr Stewart's findings concluded that there was a delay in implementing fluid therapy and deficiencies in the prescription and recording of volumes of fluid administered. She did not mention

hyponatraemia and its possible effects specifically. (Insofar as she suggests otherwise, the Inquiry is reminded that the contemporaneous documentary evidence tends to support Dr Kelly on the issue, a point that is expanded on later in these submissions.)

8. The specific issues identified for Dr Kelly by the Consolidated Advisors' Report dated 15th May 2013 are:
    a) Not establishing an external review once the internal review was found to be inconclusive regarding the cause of Lucy Crawford's death.
    b) Failing to ensure that the recommendations of the internal review were actioned and adherence subsequently audited.
    c) Failure to take action in response to the information from the RCPCH 1st report and failure to inform the Coroner of this further opinion.

9. Dr Kelly recognises that the issues the Inquiry wishes to scrutinise in respect of his involvement in the aftermath of Lucy Crawford's death, go somewhat wider than the issues identified in the Consolidated Advisors' report: hence the ambit of these submissions. But it is useful for now to note that the issues identified by the Consolidated Advisors overlap substantially with issues that have already been considered by the General Medical Council, in deciding to cancel the referral of Dr Kelly to a Fitness

to Practise Hearing. This decision was made on the basis of the expert opinion of Dr Michael Durkin, whose report is dated 22nd August 2011, and is relevant to some of the issues exercising the Inquiry.

10. The allegations which brought Dr Kelly to the attention of the GMC originated in a complaint made by Mr and Mrs Ferguson. In short, it was alleged that Dr Kelly at no stage had informed the Coroner of the events of Lucy Crawford's death; that when Dr Quinn was suggested as an expert Dr Kelly should have known he was not independent; that even though the post-mortem report had mentioned hyponatraemia Dr Quinn did not identify this in his report and therefore, Dr Kelly should have realised that the report was flawed and inadequate; that Dr Stewart's report raised hyponatraemia as a cause of death, and was not shared with Lucy Crawford's family or the Coroner. As a consequence, the delay in passing on the information, and inadequate investigation, may have contributed to other children's deaths including that of Raychel Ferguson. Commenting on these allegations, Dr Durkin conclusions included the following:

    a) There was little guidance at the time of Lucy Crawford's death on the requirements of reviewers or commissioners of reviews to ensure that there were no conflicts of interest (although Dr Kelly should have made enquiry and sought confirmation as to whether there were any issues precluding Dr Quinn from acting as an independent expert).

b) A previous interaction by Dr Quinn with the Trust would not automatically have disqualified him from acting.

c) Although Dr Kelly might have requested a more thorough review, it is not reasonable to conclude that Dr Kelly failed to identify that Dr Quinn's report was flawed because Dr Quinn did not consider hyponatraemia as a cause of death. It is only more recently that Root Cause Analysis and Incident Decision Tree methodology have become common.

d) It was not below the standard expected at the time that Dr Kelly did not share Dr Stewart's report with the parents of Lucy Crawford or the Coroner.

e) Dr Kelly made reasonable efforts to investigate Lucy Crawford's death.

11. Dr Durkin concludes by saying that in his opinion, the actions of Dr Kelly did not fall below the standard expected of a reasonably competent Medical Director when the time of the incident is considered.

12. Those representing Dr Kelly freely recognise that the Chairman is free to roam, in the context of a public inquiry, over wider ground than the narrow application of the *Bolam* test in a clinical negligence claim would permit. But, in short, Dr Kelly adopts the analysis of Dr Durkin. The Inquiry is respectfully asked to bear in mind that Dr MacFaul's criticisms

are not echoed even by the GMC's expert of choice. It will have not have escaped the Inquiry's notice that this was a doctor chosen by the GMC for his considerable experience of the roles and requirements of a Medical Director (in contradistinction to Dr MacFaul, who lacked such experience, though in fairness Dr MacFaul said he would "*defer*" to the views of Dr Durkin [T26/6/13 P5 L22-P6 L3], despite later mildly qualifying this concession when indicating there were a few matters on which he still differed from Dr Durkin). This is something that the Inquiry is invited to consider when assessing whether Dr MacFaul's criticisms are fair.

THE EXTENT TO WHICH DR KELLY IS OPEN TO FAIR CRITICISM FOR FAILING TO ENSURE THAT THE REVIEW OF LUCY CRAWFORD'S TREATMENT AND DEATH WAS BETTER CARRIED OUT AND THE RECOMMENDATIONS ACTIONED

13. Responsible delegation of tasks is a necessary function of senior management in every context. That is particularly so for a senior manager such as Dr Kelly, who at the relevant time was in the invidious position of only being able to work one fifth of his time at work on his role as Medical Director [T12/6/13 P4 L7-8]. (Contrast this with the position now, where "*the modern medical director would have a whole time post, they would have two assistant medical directors, and usually a team around them called a risk management team to effect the policies and the governance agenda*" [T12/6/13 P4 L8-12].)

14. And so it was that on 14th April 2000, Dr Kelly agreed with Mr Mills that the Acute Services Manager, Mr Eugene Fee, should lead the review into the events leading up to the death of Lucy Crawford, supported by the Clinical Director for Women and Children's Directorate, Mr Trevor Anderson. Dr Kelly requested that all Lucy Crawford's medical records be photocopied to assist in the review. Mr Fee spoke with Dr Kelly and confirmed that he would lead the review.

15. The reason these individuals were appointed to undertake the review was that (see [T12/6/13 P43 L21 – P44 L3]):

"Mr Fee is very senior, acute services director but also the senior nurse from the Trust, had experience of doing significant reviews in the past. Dr Anderson is the clinical director and had been for a number of years, and again would have had that understanding of the directorate. So they were two of the most senior people we could have put in charge of it."

16. Parenthetically, Dr Anderson's evidence, to the effect that was not up to the role, is, it is submitted, an unedifying and distasteful attempt to shirk responsibility. As Dr Kelly said, Dr Anderson was a Clinical Director who *"if he's asked to do something and he agrees, he's agreeing"* [T12/6/13 P44 L19-25]. And Dr Kelly deprecated Dr Anderson's bemoaning of his own lack of paediatric expertise as rendering him ill-equipped for a role in the review, noting that *"[y]ou do not always have to have the super specialist of that subspeciality… involved in reviews of this nature"* and that if *"additional pieces of information or understanding"* were needed *"you are allowed to go and get*

them, either source them yourself or bring expertise to bear as required" [T12/6/13 P45 L8-14].

17. In any event, the Chairman will recall the evidence of Dr Kelly at [T12/6/13 P21 L12 – P22 L4 that he told Mr Fee and Dr Anderson that he (Dr Kelly) would support whatever it took to complete the review, that he left it to them to get on with the view, but that they had a standing invitation to come back to him if they had concerns about its direction or wanted advice.

18. Dr Kelly accepts that, notwithstanding the contribution of Dr Quinn to the review, the review did not result in the clear identification of mistakes made leading to the sudden deterioration and collapse of Lucy Crawford [T12/6/13 P159 L19 – 23]. He also accepts that he did not realise at the time that nursing staff and clinicians were not the subject of interviews about their statements. But Dr Kelly's failure to recognise the flaws in both the methodology and the product of the review should be placed in fair context:

    a) Dr Kelly had set up a process where he had regular communication with Eugene Fee. During these regular updates, Mr Fee told Dr Kelly he was talking to people, which Dr Kelly translated (erroneously but, it is submitted, understandably) *"into that he was cross-checking items with members of staff"*, and had Dr Kelly realised

that interviewing neither had taken place, nor was going to take place, he would immediately said it was unsatisfactory [T12/6/13 P161 L8-20].

b) At the conclusion of the process, Dr Kelly was presented with a 67-page document with appendices complete with external paediatric opinion (from Dr Quinn) and concluded that it was *"a substantial and good review"* [T12/6/13 P160 L8-11]. This is understandable: cosmetically, the document must have looked impressive, extensive, referenced and thorough, certainly by the standards of 2000.

19. Dr Kelly accepts the review process was far from perfect in other respects also. For example, the family should, it is conceded, have been involved in the review process. Dr Kelly can now look back and see that the failure of the review to involve the family of Lucy Crawford was an omission, though notes, as did the GMC , that such a failure was not uncommon at the time, sometimes being the product of a misdirected desire to avoid upsetting them [T12/6/13 P59 L9-22]. Whether this is only obvious with hindsight in the light of developments on this front over the past decade or so, or whether it is something that should have been obvious in real time, is perhaps an unhelpful debate to get sidetracked into. (It is, on the one hand, easy to try and excuse the most appalling errors on the basis that the clarity of hindsight is cruel. On the other hand, it is a bit artificial – dangerous even – to acknowledge the benefit of hindsight, then to put to a doctor,

"but you should not have needed hindsight to realise x, y or z", given that the people putting such questions know the result and tend themselves unavoidably to be working back from current standards; in other words, the questioners in such scenarios necessarily possess wisdom retrospectively they are criticising the doctor for not possessing in real time.)

20. The apparent impressiveness (and thickness) of the report, the obtaining of Dr Quinn's view and what appeared to Dr Kelly to be the conscientiousness of Eugene Fee do not, of course, entirely excuse the fact that Dr Kelly did not see what might now appear to be obvious errors. But it is submitted that these factors put into sympathetic context the confidence which Dr Kelly, who could only devote one fifth of his professional time to his role as Medical Director, reposed in the review process and its product at a time when it appears beyond doubt that clinical governance was in its infancy. Reviews of this nature were extremely rare at the time. There was *"no template"* at the time and *"at the time [it] appeared to be a good or a reasonable review"* [T13/6/13 P10 L2-18].

21. Turning to the actioning of the recommendations of the report, in 2000 the report went to Hugh Mills, who shared it with Dr William McConnell and Thomas Frawley, and Dr Kelly was confident that the directorate would address the recommendations. Again, given that clinical governance was in

its infancy, there was no audit process as such to leave a clear trail of this having actually been done [T13/6/13 P33 L20-P35 L24].

22. Putting the matter very shortly, at the time Dr Kelly did his honest and fallible best with the constraints upon him. If the matter were to arise now and he were Medical Director, he would be able to devote much more time to it as that would be a full time job with the support of a Clinical Governance and Risk Management Team. And he would have the collective wisdom of over a decade's development in clinical governance to draw on. It is therefore submitted that he should not be judged too harshly for not knowing then what he knows now.

THE IMPRESSION DR KELLY WAS LEFT WITH FOLLOWING HIS MEETING WITH DR QUINN ON 21ST JUNE 2000

23. This, of course, is closely related to the discussion in the immediately preceding heading in these submissions.

24. As the Chairman will recall, Dr Kelly met with Dr Quinn on 21st June 2000 at Altnagelvin Hospital. Dr Kelly took a careful note of the meeting. Critical portions of that note include:

"Choice of fluid correct
Resuscitation volume higher than normal
…
Fluid replacement 4 hours @ 100 mls provided was greater than normal but not grossly excessive.

Dr Quinn does not feel that the extra fluids caused the brain problem.

…

Dr Kelly asked Is there an issue of incompetence – should consideration be given to temporary suspension. Dr Quinn stated that he saw no reason for suspension. The issues raised by the case are more about recording fluid prescriptions carefully and ensuring clarity of instruction."

25. Those representing Dr Kelly recognise that there is some conflict of evidence between the contemporaneously documented account of Dr Kelly, and the best recollection of Dr Quinn unaided by contemporaneous notes. But perhaps these differences are relatively unimportant relative to what, it is submitted, are the really telling features of this meeting, which are that apparently Dr Kelly:

    a) Was plainly trying to get to the bottom of what had gone wrong.

    b) Asked outright about whether the suspension of Dr O'Donohoe was warranted, on the facts as Dr Quinn saw them.

    c) Was left with the impression that the fluid replacement was "*not grossly excessive*".

26. It is submitted that the way Dr Kelly approached this meeting was, on the face of the records, consistent with his having tried to find out what had gone wrong, shown a willingness to impose discipline on Dr O'Donohoe if warranted, and runs counter to any suggestion that he was party to any attempt to brush events concerning Lucy Crawford under the carpet. In short, he left the meeting with Dr Quinn with the <u>impression</u> that the only

real issue arising related to recording fluid prescriptions carefully and making sure that clear instructions were communicated.

SHOULD DR KELLY HAVE DONE MORE TO ESTABLISH A BESPOKE EXTERNAL REVIEW OF LUCY CRAWFORD'S TREATMENT AND DEATH TO OBTAIN A CLEARER EXPLANATION FOR HOW HER DEATH WAS CAUSED? IF SO, WHAT SHOULD BE READ INTO THE FACT HE DID NOT?

27. The first question posed within this heading answers itself. If Dr Kelly had realised that the review by Eugene Fee and Dr Anderson was imperfect in the ways he now realises it was, then of course he should, and would, have set in train a further bespoke review. And given that the attempts at an internal review had yielded unsatisfactory results, it would have been sensible to the second attempt to be conducted by reviewers appointed externally. But he did not recognise the imperfections of the internal review at the time, so therefore necessarily did not realise a further review was required.

28. As to the second question the heading incorporates, the answer is that nothing (and certainly nothing sinister) should be read into the fact a further, external bespoke review was not commissioned. Despite the fact that Dr Kelly did not realise at the time that the internal review had both been inadequately conducted and borne inadequate fruit, there <u>were</u> further reviews into Lucy Crawford's death (albeit the first of those within the context of a wider clinical review by RCPCH resulting from a list of

complaints made against Dr O'Donohoe by Dr Ashgar). Not only was Dr Kelly fully engaged in those reviews: he wrote the letters instigating each (see letter to Ms Pat Hamilton dated 14th September 2000 [036a-009-016] and again dated 7th February 2002 [032-020-032]).

29. The first further review led to a report prepared by Dr Moira Stewart, and was provided to Dr Kelly behind a covering letter dated 26th April 2001 [035-007-023]. Dr Kelly did not leave matters at the receipt of her report, but met her on 1st June 2001. He made notes of questions he had for that meeting, and took a note of the answers to those questions. He then typed up those notes – both questions and answers [036a-027-067]. One of the answers he elicited is recorded as:

"Overall amount of fluids once started not a major problem but rate of change of electrolytes may have been responsible for the cerebral oedema. RVH ward guidelines would recommend N-saline not 1/5th normal as the replacement fluid."

30. Notably, on the next page of the notes [036a-027-068] Dr Kelly has noted that Dr Stewart told him:

"There is insufficient sub-optimal practice to justify referral to GMC. Cases…do not amount to incompetence but care suboptimal."

31. It is submitted that this meeting demonstrates that Dr Kelly:

    a) Was unprepared simply to leave matters on the basis of the (first) RCPCH report, but rather wanted to probe and explore it with Dr Stewart personally.

b) Was unafraid to confront the issue of whether there had been fluid mismanagement and, if so, any causal role it played in Lucy Crawford's death directly with a doctor from the RCPCH.

c) Was prepared to refer the matter to the GMC, if necessary.

32. In turn, all of this runs flat counter to any suggestion that Dr Kelly was unwilling to talk out loud about what had gone wrong, and what should be done about it. He had instigated this review, considered the product of it, and followed it up orally, all the while prepared to take whatever action was merited.

33. And, as is well known, the second RCPCH review was much more effective than the first in that this time Dr Stewart and Dr Boon reported, and felt able to say that there was "*little doubt*" that Lucy Crawford had died from "*unrecognised hyponatraemia although at that time this was not so well recgonised as at present*" [032-007-011]. Again, it is submitted that this is fruit of Dr Kelly having taken further steps to confront, and get to the bottom of, what had gone wrong, albeit his focus being on issues of clinical competence and wider patient safety.

THE IMPRESSION DR KELLY WAS LEFT WITH FOLLOWING HIS MEETING WITH DR STEWART ON 1ST JUNE 2001

34. The conflicts of evidence as between Drs Kelly and Stewart as to what was said during the meeting between them on 1st June 2001 really boil down to a single critical point. Dr Stewart says that by the end of the meeting, she is confident Dr Kelly was left in no doubt that the probable cause of Lucy Crawford's sudden deterioration and collapse, was the change in sodium and problems with fluid administration [T18/6/13 P76 L4-12]. But Dr Kelly says Dr Stewart left him with the impression that these problems merely could have caused it [T13/6/13 P68 L15-25].

35. Insofar as the Chairman considers this difference of recollection to be of significance, Dr Kelly simply makes the point that:

    a) The first RCPCH report of Dr Stewart [035-007-035 *et seq*] completely fails to identify fluid mismanagement and low sodium as the likely principal culprit for Lucy Crawford's fate.

    b) Dr Kelly is the one with the contemporaneous note of the meeting.

36. As a corollary of the latter point, the Inquiry is respectfully urged to treat with caution Dr Stewart's apparently increasing firmness in her confidence in her own recollection, apparently reaching its apogee when giving oral evidence 12 years after the event, given her lack of a contemporaneous record of her own, and the fact that the nearest thing the Inquiry has to such a record is the first RCPCH report which, with respect, is decidedly muddled when set alongside her current claims for the crystal clarity of her

asserted thought processes and oral communications. Frankly, it is difficult to square what she said in that report with what she now claims to have said to Dr Kelly.

WHEN DID DR KELLY FIRST LEARN THAT NO INQUEST INTO THE DEATH OF LUCY CRAWFORD WAS PLANNED?

37. It has, of course, been suggested that Dr Kelly must have known by October 2001 that no inquest was planned. His position is that he did not know until much later that this was the situation. In refuting the suggestion he knew this by October 2002, he relies upon the note of a meeting at the Bar Library between himself, Patrick Good and Donna Scott [036c-043-101] dated 8th April 2003, in which the following points are included:

"Patrick Good and Donna Scott clearly state should not meet / engage family while litigation is ongoing!

…

Inquest is likely – surprise that one was not arranged before now!

…"

38. Who would be expressing "surprise" that no inquest was yet planned, apart from the non-lawyer present? And who would require a steer not to meet the family of Lucy Crawford apart from the non-lawyer who thought that such a meeting might be a good idea? (Indeed this note of a Bar Library conference where this was discussed chimes with Dr Kelly's recollection that he had *"even used and quoted a phrase at the end of 2002, Lord Justice Woof's, I think it's called 'reaching for justice', which was a concept of*

mediation at the time, that I'd heard in presentations, and I said to the Trust legal team, 'Is there any chance of reaching out to the family through mediation, even if the litigation isn't closed?' And I can share with you that the response twice over was no." [13/6/13 P81 L4-19].)

39. In addition, Mr Simpson QC for the Trust, informed the Inquiry that having referred to the Scrutiny Committee Minutes, (upon which the Trust was claiming Legal Professional Privilege), that *"there is support for that proposition in relation to the meeting of 12th April 2002 insofar as the inquest is referred to..."* [T13/06/13 P1 L18-20] (albeit he also indicated that it was unclear from whom that reference emanated). This followed Dr Kelly's evidence, from the previous day, that he was not aware that an Inquest was not planned: "*I was at those scrutiny committee meetings asking what was happening about the Inquest..."* [T12/06/13 P77 L7-10], and "*I am also asking in 2002, any word yet on the Inquest?"* [T12/06/13 P78 L24-25].

40. None of this is consistent with a Medical Director who had known from an early point an inquest was not planned, and was trying to keep his head down to avoid dialogue with the family of Lucy Crawford. (A point about Dr Stewart's evidence falls to be made here. She seemed to suggest she thought Dr Kelly knew no inquest was planned in May 2001. This suggestion can be disposed of very shortly: it is so far out of kilter with all the other evidence on this issue that it can be summarily disregarded.)

UPON DISCOVERING NO INQUEST WAS PLANNED WAS DR KELLY UNDER ANY STATUTORY OR COMMON LAW DUTY TO INFORM THE CORONER OF THE FINDINGS OF EITHER RCPCH REPORT?

41. The question which forms this heading refers both to the report of Dr Stewart as provided under covering letter dated 26th April 2001 and the 2002 report by Drs Stewart and Boon (the second RCPCH) [032-007-008], which concludes that *"[w]ith the benefit of hindsight there seems to be little doubt that this girl died from unrecognised hyponatraemia although at that time this was not so well recognised as at present"*.

42. The next question therefore is: Was there an ongoing legal duty on Dr Kelly to inform the Coroner of any new information potentially pertaining to the death of Lucy Crawford?

43. A complete answer to this question is provided by Dr Bridget Dolan, at paragraphs 4.35-4.36 or her Report to this Inquiry:

"4.35 In both Northern Ireland and England and Wales there is no general statutory or common law duty of disclosure to a Coroner. The duty to report a death to a Coroner does not extend to requiring other persons to volunteer information about the wider circumstances of a death once the death has already been reported. Specifically once a death has been reported and an inquest is to be held there is no legal duty upon doctors to draw any concerns they might have about the medical management of the deceased to a Coroner's attention after a report has been made by another person.

4.36 There is no duty to provide opinion evidence from third parties who have at some later stage become appraised of facts surrounding the death (for example

where health care staff learn of fact which lead them to suspect medical mis-management by others, or where an expert opinion on the case has been obtained by an interested party prior to the inquest)….

…"

44. There was some discussion about Dr Dolan's views as set out in the passages above whilst the Senior Coroner for Northern Ireland, Mr Leckey was giving evidence. For ease of reference, the relevant passages are found at [T25/6/13 P146 L25 – P 155 L11]. Mr Leckey said he was unaware of authority for Dr Dolan's proposition. It is, with respect, submitted that no authority is needed: recourse to a basic exercise in statutory interpretation is all that is needed. And it is submitted that Dr Dolan's interpretation is the only sensible interpretation that the plain words of section 7 of the Coroners Act (Northern Ireland) 1959 bear.

45. Therefore given that the death had already been reported by Dr Hanrahan on 14th April 2000 [013-053a-290] Dr Kelly was not under any ongoing, or subsisting statutory or common law duty to report developments.

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46. The Chairman may recall that when Dr Fulton provided his evidence to the Inquiry, he expressed his view that Dr Kelly did not tell him about the death of a child (Lucy Crawford), and that this information was likely to be expressed as a *"near miss"* or *"similar problems with Solution No 18"* [T04/096/13 P90 L14-16 & P17-18]. Despite the difference in recollection of

the detail between Dr Kelly's view that he referred to a death (without understandably, breaching confidentiality and mentioning Lucy Crawford's name), and that Dr Fulton states that he recalls Dr Kelly referring to an event or near miss, Dr Kelly endorses the Chairman's realistic view that neither witness is too far apart in their recollection *"so I understand from your memory that that wasn't as clear from Dr Kelly as he recalls it, though it does rather seem as if you're almost certainly talking about the same event..."* [T04/09/13 P92 L15-20].

CONCLUSION THE CHAIRMAN IS INVITED TO REACH

47. The conclusion the Chairman is invited to reach is that Dr Kelly's actions were all motivated by true integrity of purpose, his overriding concern being the welfare of patients, and that any inaction on his part the Inquiry may identify was the result of inadvertent rather than deliberate omission. Moreover, the Chairman is invited to place all Dr Kelly's actions, as well as any inaction, in the contexts prevailing at the relevant times. These include the constraints upon the time he could spend discharging his duties as Medical Director, as well as the fact clinical governance in Northern Ireland was in its infancy and thus there was no template to follow or guidance to assist. It is submitted that if matters are viewed in this way, the Inquiry will feel able to judge Dr Kelly's involvement in the aftermath of Lucy Crawford's death sympathetically, not harshly.

SAM GREEN

23rd October 2013