Tuesday, 10 September 2013

(10.00 am)

Timetable discussion

THE CHAIRMAN: Good morning. Just before we start, Mr Stewart, I want to go over some housekeeping. This will just take a moment or two, doctor.

Two weeks ago, when we resumed, I went through the schedule for the remaining hearings. I need to tweak it slightly, but only very slightly. Instead of the segment about the issues to do with Conor Mitchell starting on Monday the 14th October, I have reconsidered that because the plan I announced was that we would start, Ms Ramsay, on Monday the 14th, not sit on the Tuesday the 15th, and then sit on the Wednesday, but I'm not sure that's terribly good.

So we're going to start on Wednesday the 16th. So in other words, we won't start on the Monday, break on the Tuesday, come back on the Wednesday; we'll start on Wednesday the 16th and we will sit that week from Wednesday the 16th to Friday 18 October and we'll continue into the week of Monday 21 October for as much of that week as is required. I'm not sure we'll need all of that week, but we'll take whatever days that week are required.

In this context I should mention that there is some

outstanding information from the Southern Trust, which we've asked for and we've asked for it by tomorrow.

I'm not sure, Mr Stitt and Mr Lavery, if there's a -- I think both of you can duck for the moment because, as I understand it, there has been no decision yet as to who will represent the Southern Trust in this segment, but I know who your solicitors are. So what I just want to say is that we need the response to the outstanding information by tomorrow as scheduled, and we also then have asked for witness statements from the Southern Trust, as successor to Craigavon Trust, by Friday week, that's Friday the 20th. I'm just emphasising the need for those, so if you could please pass that on to the DLS, thank you very much.

The result of that is that the historic segment of the department's involvement will start on Monday 28 October and will run for the two weeks beginning 28 October and 4 November. That will then lead us directly into the final week, which is Monday 11 November, in which the Belfast Trust and the department will come here with panels to bring us up-to-date with what happens now and how those procedures and practices have evolved and improved since the periods that we're talking about, ten and more years ago. That will be the final week of the public hearings

of the inquiry. Therefore, the last possible sitting day is Friday 15 November.

So it's almost exactly the same timetable as I set out before save that we'll start on Wednesday 16 October, instead of Monday the 14th, and we will also take the week of Monday the 11th to finish. Okay?

As a general point, I know that there has been contact between the inquiry team and DLS and between the inquiry team and the department. This timetable is perfectly achievable, the only thing that might jeopardise it is if information is slow in coming through. At this stage of the inquiry, there isn't any time for further delay, so I'll be hitting fairly hard to make sure that it comes through as required.

Mr Stewart?

MR STEWART: Thank you, sir. I call Dr John Jenkins, please.

DR JOHN JENKINS (called)

Questions from MR STEWART

MR STEWART: Good morning, Dr Jenkins. You have supplied the inquiry with two statements: WS059/1 on 1 July 2005 and WS059/2 on 24 June of this year. Are you content that the inquiry should adopt those as part of your formal evidence today?

A. I am. I have clean copies of both statements. I hope

that's acceptable.

THE CHAIRMAN: Yes.

MR STEWART: Yes, thank you.

You have also provided us with your CV, which appears at 317-044-001. It runs to several pages. On the first page, could I just draw attention to your post at the time of Raychel's admission to hospital, down towards the bottom of your record of employment? From 1 November 1999 to 31 December 2010, you were senior lecturer in child health at Queen's University and consultant paediatrician at Antrim Hospital. Below that is noted your retirement in 2010, from both clinical practice and teaching.

A. That's correct.

Q. Below that you list two governance positions that you held by way of management appointments. You were both a clinical director in a women and children's health directorate and medical director.

A. Yes, correct.

Q. So you have much experience to draw on relevant to our inquiry. Over the page, please, at 002. In July 2003 you were elected from here as Northern Ireland doctor to the GMC in London. And you were appointed in 2009 to the reconstituted GMC.

Below that, in 2005, you were appointed chairman of

the standards and ethics committee. That's of the GMC?
A. Yes.
Q. In London?
A. Yes.
Q. That is the main ethics committee of the medical profession in the UK?
A. The ethics committee of the regulator, yes. There is an ethics committee within the British Medical Association as well, which would give professional advice, but of the regulator, this is the main committee.
Q. Yes.
THE CHAIRMAN: The BMA gives advice to its members and the GMC then enforces the standards?
A. It's an interesting relationship because the BMA, while being a trade union on the one hand, is also a professional organisation, and so seeks to advise its members, but does not have any statutory authority to do so.
THE CHAIRMAN: Right. For instance, in a hearing before the GMC a doctor who said, "I was following the advice of the BMA", might not be entirely in the clear, but would be a long way along the safe path?
A. That would be very supportive, yes.
MR STEWART: You note furthermore below that in September 2003 a post arising from your continuing

education in medical education, a founder member of the postgraduate medical education and training board, and presently you sit as a non-executive board member of the Regulation and Quality Improvement -- the RQIA.
A. Since May of this year.
Q. Over the page at 003, and relevant to our issues, October 2005, the second item under "national", October 2005 to March 2007 you were member of the NPSA working group, which developed the National Patient Safety Alert in relation to reducing the risk of hyponatraemia.
Again, over the page to 004, you note again in the realm of education you were vice-chairman of the Northern Ireland Council for Postgraduate Medical and Dental Education.
So your committees and experience render you ideally suited to comment on much of the issues that concern us.
In your first witness statement, you described at WS059/1, page 3, at the top of the page there, the topic of fluid and electrolyte balance and their disorders as being an area of interest for you. Is that something that you have kept up since your time as a student or has it always been one of your interests?
A. It developed in my second year as a medical student and on my CV I mentioned the Milroy medal, which was

specifically in the field of physiology and so fluid balance would have been one of the things that would have been part of those studies at that time. After qualification, because I chose quite quickly to move into paediatrics, the area of fluid balance was one that was always recognised to be important in the care of children and so my interests would have continued. However, it wasn't to the extent that I would have seen myself as a specialist in that area, which would have been more in the line of Professor Savage, for example, as a paediatric nephrologist. But as it impacted on my duties as a general paediatrician and as a neonatologist, I did see that as an area of special interest.
Q. Because you go on, on the same page, in the second paragraph, halfway down on the right-hand side:
"It was only in reviewing the literature following this that I [this is following 2001] became aware of the papers that had been published on this topic, mainly in specialist journals."
I wanted to ask whether, in fact, you have come across the initial Arieff article published in 1992 in the BMJ.
A. Not at that time.
Q. Can you tell me a bit about the BMJ and its articles?

People don't seem to pick up on them. Is that something you have noticed?
A. Yes, it's something which I think most doctors become aware of. The BMJ is a strange journal in some ways, as I was trying to describe the role of the British Medical Association, there's a sense in which the British Medical Journal also carries a dual purpose. Each week's edition gives news about developments, political developments, and other things, which doctors are interested in over and above the clinical aspects, but it also contains clinical material, some of which are reviews, some of which are original articles reporting research.
In doing so it tries to appeal to the entire breadth of the medical profession. So some of those articles will be relevant to GPs, but not to anyone else. And some might be relevant to only a very small proportion of the profession, a neurosurgeon, for example. So what most doctors do when the BMJ drops through their letterbox at the weekend -- I shouldn't say "most doctors", I'm sorry. What I would have done is to have quickly scanned the news items and then to have looked at the contents page, and to have only then read the abstracts of those papers which seem to me to be relevant to my areas of practice.

Q. Yes.
A. If on reading the abstract of an article, I believed it was indeed an important and relevant matter for my attention or that of my colleagues, I would then usually have torn out that article from the journal and put it into a file in my office, and so over the years I have built up a considerable volume of journal articles in relation to things which I had at the time considered to be important and relevant.
Q. And as a practising paediatrician, one with an interest in fluid and electrolyte management, the 1992 article would have been just such a thing that you would have ripped out and put in your file?
A. It seems, looking at it in retrospect, that that should have been the case. Now, it is also possible that there were weeks when I didn't read the thing at all or when it wasn't delivered or when I missed -- as I said, in scanning the contents page, I might have missed something. But in any case, this article was not in my collection of articles and I had no awareness of it until much later.
Q. Would you have used --
THE CHAIRMAN: Sorry. Is the BMJ published by the BMA or is it an entirely separate --
A. It's not entirely separate, but they are separate

commercial organisations.
THE CHAIRMAN: So it's not that each member of the BMA automatically receives a copy of the BMJ?
A. It is part of one's subscription to receive --
THE CHAIRMAN: Thank you.
MR STEWART: So all doctors get it?
A. BMA members.
Q. Yes.
A. Not all doctors are BMA members.
Q. Most of them would be?
A. A majority, but not by any means an entire ...
Q. If you had extracted that article at that time, would that have been the sort of thing that you would incorporate into your teaching at Antrim?
A. In retrospect, as I looked at that and other articles, it seemed to me that the majority of those had originally been focused on the post-operative period, and as such, as a paediatrician, that was not an area in which I had active practice. So it's unlikely that I would have directly incorporated that teaching into my teaching, which did not deal with post-operative management. But the principles, which had been elucidated in such articles, would be those that I would have wished to make trainees aware of.
Q. Yes, because the Arieff article deals not just with

post-operative children, in fact the article is entitled "Hyponatraemia in Healthy Children", isn't it?
A. In retrospect, I can see that that article had a wider application, and if I had been aware of it at that time, it is likely that I would have incorporated it into my practice and into my teaching, where relevant.
Q. Can we just go over the page here to page 4? 059/1, page 4. It's the last paragraph there, it was something you mentioned, it was a letter published in the Archives of Diseases in Childhood by Dr Playfor, who is a consultant paediatric intensivist in Manchester. You note in this letter he points out that he has recently cared for a 13-month-old girl with a short history of diarrhoea and vomiting, who subsequently died as a result of hyponatraemia.
He went on to point out that:
"Despite clear and repeated warnings over the past few years, the routine administration of Solution No. 18 remains standard practice in many paediatric units."
Do you know what the clear and repeated warnings over the past few years he referred to were?
A. I don't know, but I can speculate. Certainly within Northern Ireland, there was the guidance which had been issued in March 2002 --
Q. Yes.

A. -- and which we had sought to ensure as wide a population of doctors was aware of as possible, including through the publication in the Ulster Medical Journal of an editorial which reflected that guidance. It's my understanding that the anaesthetic community in Great Britain had issued some guidance to their membership on this issue, but I'm not -- never have been a member of that community, so I had no knowledge of exactly what that would have been.
Q. When you first became aware of hyponatraemia locally in terms of the working group set up by the CMO, working towards publication of the guidelines, you must have realised that there was ignorance, as it were, out there in the medical profession about this particular illness and condition. At that stage, did you think it appropriate to incorporate what you knew into your teaching?
A. Well, I think that I would have done that when the guidance had been produced. It was a short period between September 2001 and March 2002 that we were developing the guidance, and we had received a memo from Dr Taylor in the Children's Hospital, alerting paediatricians across the Province at the beginning of October 2001 to the fact that there were moves afoot to produce guidance, and possibly to change the

recommended fluid management. So in that sense it was becoming a topic of interest and concern across the paediatric community.

Q. I wonder, can I ask for page WS008/1, page 15, please? This is not something with which you were personally engaged, but I hope it will set the scene for a chronological run through the events of 2001. This is a meeting of the Sick Child Liaison Group on 26 June 2001; this is really very soon after Raychel died. And your colleague, Dr Jarlath McAloon, was there, as indeed was Dr Taylor, and you'll see running down the page:

"Chairman's Business: Hyponatraemia. BT [Bob Taylor] presented several papers which indicated the potential problems with the use of hypotonic fluids in children. Work to take place on agreed guidelines from the Department of Health on this subject."

So that's quite early on and Dr Taylor knows that the Department of Health is going to look at producing guidelines. And the reason I mention that is that the following day, Mr McAloon, then circulates you with a letter and it's at WS059/2, page 14. This is from McAloon to a number of people and you can see by the received stamp up there in the right-hand corner that you or your secretary received it on the following day,

28 June. You can see that Dr McAloon writes:

"Dear John, you may be aware of the recent concerns about the appropriateness of the use of hypotonic solutions and the issue has recently been highlighted by the death of a child in the Province."

Had you spoken with Dr McAloon after his return from the Sick Child Liaison Group meeting?

A. No.

Q. Was this your first notification or information about the death of a child in Northern Ireland?

A. Yes.

Q. And do you see at the bottom, Dr McAloon says:

"As you know, in the induction programme there is a session on dehydration and intravenous fluids, in which I would like to highlight this new awareness and the consensus, if possible, on management."

In other words, Dr McAloon is noting the relevance of this new information to education. Did you take that forward in any way?

A. Not at that time, but through my membership of the working group.

Q. In June 2001, did you learn anything more about deaths locally from hyponatraemia?

A. Sorry, can I just go back to your previous question for a moment? Just to point out that the document which is

on the screen is my annotated copy of the memo.

THE CHAIRMAN: It's attached to your second witness statement.

A. Yes, and you will see that I have forwarded it to Dr Granger -- it's in the top right-hand side of that page -- because Dr Granger was both of one of the consultant anaesthetists in Antrim Hospital and also the clinical director for surgery, and so would have had responsibility for paediatric surgery. So I was unaware as to whether Dr McAloon -- his circulation list was to consult paediatricians. I wanted to ensure that the surgical side of the house and anaesthetic side of the house were also aware of this. And I'm sorry, if you could repeat your most recent --

MR STEWART: That's a perfectly proper thing to point out. I was asking about what other information you had coming to you in June 2001 about deaths from hyponatraemia in Northern Ireland.

A. I'm not aware that I received any further information over the summer period.

Q. I wonder can I ask for page 068b-036-247? This is from a transcript of an interview you gave to UTV on 7 June 2004. I wonder can the previous page, 246, be shown next to it so we might read the question? That's the bottom of the left-hand page. The questions are

slightly hard to follow:

"But in [sic] was there because the Royal dealt with the two cases was it the Royal you think that brought it to the attention of the medical community here that they were seeing children coming through that seemed to be suffering from or had suffered from hyponatraemia?"

And you answer:

"Well, certainly informal contact was made and that was in June 2001 where a colleague working in the intensive care unit in the Children's Hospital in Belfast made contact with a number of paediatricians, saying that they had seen a second child who again unfortunately died of this condition, and that they felt that the current fluid regimes while they had been in place for many years (and were indeed used throughout the UK) really needed to be looked at again, and that was where the process started, before the formality of the working group."

So you were asked:

"Who was that in the Royal did that?

"Well, the contact that I'm aware of was from Dr Bob Taylor.

"So Dr Taylor, having spotted these coming through in the intensive care unit, alerted the medical community here that there had been two cases,

Lucy Crawford and Raychel Ferguson, within 14 months of each other?

"That's my understanding; it's certainly how I became aware of it and how the process started to try to bring something good out of these two tragedies, if we can do a little in that respect."

Is that an accurate transcript of that interview?

A. I cannot recall the interview, but I had seen it shortly after the time, and I have no reason to say that it is not an accurate record of what I said.

Q. Is it correct to say that Bob Taylor made contact and was telling you and your fellow paediatricians that there had been a second death in the Children's Hospital in Belfast?

A. Well, I cannot now reflect exactly why I used that form of words in 2004. This was in May 2004, I think, when I --

Q. June, yes.

A. -- when I was interviewed. And at that time, this was what I had in my mind as being the sequence of events, but as I have looked over all of the paperwork, which I still have, and my best recollection of all that happened, I certainly was not aware of a second child at that time. So I'm unclear as to whether I'd simply confused my timings whenever I gave that response to

Mr Birney.

Q. How could you have confused it? Because you're saying here that there are two deaths -- Lucy Crawford is one, Raychel Ferguson the other -- and within 14 months of each other:

"That's my understanding. It's certainly how I became aware of it and how the process started."

How could there be a misunderstanding?

A. Because I think I was confused in relation to the dates, and that was also the reason why, at a different point in the interview, I identified Lucy as being one of the two children.

Q. This is an explanation of what you heard. You see the top paragraph there, you say:

"That was where the process started, before the formality of the working group."

In other words, this is put in a time frame before the CMO's working group is established, before the formality starts.

A. Yes. What I intended there was that the contact from Dr Taylor had taken place before the formality of the working group had started.

Q. Yes. And was that contact from Dr Taylor to say that there were two deaths or there had been?

A. Well, that is what I'm now unable to recall. The

contact had not been with me, so I -- in retrospect I can see that I was unclear in the way in which I spoke to Mr Birney because I was reflecting a contact which had been made through a colleague and I was speculating unwisely as to exactly what information had been provided at that time because of what I then had later learnt.

Q. Well, with respect, it doesn't sound like speculation; it sounds like a clear recollection. And furthermore you do say there:

"Well, the contact that I'm aware of was from Dr Bob Taylor."

Who was the contact with?

A. With Dr McAloon.

Q. And furthermore, it seems to be your understanding that there were two deaths that were 14 months apart.

A. Yes, yes, I can see that, but what I'm attempting to explain is that as I now look at it, my understanding is that I had put the information together retrospectively, and incorrectly, as to the timings and the identities of those two children.

Q. I'm struggling to understand how you can have put it together incorrectly because what you say is so clear there. So what you're saying now is that contact was made by Dr Taylor with Dr McAloon in June 2001,

probably, before the formality?

A. At the time that Dr McAloon then sent the memo, in which he only mentioned the death of one child.

Q. Yes. But it seems that, at least in 2004, it was your understanding that two deaths had been referred by Dr Taylor to Dr McAloon.

A. That was what I said at the interview, but I am now -- I'm unable to explain why that was my understanding because certainly I was not aware of any second death at that time.

Q. Of course, your recollection then would have been fresher than it is now.

A. Well, I'm quite clear in my mind that I was not aware of any second death for a considerable period after that.

Q. Can we go on to page 251 of this document? It's the bottom paragraph, and you say:

"It may be that in looking back, we could see ways in which this could have been recognised more quickly, although I have to say that the two cases out of the thousands of children who are treated in this way and while there were common factors in the two cases, i.e. the hyponatraemia, there were also different situations: one child had an operation, one didn't; one was older, one was younger; so there were differences as well."

So you're discussing there with your interviewer the

two children and the differences between them. Can you have done that if you were confused?
A. Yes, but at this point this was in 2004, so I had all of this information in 2004 and what I was saying was that we -- that is the medical community in Northern Ireland -- could perhaps have picked this up more quickly.
Q. And the last question is:
"It was, how can I put it, so important that Bob Taylor took those two cases to the chief medical officer back in June 2001. I'm not sure that he took them to the chief medical officer, i.e. I'm not fully aware of the circumstances that led to her being fully informed of this, but by whatever method certainly it came to the attention of the paediatric community and was taken forward from there."
So again, you were still clear later on in the interview that there were two cases.
A. Yes, but not in June 2001 --
Q. That's the question, you see. It's June 2001.
A. Yes, but that is not what I intended by that answer. When I was saying it came to the attention of the medical community, I didn't say it came to the attention in 2001.
THE CHAIRMAN: So as I understand it, doctor, what you're

saying is that, notwithstanding this transcript, you weren't aware of Lucy's death in 2001 and what then happened, by the time you were interviewed by UTV in 2004, was that you were aware of Lucy's death by then, you were obviously aware of Raychel's death, and you were aware of Adam's death?
A. No, I was not. At the time of my interview I was not aware of Adam's death.
THE CHAIRMAN: So in reading this, we can disregard Adam completely?
A. In my mind, there were two children, and they were the two who I have become aware of at different points in time and they were Raychel and Lucy.
THE CHAIRMAN: Okay. So you went all the way through the working group without ever hearing or knowing anything about Adam Strain?
A. That is correct. And Mr Chairman, if I can -- I think it was the previous pages that you were showing me, I said something about how it was through my involvement with the inquest that I came to my knowledge of these. So I'm seeking to explain.
MR STEWART: Which page is that?
THE CHAIRMAN: Can we bring back up again 246 and 247 from the same sequence? That's 068b-036-246 and 247, please.
MR STEWART: Yes.

THE CHAIRMAN: Is that what you were referring to?
A. Yes. On the left-hand page, the penultimate question:
"Well, what is your information?
"Well, I suppose from my point of view I became aware of them [and those were the two cases] because the trusts concerned asked me to look at the details and in relation to the coroner's inquests."
Et cetera.
MR STEWART: So you're saying you only became aware of Raychel Ferguson when you were asked by the trust to look at it and write a report?
A. The identity of Raychel Ferguson only became known to me when I was asked to become involved.
Q. Leaving aside the name of the individual and reflecting upon the case itself, you were aware of the case itself from the time you were co-opted on to the working group?
A. Not in detail because I was unable to attend the September meeting.
THE CHAIRMAN: Yes. I think we need to be careful. When Mr Stewart says you were aware of the case itself, the letter from Dr McAloon that's just been referred to, you were made aware of a case; is that the difference you're making? You're aware of a case of a child who has died, but you don't know from that letter at that point that it's Raychel?

A. Well, I ... The information that came to me was that there had been the death of a child in Altnagelvin Hospital.
THE CHAIRMAN: Okay.
A. I did not know any further details.
MR STEWART: Did you speak to --
MS GOLLOP: I hesitate to interrupt. I wonder if I can possibly help with a little bit of clarification here because I think the sequence of events might get muddled, and I'm conscious of not wanting to put words in the witness's mouth.
THE CHAIRMAN: Good.
MS GOLLOP: But the facts are, I think, there was the memo from Dr McAloon in June 2001, which clearly referred to Raychel Ferguson, and I think this witness's evidence is that he was aware of that death and clearly received that memo, and we know that from his handwritten annotation that he received it in June 2001, and either was at the time of receiving that memo or afterwards became aware that that was Raychel Ferguson.
The working group, as I understand it, had its inaugural meeting in September 2001, at which meeting Dr Jenkins wasn't present, but that's when it started, and Dr Jenkins again, as I understand it, as a matter of fact that's already before the inquiry, was instructed

by DLS to prepare an expert report for the purposes of a clinical negligence action in relation to the care of Lucy Crawford. And that letter of instruction, which is a privileged document, which therefore the inquiry doesn't have, is dated February 2002. And Dr Jenkins' report is dated 7 March 2002. Whether he subsequently, by the time he came to be interviewed at some length, it would appear, by Mr Birney in June 2004, having already at that point attended and given evidence at the inquests of both Raychel Ferguson and Lucy Crawford, had got matters somewhat mixed up, is a matter for the inquiry. But that is the factual sequence of events.

THE CHAIRMAN: Well, yes, insofar as that's a factual sequence of events on the documents.

MS GOLLOP: Yes.

THE CHAIRMAN: But what we're exploring is whether there's actually more of a factual sequence which isn't just about documents and around discussions. I'll let Mr Stewart come on to this in due course about what was known or not known by members of the working party because, as I said a few days ago, I'm somewhat at a loss to understand how a working party can meet to draw up guidelines following the death of a child or children and not be aware of the number of deaths to which those guidelines are relevant because if you're

drawing up guidelines you'd surely want to test them against the deaths of the children which have led to the guidelines being introduced.

MS GOLLOP: Noted.

THE CHAIRMAN: What I understand from Dr Jenkins, from what he has already said and what he said in his statements, is he was a member of the working party, but wasn't aware of Adam's death, so he would not have known from his work in the working party whether the guidelines which were drawn up would cover anything to do with Adam Strain.

A. I may be able to help you, chairman.

THE CHAIRMAN: Yes, if you can start to put me right on that.

A. I'll certainly not try to put you right because I think you have described exactly the sequence of events in the minds of the working group, and that was to develop guidelines and test those against the cases of which people had awareness. So at the time I became involved in drafting guidelines I was only aware of the one death, which was Raychel's death. I had no knowledge of whether other members of the working group had knowledge of other deaths, obviously because I wasn't aware that there were other deaths at that time. So the way in which we would work in those circumstances is we'd go

back to the basic principles, the physiological principles, the knowledge of fluid balance, the existing guidance, and we'd test that against the literature that we're now aware of, which demonstrates the failure of that guidance to take account of rare situations. And we seek to write guidance or revise guidance in order to address those deficiencies.

And you're absolutely right that an essential part of that process is for that guidance to be tested against individual cases that took place. And certainly I regarded it as my responsibility to test the guidance against the knowledge that I had and subsequently was afforded to me, as has just been described, through my involvement in Lucy's case, which was in a different forum, but which provided me with knowledge, albeit in a sense privileged knowledge, in February of 2002. And so I would have wanted to test the guidance as it had been developed at that point, and indeed finalised prior to that point, against my knowledge of the two cases, which were the only two cases I was aware of.

If I can just say, finally, this was also the process that was undertaken by the NPSA, as Mr Stewart has helpfully pointed out my involvement in the external reference group in 2005 to 2007. It followed exactly the same process that the reference group did not

undertake a detailed analysis of any individual case, but we became aware that there had been a number of cases, and so we developed guidance and we expected those involved and the clinical community to review that guidance and to identify if it failed to address those issues.

THE CHAIRMAN: We'll develop this maybe later, but it strikes me as curious that the members of the working group who helped draw up the guidelines then tested them against deaths which they individually knew about but which were not known about by other members of the working group.

A. Yes.

THE CHAIRMAN: Do you understand why, to an outsider like me, that sounds like a curious way of going about things?

A. I fully understand that, and in retrospect, to me, it also sounds perhaps to be curious. But I can perhaps speculate, if you like, as to two reasons why that might be the case. The first was that the working group, to the best of my knowledge, only met on one occasion, the September occasion, formally. And the drafting of the guidance all took place by e-mail, and I know that the inquiry has seen the e-mail trail.

THE CHAIRMAN: Yes.

MR STEWART: I'm sorry, sir, I regret to interrupt you, but I don't think we have. I don't think we've seen your e-mail trail for a start, have we?
A. There's certainly at least one, and possibly two, e-mails from me in the CMO file 7 e-mail trail, which was the correspondence collected by Dr McCarthy as she coordinated the comments of the working group. The reason this was done by e-mail rather than by --
Q. Could I interrupt? I think it might be better to go through this process in a methodical step-by-step way rather than allowing you to comment on individual parts of it without reference to the scheme.
THE CHAIRMAN: I think that's fair, and to an extent, doctor, I began to go off track and you followed me off track. So we'll go back on track with Mr Stewart and then we'll come back, we'll round off any of the points that are left hanging later.
MR STEWART: Please be assured you'll have every opportunity to say all that you wish, but I think it might be better if it were set out in a more straightforward way.
A. Sorry, I was simply responding to the question.
THE CHAIRMAN: You're quite right. It's my fault. Mr Stewart's really blaming me!
MS GOLLOP: Can I just suggest Dr Jenkins finishes off his train of thought in case that gets lost and then we go

back to Mr Stewart's questioning?
MR STEWART: Would you like to finish your train of thought?
THE CHAIRMAN: I think the point you were making, doctor, is that you were going to speculate on two reasons why the working party might have operated in the way that it did.
A. And they're very simple. The first is that we were aware of the urgency of having this work completed, bringing busy professionals together to meet in a room in Castle Buildings in order to do guidance would have taken forever, and that was the main reason why this was done by e-mail. And the second reason, possibly -- and I am speculating -- that individual doctors might have been reluctant to mention individual cases was in relation to issues of confidentiality.
MR STEWART: Whose confidentiality?
A. The confidentiality of those individuals.
Q. The patients or the doctors?
A. Of the patients.
Q. Can't that be very readily anonymised?
A. That's possible. I'm only speculating because, as I say, I was not aware of any other cases.
Q. As I understand it, you're saying that individual cases are very useful against which to test your guidelines, but that was something which you did later on in the

process, you drafted the guidelines first?
A. It was something which I was not personally involved in. I was part of the drafting group. The guidelines were being produced by the Department.
Q. So the group would be interested to gather up information in relation to specific cases because they were going to use those cases to test the guidelines, so there was interest in obtaining, receiving and collecting the information?
A. That would have been an alternative way to have approached this.
THE CHAIRMAN: Doctor, I can understand your first point, I understand that paediatricians and others can't just drop things and go up to Castle Buildings. It's awkward even for people in Belfast, but for people travelling further afield whose primary duty is to their patients, I can understand how that will lead to some e-mail exchanges in order to try to reduce the number of exchanges. I don't have a problem in principle in that.
I do have a problem -- and, to be fair to you, you were speculating on this -- about how the reluctance to discuss other cases as part of a group might have been on the basis of protecting the confidentiality of dead children. I have to say, that seems to me to be a very significant stretch and I can't think that if any of the

parents of these children had been approached and told, "We are working on ways to improve the Health Service, do you mind if we share the information about your dead son or dead daughter with other specialists on this working party?", that any of them for a moment would have said no.
A. I accept that, and as I said, it was a speculation. And since I had no such information, I wasn't in a position to have to make that judgment.
THE CHAIRMAN: Thank you.
A. I think it would have been easier, if I might just complete, for doctors to have shared that type of information in a face-to-face meeting other than in e-mails.
MR STEWART: Yes.
THE CHAIRMAN: It would also mean in Lucy's case telling her parents what had actually gone on, and as you know, one of the concerns -- we have to be careful about the way it's dealt with in this inquiry, but one of the concerns is what lessons did come out of Lucy's case and whether more could have been picked up before Raychel went into Altnagelvin just over a year later.
A. Yes.
MR STEWART: Did you have any contact with Dr Taylor yourself over the summer of 2001?

A. No.
Q. Did you learn anything during the summer of 2001 about other cases of hyponatraemia in Northern Ireland?
A. No.
Q. Did you receive an invitation to join the working group in August of 2001?
A. I can't recollect exactly when the invitation came, but it was, I believe, from Dr Darragh.
Q. Yes. Can we look at 007-050-099?
THE CHAIRMAN: Just as that's coming up, in fact you didn't know anything, you hadn't yet been engaged in Raychel's case in the summer of 2001; isn't that right?
A. No.
THE CHAIRMAN: That came later. So by the time you were moving on to this working party, you weren't aware about the details of the deaths of any children?
A. Other than that a death had occurred. That is the only information.
THE CHAIRMAN: You were aware of the fact that there had been a death because that is from Dr McAloon's letter?
A. Yes, and from the grapevine I knew that had been in Altnagelvin, but that was the only information I had prior to the initiation of the working group.
MR STEWART: Can we have a look at 021-056-135, please to see what sort of information might have been available

to you on that grapevine. This is Dr Carson writing to the CMO at the end of July 2001, and he's been talking to Bob Taylor, and he informs the CMO and he also informs Raymond Fulton at Altnagelvin that the anaesthetists in the RBHSC would have approximately one referral from within the hospital per month:

"There was a previous death six years ago in a child from Mid-Ulster. Bob Taylor thinks there have been five to six deaths over a ten-year period of children with seizures."

Was that the sort of information that was coming to you?

A. No.
Q. Do you know Dr Fulton? Did you know him then?
A. Only by name.
Q. Do you know Dr Carson?
A. Yes.
Q. And you knew Dr Campbell, the CMO?
A. Yes. Primary communication, as we saw from the memo of June, was between Dr Taylor and Dr McAloon as the lead from the Antrim team on this liaison group.
Q. I'm asking what might have been available to you on the grapevine, not primary, formal communications. Do you know how it was you came to be selected and included on the CMO's working group?

A. No.
Q. Were you sounded out and approached before you got the formal letter of invitation?
A. No. I mean, again, if I had to speculate, it might have been related to my membership of the specialist advisory committee, the paediatric specialist advisory committee, but I don't know, and I just received the letter along with every other member of the working group, I assume.
Q. And that was 21 August 2001, the letter won't come up on the screen, sadly, but it is a pro forma round-robin letter.

At that stage, when you received the invitation to join the working group, did you know who else might serve on that group?

A. Unless it was -- unless there was a circulation list on the letter, I would have had no way of knowing who else was going to serve on the group.
Q. But you might have been on the phone to some of your good chums to ask, what's happening, is this Bob Taylor, who else is on it?
A. I certainly didn't do so.
Q. You didn't do so? Do you sit on so many committees that you're not interested in who else might be with you or what you can do?
A. Well, I'm interested in what the group is being set up

to do, but I'm quite happy to wait until I either attend the meeting or see minutes of the meeting to find out who else is involved.
Q. All right.
A. I certainly don't try to prejudge meetings by phoning round in advance to see who else is involved.
Q. I wasn't suggesting you prejudge a meeting, but you might be curious to know who your colleagues were serving on the group.
A. I was -- I made no such contact.
Q. Can we please see 007-048-094. This is the first meeting. This is the first meeting, 26 September 2001, that's the meeting in Castle Buildings that you referred to that you couldn't attend. Also on the committee we can see, apart from Dr Darragh who you have mentioned, Dr Taylor, Dr Nesbitt from Altnagelvin, Mr Marshall from the Erne, and Dr Loughrey from the City Hospital, who wrote the chemical pathologist's report in Raychel's case, and of course Dr Crean and yourself.

Why was Mr Marshall there, do you know?

A. No.
Q. Dr Lowry, what was his expertise?
A. Dr Lowry, as far as I understand it, was an anaesthetist. My understanding was that this was a group who had been selected to represent the breadth

of units in which paediatric care was provided across the Province.

Q. Yes, but they also may have been selected at least in part because of their knowledge of some of the more recent cases of hyponatraemia. Certainly Dr Taylor knew of Adam, he knew of Lucy, he knew of Raychel. Obviously Dr Nesbitt --

MR UBEROI: I rise for clarification on a point I raised last week. There is some uncertainty about that and I think it needs to be trodden around more carefully than my learned friend has demonstrated there.

MR STEWART: I did not say Claire Roberts. I said Adam Strain, Lucy and Raychel.

MR UBEROI: Even for example in the case of Lucy, one of the chairman's interventions during that part was to the effect that there was significant doubt as to whether that death was ever presented at a mortality meeting, so I think there is uncertainty about it and I think it needs to be trodden around more carefully than that.

MR STEWART: I'll come back to that if I may.

Dr Nesbitt certainly knew about Raychel's case. Dr Loughery knew about Raychel's case. Dr Crean knew about Adam's case, he knew about Lucy's case, he knew about Raychel's case. So it might look as though some members had been selected because of their specific

knowledge of specific cases.

A. You would have to ask those who decided on the membership of the group as to why they selected individuals.

Q. Dr Taylor is then noted at paragraph 2 as:

"... informing the meeting about the background, incidence of cases seen in the RBHSC, and patients who are particularly at risk of hyponatraemia."

He is noted as having said that this is a problem that's been present for many years. Were these notes sent to you immediately after the meeting?

A. I have no recollection of when I received them, but I did definitely receive them.

Q. Well, may we assume that it was shortly after the meeting?

A. No, I don't think so. It's quite common for minutes not to be circulated until sometime after a meeting takes place.

Q. How long a gap might intervene?

A. Up to a month.

THE CHAIRMAN: That might well be right, but in a group which is not going to have regular meetings because of the urgency of bringing in guidelines, one would hope and expect that there might be some greater urgency to it than that.

A. Yes, and it may well have been the case. I'm not in a position to say when I received the minutes.

MR STEWART: You see there Dr Taylor informs that meeting of the incidence of cases seen at the RBHSC. And we know that Dr Taylor prepared a bar chart, which purported to show the incidence of hyponatraemia in the RBHSC. We know that Dr Taylor shared that with Dr Darragh, who is there, and we know he shared it with Dr Nesbitt, who is also there. Did you see the bar chart?

A. I'm not aware that I did.

Q. Perhaps we'll just have a look. It's at 321-020a-034. Have you seen that before?

A. I have seen it more recently as part of the inquiry papers.

Q. Did you see it at the time you were serving on the working group?

A. That's not my recollection. I have no record of having seen it at that time.

Q. Can we go, please, to page WS059/2, page 16? We have a letter sent to your colleague, Dr Jarlath McAloon, and it's from Bob Taylor, and it seems to have been received by 1 October 2001 by Dr McAloon, and he forwards a copy to you, and in fact to all consultants, and your receipt is signified by the stamp in the bottom right-hand corner, 2 October 2001.

If you look to the third paragraph down, the final sentence:

"Dr Taylor states I have also audited our incidence of admissions to PICU with hyponatraemia."

When you received that, you were a serving member of the working group for the CMO and you receive notification there that Dr Taylor's gone to the trouble of auditing the incidence of hyponatraemia in PICU. What do you do when you learn there's an audit of admissions?

A. I didn't take any action in respect of that.

Q. What did you think when you received that information?

A. I don't think that any particular thought process took place.

Q. Might it not have occurred to you that this was useful information for your work on the group and that perhaps you should find out what the incidence was?

A. No.

Q. Why didn't that occur to you?

A. Well, I can't say. All I can say is that the focus of the working group was on developing guidance. And I saw my role as being part of that process, not undertaking an audit of cases.

Q. Well, Dr Taylor thought it was part of the process and he thought Dr McAloon would be interested in that too.

A. Well, he had done this audit because he worked in the unit where the specialist care was being provided.
Q. Yes. And for that reason, he had some figures which he thought relevant to the work of the working group.
A. He may have done, but it was not brought to the attention of the working group.
Q. If you go down to the final sentence in this letter, Dr Taylor says:

"I think you may be getting a few letters on this topic as I have discussed the subject with as many colleagues as possible."

You're a colleague who's serving on the same working group. Did he discuss this topic with you?
A. As far as I understand it, the topic that he mentions in that sentence is the topic of hyponatraemia and the development of guidance and not specifically the audit.
Q. Well, he does mention specifically the audit and he mentions it in the context of people who might be interested in it for the purposes of the working group. There must have been discussions. Quite clearly here he refers to "discussions with as many colleagues as possible".
THE CHAIRMAN: If I take your point, doctor, that one interpretation of this letter is that there's a debate which has emerged about whether, if you move away from

Solution No. 18, what you move to, and whether the replacement fluid should contain 0.45 per cent sodium. And there is some toing and froing about that. In other words, it's a perfectly reasonable debate. "We're going to move away from Solution No. 18, but what are we going to move away to?", is the gist of it, isn't it?
A. Yes. There was an attachment to this memo, which was draft guidance, and the focus of the memo, certainly in my mind -- and as I understood it in Dr Taylor's mind -- was to circulate that draft guidance as widely as possible so people could comment exactly on the issue you've mentioned.
THE CHAIRMAN: But again, when people who are experts like you are being asked for their contributions on this or being forwarded this for their information, you can have your different views, but one thing that you all seem to be working in the absence of is information about the circumstances and incidence of hyponatraemia.
A. Yes.
THE CHAIRMAN: Well, I think it's gone round in a bit of a circle because I'm not sure how you resolve issues about what the guidelines should be, or a more specific point about what we move away from Solution No. 18 to, unless you all know the details of how the problems have emerged in different cases. Because it might be that,

with some children, moving to 0.45 would be acceptable; it might mean that in other children that might be an improvement, but there's more that could be done. But you won't know that, and the group won't know that, if everybody's working at this point on their individual knowledge rather than a collective knowledge.
A. Yes. Well, the collective knowledge was the knowledge, as I've described it, of the underlying physiology and the principles and the literature and the added value that the group brought at that point was to draw together the different areas of expertise, if you like, from the anaesthetic side, the paediatric side, the chemical pathology side and try to draw that together into a draft guideline which could then be tested against whatever cases people were aware of.

If I can also point out that at the beginning of the third paragraph Dr Taylor specifically mentions the death of only one child.
THE CHAIRMAN: Yes. Well, I have to say that's unfortunate, because there was more than one child's death known about.
A. But certainly in my mind, I was only aware of one death and he only mentioned one death.
THE CHAIRMAN: Thank you.
MR STEWART: Can we move on? Did you attend any meetings of

the working group?
A. I looked through my papers and I have no record or recollection of having any further face-to-face meetings. In fact, any, because I wasn't at the first meeting.
Q. Okay. Can we go to 007-038-072 and 073? It's not available.

This is a two-page, handwritten memo of a meeting of the working group, which took place on 10 October 2001 and is referred to by Dr McCarthy in her witness statement WS080/1, page 5. It deals, as indeed you were indicating a moment ago, with much of the debate about the nuts and bolts, as opposed to the incidences, of hyponatraemia. But of interest to me, the individual participants are noted by their initials. "JJ" I take it is you?
A. Yes. It's unfortunate I can't see the document.
Q. Yes, I'm sorry about that. (Pause). There's a copy for you and I hope by lunchtime it can be on the screen. (Handed).
A. Thank you.
THE CHAIRMAN: Could we just try it one more time so that the public can see this? Okay, the reason why it's not available yet is it's part of the departmental papers, which are not yet available publicly. So when this

becomes publicly available, it will be 007-038-072, but we'll try to put this one up as the morning goes on.

MR STEWART: Perhaps I could read into the record what Dr McCarthy says about this meeting and of the meetings in general. She says:

"The first meeting was chaired by Dr Darragh, after which I chaired a subgroup responsible for drafting the guidance. In addition to the original members of the group Dr Maurice Savage, RBHSC, was invited to participate and a second meeting was held on 10 October 2001, at which it was agreed that further communication would be via e-mail."

And she gives the reference from these pages as 007-038-072.

MS GOLLOP: Sorry to interrupt, but we've got two pages of 073 and I just want to check that the witness has 072 and 073. A copy of 072 would be appreciated if someone could hand a copy back.

MR STEWART: I do apologise. We may come back to this and we'll supply it in due course.

A. Can I just say that I stand corrected? There must have been a second meeting. I had no record of it. I also haven't seen Dr McCarthy's witness statement, so I have no knowledge of that.

Q. Yes. Can I ask, I take it the initials "PC" is Peter

Crean and "JMcA" is Jarlath McAloon?

A. I have no memory of this meeting, but yes, I suspect you're correct in those assumptions.

MS GOLLOP: Sir, can I suggest that we do come back to this when everybody has the document? I'm finding myself somewhat handicapped.

THE CHAIRMAN: Okay.

MR STEWART: There's no great point arising out of this document, so please don't be concerned.

I wanted to ask you merely this one question, that Dr McAloon does not appear at the first meeting of the working group as being a member of the working group, and yet he appears to be e-mailed in to some of the correspondence and he appears here at the second meeting. Do you know how that was?

A. No, I wasn't aware of that, but I don't understand that. He certainly was an active member of the drafting subgroup.

Q. He was?

A. Yes.

Q. Perhaps the list of membership is incomplete.

I wonder can we now move to 012-071e-412. This is a letter from Dr Bob Taylor to the Medicines Control Agency. Part of this correspondence was sent to you; is that correct?

A. I'm not sure. At that time, I'm not sure. I'm not on the copy list.

Q. You do make reference to it in your witness statement at 059/1, page 2.

THE CHAIRMAN: This is the alert or the yellow card, Mr Stewart? Is this the yellow card?

MR STEWART: Yes, this is the yellow card that Dr Taylor reported.

You see the second page, second paragraph:

"Dr Bob Taylor [you advise], consultant paediatric intensivist to the RBHSC, informed the Committee on the Safety of Medicines of his concerns in October 2001. He received an initial reply in November 2001, followed by an substantive reply dated 26 November 2001 from the Medicines Control Agency, copy enclosed for information. No amendment was made to the product information relating to this solution."

We do know that Dr Taylor copied Dr Nesbitt of the working group into this correspondence, and we also know that he copied Dr McCarthy of the working group into this correspondence. I can take you through those references if you want. And I take it from your reference to the correspondence in your first witness statement that you were aware of it and you were probably also copied into it.

A. No, I certainly accept that I was aware of it, because Dr Taylor had agreed to do that and reported back subsequently that he had done so.

Q. Yes.

A. But I have no recollection -- and in fact I do not believe that I received a copy of this, of the letter itself.

Q. And you were able to pick up the letters and their dates from the inquiry website or what?

A. At the time I was doing my report in -- I think in 2005 -- I could have picked them from the website or I could have picked them up from the discussions that had taken place when Dr Taylor had reported back to the working group, particularly in terms of the response. Because I remember discussing this response with Dr Taylor in the context of our preparation of the paper for publication, in which we wanted to refer to his communication with the MCA and their response.

Q. The letter on the left, on 23 October 2001, he has sent in the yellow alert to them, it may have come back and they've asked:

"Could you please give us some information about this patient RF?"

Raychel, and he does so in ten numbered paragraphs. The part I wish to refer to is the last sentence, in

which he advises Dr Cheng:

"I am also conducting an audit of all infants and children admitted to the PICU with hyponatraemia. My initial results indicate at least two other deaths attributable to the use of Solution No. 18."

He brought this letter to the attention not only of Dr McCarthy and Dr Nesbitt, but also to the coroner at that time, and to Dr Herron, who wrote the post-mortem report, who of course was working with Dr Loughery on the post-mortem report, and she sat on the working group. Was this letter discussed to the working group or the content discussed?

A. No. This letter, of course, post-dated the second meeting of the working group which you've now made me aware of.

Q. Was information exchanged by e-mail then in relation to this correspondence?

A. Certainly not to my knowledge. And not in the e-mails that I have made reference to, which I understand to be the record of all of the e-mails that were exchanged.

Q. But we know that at the very first meeting Dr Taylor more or less opened the discussions of the group by referring to the incidents and we saw the reference to him circulating information about incidents at RBHSC. And here's correspondence which is also circulating the

working group, in which again he comes back to his audit.

A. Well, I don't believe it was circulated to all the members of the working group and I certainly have no record of receiving it.

Q. Do you recollect any discussion, exchange or reference to it in your e-mails with other working group members?

A. No.

Q. Or any discussions with working group members individually or collectively?

A. Not in relation to the content of this letter. There was discussion in relation to what we perceived as the lack of responsiveness of the MCA to the concerns that had been raised about this solution.

Q. In October 2001, how many deaths were you aware of from hyponatraemia in Northern Ireland?

A. One.

THE CHAIRMAN: And that was still in a general way, it was a child in Altnagelvin?

A. Yes.

THE CHAIRMAN: You still weren't aware of Lucy?

A. That's correct.

THE CHAIRMAN: And you weren't aware of anybody else?

A. That's correct.

MR STEWART: You mentioned earlier on the specialty advisory

committee on paediatrics, upon which you sat. And it seems that such a meeting of that took place very soon after this letter was written on 30 October. Can we go, please, to 320-055-001?

This looks like it has been corrected to date it as at October 2001. I draw this to your attention -- you in fact were present at this meeting because, if one reads through the minute of the meeting, your name appears on numerous occasions as having made contributions, confirmation, summaries and so forth. But you're not actually mentioned in the list at the top.

I draw this to your attention because this is an occasion during the course of the working group deliberations where the chief medical officer, Dr Campbell, met with no fewer than seven members of her working group on hyponatraemia. And apart from yourself, there's Dr Crean on the left-hand side. On the right-hand, Dr McAloon, Dr Taylor as a representative and, on the bottom left, Dr Kennedy was part of the working group. We've got Dr Darragh and Dr McCarthy and yourself.

The issue of hyponatraemia and your work was referred to at that meeting, and it's at 320-055-006. In "Any other business":

"Dr McCarthy refers to hyponatraemia and summarises the brief guidelines on the prevention of hyponatraemia in children receiving intravenous fluids. Members welcomed the guidelines, which will be published soon."

So that would suggest that the drafting is well advanced.

A. At the end of October, we were certainly in the process of drafting. I'm not sure how I can distinguish what well advanced was because there was still a lot of debate which went on until the end of the year. But, yes, there was a draft at that point, which, as I understand it from these minutes, was what Dr McCarthy referred to, but this would have been a very short issue which she raised briefly under any other business at the very end of the meeting.

Q. Would the chief medical officer perhaps have taken the opportunity of you all being in the same room to mutually discuss the incidence figures that she'd had e-mailed to her in July 2001, we looked at it earlier, the five to six deaths, the death in the Mid-Ulster, and perhaps discussed it with you, with Dr Taylor, who might have contributed his own audit figures?

A. That was not what happened.

Q. So when people meet to discuss hyponatraemia in Northern Ireland, they never mention the victims of

hyponatraemia?
A. I'm not sure how you want me to answer that question. I'm not sure it was a question.
Q. It seems to be your evidence that actually the individual deaths aren't referred to.
A. All I can say is that at the time of all of these events, I had knowledge of only one case, and as I've said, that was incomplete knowledge. There may have been others present who had knowledge of other cases, but since I had no knowledge of those, I was certainly not in a position to raise issues or ask questions about them, and I saw my role as being that of contributing in a positive way to the development of guidelines in order to prevent recurrence.
THE CHAIRMAN: Sorry, doctor, remind me, when were you engaged by Altnagelvin to provide a report on Raychel's death?
A. November of 2002.
THE CHAIRMAN: Okay. As Ms Gollop said earlier, you were instructed in Lucy's case in February 2002?
A. That's correct.
THE CHAIRMAN: So the work of preparing the guidelines is coming to an end and, in effect, you know nothing about any death from hyponatraemia in Northern Ireland?
A. Other than the bare details of a death in Altnagelvin.

THE CHAIRMAN: But it's the bare details you have --
A. Yes.
THE CHAIRMAN: -- not the greater details?
A. That's correct.
THE CHAIRMAN: Thank you.
MR STEWART: I'm trying to chart a chronological course through the events, so please, if there were events or things that happened in the course of this narrative, please let us know.
Can I refer, please, to -- maybe this is another of these pages, 007-028-053. Again, the problem, sir, is I've been quarrying a file, which isn't online.
This was -- and we'll get copies for you, I assure you -- an e-mail of 5 November 2001 from Dr McCarthy to members of the working group, and it is forwarding a draft of the guidelines as they were at 5 November 2001. And they are clearly a draft, but really a very advanced draft and close to the final guidelines. So we'll come back to that document, it's just to mark in your mind that at the beginning of November the guidelines were well advanced in their preparation.
A. I would certainly accept that they were well advanced, but it was not until, in my mind, immediately prior to Christmas when, I think, we will find in that file an

e-mail from me to Dr McCarthy on 21 December.
Q. I'd be grateful if we could find that.
On 8 November, you go to a meeting of the CREST at Castle Buildings in Belfast. That's at 075-066-210. There you are, about the seventh name down, I think, "Dr J Jenkins". And in attendance, Dr McCarthy, for item 5, and item 5 appears at 075-066-213.
MR UBEROI: Sorry to interrupt my learned friend's flow, but just for assistance, in case it does assist, picking up on his last comment about finding the e-mail, which the witness has referred to, I do have a reference for that, which is 007-012-025.
MR STEWART: Thank you.
THE CHAIRMAN: Thank you, Mr Uberoi.
MR STEWART: Again, that's another one which is not yet live.
THE CHAIRMAN: Thank you anyway. If Mr Uberoi has it, it should be live, but we'll come back to it later.
MR STEWART: This is the CREST meeting, and it's 8 November 2001, and you are there and Dr McCarthy is there, and Dr McCarthy is there in order to report to CREST on the guidelines for the prevention of hyponatraemia in children receiving intravenous fluids.
We see that from the third line down, Dr McCarthy is introduced, and she states that:

"The problem has come to the attention of the department through clinicians who reported an increase in the condition and felt in need of urgent guidance."
What did you understand Dr McCarthy to mean by a report in the increase of the condition?
A. I don't think the phrase breached my consciousness to the extent that I picked up anything significant by that phrase. Just that this had come to the attention of the department and so they had taken action.
Q. Well, it's one thing to say it's come to the attention of the department following a tragic death in Altnagelvin. That's one thing. It's a somewhat different thing to say, "It has come to our attention because clinicians are reporting an increase in the condition". It's a different thing.
A. I can see that in retrospect, but I did not pick that up at the time.
Q. You didn't pick it up at the time?
THE CHAIRMAN: Okay.
MR STEWART: Okay. Sir, I come to a series of e-mails, which I know by their 007 page numbers are likely to be problematic.
THE CHAIRMAN: Let's take a break for a few minutes to see if we can improve on this. I think what has happened is that the parties may have the hard copies of the 007

file and some other departmental papers, but they haven't been put up on the public system yet. We'll see how we can get through that over the rest of the morning. We'll take a break for 10 or 15 minutes, doctor.

(11.28 am)

(A short break)

(11.48 am)

MR STEWART: Thank you, sir. I wonder might we, for the sake of completeness, go back and have a look at the documents I was unable to call up. The first is at 007-038-072 and 073.

This, to remind you, was the minute of the 10 October 2001 meeting, and I described to you how Dr McCarthy indicated that that is what it is and the initials down the left-hand side are given as "JJ", which I assume is yourself, "PC", and "JMcA", and you'll see the discussion is a fairly technical one and not related to any particular incident or patient.

A. Yes.

Q. The next one we looked at briefly --

A. Sorry. Can I just say that I'm unclear as to whether the fact that there are only three initials implies that only those three members were present on that occasion together with Dr McCarthy. It may be that that is the

case or it may be that she has only recorded the comments of those three individuals.

Q. Indeed.

A. So I don't think this could be regarded as a meeting of the full working group if that was in fact the case.

Q. You'll recall that Dr McCarthy established a smaller subcommittee to take ahead the detailed drafting of the guidance.

A. Most of whom are not present if we go by the initials.

Q. Yes.

A. So I think that it's my understanding, and again as I said, this is news to me, but I fully accept that this meeting must have taken place and this must have been at a very early stage and possibly prior to the identification of those who were going to be part of what I would describe as the drafting subgroup.

Q. Well, you will recall that that drafting subgroup was going to be formed after the initial meeting of 26 September. So it would seem logical to assume that this meeting is of the subgroup, but as you correctly point out, there are some names which are missing, which would underline the importance of e-mail as the channel of communication between the members of the group?

A. Yes, that was the agreed way forward.

Q. Then we go to 007-028-053. This was a covering e-mail

from Elizabeth Garrett, who I take it is in fact acting on behalf of Dr McCarthy, and she e-mailed this to members of the committee, doctors Darragh, Taylor, Loughery, McElkerney, McAloon, but not yourself. Why would you not be part of this round circular?

A. I don't know.

Q. "Dear all, I have been asked by Dr McCarthy to forward the attached document to you."

If we go over to the next two pages, 054 and 055. You'll see the draft of the guidelines beginning to take shape. Do you recognise the individual sectioning of the draft?

A. Yes, the pages are reversed obviously.

Q. Of course, yes.

A. Insofar as I recall, this was how the early drafts looked, and each draft was then subjected to comment from the drafting subgroup. I can't explain why my name didn't appear on that list, so I'm unaware as to whether I in fact saw this draft, but I did see subsequent drafts.

Q. Can I just ask you about the final paragraph on the left-hand side, which is in fact the second page. And it's a bullet point:

"In the event of problems that cannot be resolved locally, help should be sought from consultant

paediatricians/anaesthetists at the PICU RBHSC."

Was it the intention of the working group that the expertise of Belfast should be available regionally?

A. That would always have been our understanding in any paediatric circumstance that our colleagues in Belfast would be the place that we would turn to for expert advice, including in an area such as this.

Q. When did you first become aware that Belfast had moved away from its use of Solution No. 18?

A. Um ... well, there was talk about it in memos that we've already discussed. I can't recall exactly when I became aware that they were in the process of making changes.

Q. Because the evidence has been that it was understood that they had moved away from using Solution No. 18 at the beginning of 2001, and figures have shown that from April 2001 the use dramatically subsided.

A. I was certainly not aware of that.

Q. As a major centre, would you have expected the RBHSC, if they'd moved away from Solution No. 18, to have shared that information with other hospitals and paediatricians?

A. I would have hoped so, but at that time the systems that would now be in place for dissemination of such information were just not in place, and so I am unclear as to how far my colleagues at the regional centre saw

their responsibility. I certainly had examples of where they had changed their practice in my area of specialism, which was neonatal care, and where we would not have been formally notified by them of those changes in practice, but we would usually have heard fairly quickly, particularly because of the rotation of our junior doctors who tended to come out to work in the peripheral hospitals having spent time in the regional centre.

Q. Would you have expected such information to be discussed at one of the specialty advisory committees in paediatrics?

A. No, that wouldn't have been the forum that would have been used.

Q. Would there have been other fora?

A. The one which you described earlier, with Dr McAloon, the day before Dr McAloon's memo.

Q. Yes, that was the Sick Child Liaison Group.

A. That's the type of forum in which this sort of information would normally have been shared.

THE CHAIRMAN: I think there's one more. Dr Jenkins has raised one other document which we couldn't turn up, Mr Stewart. It was 007-012-025, I think you wanted to refer to this, doctor. It was a December 2001 e-mail.

A. It was simply because we had been asking about my

contribution and this was an e-mail -- I think Mr Stewart had said he wasn't aware of any e-mails -- of my contribution within the e-mail chain, and I was just pointing out that at least on this occasion I had contributed comments.

MR STEWART: I'm grateful for that, yes.

THE CHAIRMAN: Thank you.

MR STEWART: Perhaps we could go then to 30 November 2001 at 007-025-048. This is November 2001, and we have an e-mail from Dr Clodagh Loughrey, who's on the working group, who Dr McCarthy, and she starts it "Dear Miriam" and if we go to the final paragraph of it, she is e-mailing her fellow working group members to say:

"Were you aware of the death of a four-year-old child in what sounds like very similar circumstances in Northern Ireland in 1996? I was speaking to the coroner about it today and he is to send me a copy of his report in that case. Let me know if you'd be interested in seeing it. Perhaps you're already aware of it. Best wishes, Clodagh."

So it looks as though at least among two members of the working group, there is an interest in sharing information about individual cases of deaths from hyponatraemia.

A. Well, Dr Loughrey obviously felt that it was important

that the Department of Health, as in Dr McCarthy, was aware of this information that she had become aware of. But I think it's quite clear that she didn't copy this to the other members of the working group; it was an e-mail specifically to Dr McCarthy.

Q. Yes. She got it from the coroner and he was keen that she receive that information because she was working on the working group. Did she draw this to the attention of the members of the group?

A. No.

Q. That's the end of November. But meanwhile, on 15 November, and perhaps unbeknownst to you, the Sperrin Lakeland Trust had decided to commission a report from you in relation to Lucy's case. That appears at 047-104-234.

You can see the top:

"Clinical negligence claim, Lucy Crawford deceased, against the Sperrin Lakeland Trust. Chronology of key steps. 15 November [at the very bottom] case discussed at the trust's scrutiny committee. Independent expert identified and agreed. Report to be requested from Dr J Jenkins."

Had you previously provided reports for the Sperrin Lakeland Trust?

A. Not to the best of my knowledge. I have no recollection

of having done so.

Q. Or indeed for Altnagelvin --

A. Well --

Q. -- before Raychel's case.

A. Reports which I had previously prepared had been on the instructions of DLS or CSA, as they were, in relation to a number of trusts in Northern Ireland. And I have no specific recollection of either of these two trusts, but it's quite possible that I had done a report on a medical negligence case in respect of them because I had done that on other occasions.

Q. How many previous occasions might you have provided reports for the DLS, CSA?

A. In medical negligence cases, this averaged at about roughly four a year.

Q. And how many years had you been offering this service?

A. I had first been asked to do this within five years of my appointment in 1982, so mid-1980s, and had certainly not sought this work, but those legal advisers were approaching me from time to time and so if a matter, I felt, was within my area of expertise, I was prepared to provide an expert report.

Q. Yes. I think Ms Gollop said that you received a letter of instruction in respect of which privilege is claimed, in February of 2002.

A. That's correct.
Q. And can you recall in what terms that letter was couched?
A. It was in relation ...
MR STITT: I have to rise to that one.
THE CHAIRMAN: I think if the trust has claimed privilege, Mr Stewart, you can't ask the witness for the terms in which the privilege letter was couched.
MR STEWART: Very well, sir, thank you.
Can I ask, please, that we have a look at your report that you did furnish on 7 March, which is 013-011-037 and perhaps 038 beside it? Of course, Lucy had died in April of 2000, and this was a liability report that you prepared in relation to the clinical negligence action, and we can see you have headed your report with the title of the case "Lucy Crawford, deceased, against the Sperrin Lakeland Health and Social Care Trust". It's dated 7 March 2002. And of course at that stage, the CMO had yet to publish the working group's guidelines and so you were still then, I take it, a member of the working group prior to the final publication of your deliberations?
A. As far as I was concerned, the working group had completed those deliberations in January. There's no further communication back and forward in any further

drafting that took place after the middle of January.
THE CHAIRMAN: Yes. In fact it was so far advanced, as we've just seen, in December that you were making a suggestion about the appearance of the poster.
A. Yes.
THE CHAIRMAN: So if they weren't technically complete, they were effectively complete?
A. Yes. I'm not aware that the working group was ever formally stood down, but as far as the members were concerned we had completed our work in January, if not by Christmas.
MR STEWART: The work was over, but the product had yet to be delivered?
A. It was in the process of being prepared for publication and the poster had to be -- there was some artwork had to be done in relation to the wall poster.
Q. I wonder can I take you, please, to the bottom of the second page there, the paragraph commencing "over recent years", and I wonder can we take down the page on the left, 037, and put up 039 beside 038?
013-011-038 and 039. It's the bottom sentence on the left-hand side:
"Over recent years concerns have begun to be expressed regarding the use of 0.18 per cent saline in dextrose [Solution No. 18] as a standard solution for

intravenous use in young children and a number of cases of symptomatic hyponatraemia have been identified, some resulting in death or cerebral damage."
Can I ask you what cases you were referring to?
A. I was referring to cases -- the one case that I had previously been aware of and cases reported in the literature.
Q. So at that time, you say you still had no knowledge of Adam Strain's case?
A. Correct.
Q. You had knowledge, of course, of Lucy's case and you had knowledge,of course, of Raychel's case.
A. Yes.
Q. In the course of the working group meetings, was reference made to victims of hyponatraemia suffering brain damage as opposed to death?
A. I would have seen that in the literature that I had reviewed as part of the guideline development.
Q. Did the working group not discuss the consequences of hyponatraemia?
A. I'm sorry, I'm not sure what it is that you're asking me.
Q. Well, hyponatraemia can presumably finish with a range of outcomes.
A. Yes.

Q. One is recovery, one is death, and there's a spectrum in between, which must include cerebral damage.
A. It's quite possible that that range of outcomes was discussed at some point. I can't remember whether there was any detailed discussion of that, but it certainly is a fact that there is a range of outcomes.
Q. When you got the papers in relation to Lucy's case and you were asked to draft the report, did you think at that stage it might be relevant, even though you felt the substantive work of the working group was complete, to contact your fellow working group members and say, "By the way, I've just learnt some interesting information about another death; I wonder do you know about it?"
A. As I said earlier, I certainly understood myself to need to review the guidelines against any information that I had and so when I was preparing this report I was thinking "Do the guidelines cover this insofar as -- because they hadn't still been published, as you've pointed out, but my understanding of the guidelines as they were about to be published, did they cover this situation? And the answer that I reached, the conclusion that I reached, was that, yes, indeed they did cover this situation.
Q. And what about asking your fellow working group members

if they agreed and they thought that the guidelines covered this situation?
A. I didn't consider doing that, and I suppose, possibly in my mind, there was the issue of the circumstances in which I had been provided with this information.
Q. Do you mean to say you felt it was confidential?
A. Yes.
Q. Could you not have anonymised it so the working group might have had access to the information to better test its guidelines?
A. If that had been the way the working group was operating, then I could have found a way to do that, but in testing it myself I believed I had done all that was necessary.
Q. Do you think now, looking back, that you should have shared that information with the working group?
A. No.
Q. We saw earlier how Dr McCarthy was contacted by Dr Loughrey, who felt that she should see information about Adam's case. Did you not feel the same approach was something you should have adopted?
A. Well, I wasn't, of course, aware that Dr Loughrey had done that, but no, that didn't cross my mind.
THE CHAIRMAN: Were you aware from the documents that you received that there had been no inquest on Lucy?

A. No, I was not. I had received as part -- I'm not sure whether I can say what I received as part of those documents.
MR STEWART: You can if you like.
A. I had received a post-mortem report, but it was not clear the circumstances in which the post-mortem had taken place.
Q. A post-mortem report is normally headed by who commissions it, so therefore it'd be a report on behalf of the HM Coroner or it'll be on behalf of the hospital or whatever, won't it? You can tell very quickly.
A. Well, the significance of that did not strike me at the time.
Q. You received a brief, as it were, to furnish a report in respect of a clinical negligence action, not to attend an inquest.
A. That's correct.
Q. So you could assume therefore there was no inquest coming up.
THE CHAIRMAN: Apart from that, there was no inquest finding in the brief, which you might expect to find. If you're asked to advise on a medical negligence case where there's been a death and also an inquest, you would expect a full brief to include the findings of the inquest, wouldn't you?

A. In retrospect, perhaps I should have expected that, but it certainly wasn't something which I was aware of at the time.
MR STEWART: You may not have had it spelt out for you, but it was perfectly clear, I would suggest from the document you had and did not have, that there'd neither been a finding of a coroner nor were you asked to attend or report for a coroner. So there was no inquest.
A. That, I'm sure, is correct, but that was not the circumstances in which I had been asked to prepare my report.
Q. You were asked to prepare your report in respect of this medical negligence action.
A. Yes.
Q. If another member of the working group had had information in relation to individual cases, would you have expected them to mention it by e-mail so that you could test your guidelines against it?
A. That was not the way in which the working group was operating. I had no such expectation.
Q. Well, apart from the fact that your expectations were based upon the way it was operating, would you have expected that's how it should have operated?
A. No.
Q. Because the working group you describe is one of

hermetically sealed units not actually interchanging information.
A. Well, I don't think that's correct in that we did exchange a lot of information about the guidelines and about our suggested amendments and improvements to the guidelines and that was the entire focus of our discussions throughout this period. The focus was on the guidelines, not on any individual cases.
THE CHAIRMAN: I've got the point, Mr Stewart.
MR STEWART: Thank you.
Moving on to 25 March 2002, which is the CMO's letter which appears at 012-064c-328. This is the letter that the CMO sent out across Northern Ireland to relevant interested parties, announcing the publication of the guidelines and guidance. You can see the second paragraph begins:
"Hyponatraemia can be extremely serious and has in the past few years been responsible for two deaths among children in Northern Ireland."
What did you assume that to mean?
A. I assumed those to be the two children that I was aware of, Raychel and Lucy.
Q. Did you think how the chief medical officer might have come by the information in relation to Lucy?
A. No.

Q. Had it been discussed in your presence with her representatives, Dr McCarthy, Dr Mark?
A. No.
Q. Of course, you didn't know who she had in mind, did you? You just made the assumption those were the two cases that had come to your attention, as you've said?
A. Yes, the assumption was that I was aware of two cases and those were likely -- in my mind those were the two cases she was referring to.
Q. Later on that year, in the autumn of that year --
THE CHAIRMAN: I'm sorry. Can I or can I not take it, doctor, that you think that Dr Campbell, as chief medical officer, should have been made aware of Lucy's case?
A. I think it would have been important for the Department of Health to have been aware of, as I later discovered, the circumstances of the death of Lucy.
THE CHAIRMAN: In the same way that Altnagelvin made the CMO and the department aware of the circumstances of the death of Raychel?
A. Yes.
THE CHAIRMAN: And what about the way in which we understand the CMO was not made aware of the circumstances of the death of Adam Strain?
A. In retrospect, I think that systems were simply not in

place and individuals did not see it as being their responsibility to make that referral or that communication.
THE CHAIRMAN: But there wasn't a system in place in 2001, was there? When Altnagelvin informed the CMO, was there a system in place?
A. No. My understanding is that Altnagelvin -- there had been an opportunity where, I think it was Dr Fulton, had mentioned to one or two other medical directors over lunch at a meeting the possibility of there having been something in Enniskillen was mentioned. Following that then either Dr Fulton or Dr Nesbitt decided that they needed to make the department aware. So I think the circumstances were that they were putting together information which became known to them that there had been more than one case.
THE CHAIRMAN: That's not a system in place, that's Dr Fulton in particular, but also with Dr Nesbitt, being resolved to advise the CMO about Raychel's death. And you've said that doesn't sound to you like a system in place. That sounds to me like their determination, that this is something the CMO should know, right?
A. Yes, I agree.
THE CHAIRMAN: You think on that same approach the same might be said in Lucy's case, and when I asked you about

Adam's case you said that there wasn't a system in place. But I don't see a system in Raychel's case; what I see is good work done by doctors Fulton and Nesbitt. If we take that approach then why would that same expectation not fall on the Royal in relation to Adam?
A. Yes, sorry, I was --
THE CHAIRMAN: I know it's some years earlier, but does the same expectation not arise?
A. Yes, I agree, but the point I was making, I think it was the fact that Dr Fulton became aware of another case was probably the thing that then triggered them in those circumstances to have made that contact. And whether an individual in another hospital who was only aware of one case would have felt that they should do that, I think is a different question. But I'm agreeing with you that in the circumstances of the Royal, that that would have been a very wise step to have been taking.
THE CHAIRMAN: And in Claire's case, that might depend on what view I took, but if I didn't take the view that there was a hopeless misunderstanding in the Royal about what had happened to Claire, then the same would apply to advising the CMO of her death?
A. I'm sorry, I know nothing of the circumstances of Claire's death.
THE CHAIRMAN: Okay.

MR HUNTER: Just before you move on, sir, on the same point, given that Dr Jenkins was at meetings and certainly at one meeting where Dr Taylor, Dr Crean and Professor Savage were all there, if I'm correct, this was all involved in trying to draft guidelines. Would Dr Jenkins not have wanted to have known that Dr Taylor and Professor Savage had first-hand experience of a case of hyponatraemia and Dr Crean knew of Adam's case and that they didn't mention that? And secondly, would he feel that it would have benefited the group that Dr Sumner's report could have been produced to the group, as it was in their possession?
THE CHAIRMAN: Well, on the first point, I think the first point you're raising is emphasising a point I've already asked about, how the members of the working group were drawing up guidelines without any collective knowledge or sharing of knowledge about the circumstances in which children had died. And I'm curious about that, which is I think the point of your first question.
But on the second point, by the time the working group met, there had been -- Adam's inquest had taken place and you, I understand, weren't aware of that, but the coroner had received what I might crudely describe as an ABC of hyponatraemia by Dr Ted Sumner, which was used in Adam's inquest. As you know, he was used again

in Raychel's inquest and then in Lucy's. Would it have been helpful, do you think, to the working party to have had Dr Sumner's public document, his report in Adam's case, before it?

A. Yes.

THE CHAIRMAN: Thank you.

MR UBEROI: Might I rise, sir, for a small point, just picking up on a detail inherent to the first point. I am not actually sure we have factually established all those people were in the room at the same time for a meeting, but of course your succeeding points about e-mails, et cetera --

THE CHAIRMAN: I accept that query because there's a degree of uncertainty, but I don't think it detracts from the main issue. I'll accept that.

MR UBEROI: Thank you.

A. Is this an appropriate moment for me to make a further comment on the point that you raised earlier this morning and have just repeated in respect of the method of working of the working group or would you prefer me to leave that?

THE CHAIRMAN: It's okay, if it's in your mind, let's not lose it again.

A. Simply, I referred this morning to two circumstances in which I had been in a working group producing this type

of guidance, the one that we're discussing today and the NPSA working group. I had said my experience was that other group had worked in a similar way. There is a third example, which has been more recent, and that is, as reported in my CV, I have recently been a member of a working group set up by the chief medical officer looking at group B streptococcal disease in the newborn. That working group has also worked in the same way: that a group of people with expertise have been brought together, have discussed and formulated guidelines without reference to individual cases. I just simply provide that as another example. I understand the points you've made about that way of working, but that has been my experience.

MR STEWART: May I take you back to something you said a moment ago? It was in relation to the Altnagelvin response to Raychel's death, and you said that Dr Fulton went to the meeting and he learnt of another death.

A. No, sorry. If I said that, that was not what I intended. I said he learnt of something else that had happened in the Erne Hospital. Because I understand that there's some debate as to whether it was reported as a death or not.

Q. Thank you. Can we please go to 160-113-002? This is a note, the bottom of the page, 31 October. This is

an internal note from the DLS, the solicitors for Altnagelvin, and it's in relation to commissioning a report from you in respect of Raychel's case. The note is:

"Dr Jenkins has heard of the case. He will be prepared to look at the papers and do a report."

Can I ask you about this? You are being commissioned to do a report, you've heard of the case, you've sat on a working group which was convened as a response, in a sense, to the death. You have sat on it with Dr Nesbitt, who was from the hospital where the death came from. Did you feel in any sense that you weren't sufficiently independent to do a report on this case?

A. No.

Q. Did you feel that perhaps even though you might be yourself confident of independence, that you might not appear completely independent?

A. No.

Q. That never crossed your mind?

A. No.

Q. The brief you received appears at 172-002-001. We can see, I think, some of your own annotations, on this; is that correct? Is that your handwriting?

A. That's correct.

Q. And at the top you've underlined several times that you were to look at these papers on behalf of the trust. And then further down you're informed that the coroner is to hold an inquest into the death and you're asked to prepare a report on the matter, having been told that an independent report has been obtained from Dr Sumner. And you have noted on it a number of things. First of all, on the left-hand side:

"BJHM article 1985."

What's that?

A. That was simply for my own recollection of a paper that I had been involved in publishing in 1985 in relation to cerebral oedema in a different condition, a condition called Reye's syndrome. But cerebral oedema was a common feature of severely -- of adverse outcomes in both of these conditions.

Q. That's another metabolic disorder, is it?

A. Yes, it just triggered a memory when I was reading this that I'd had some previous experience of cerebral oedema leading to adverse outcomes, but in a different set of circumstances.

Q. On the right-hand side you have noted "Query". You don't seem to have got the statement from Staff Nurse McAuley.

A. That's correct.

Q. And:

"Query Ward 6 nursing notes for the 8th."

Was that because you didn't have those?

A. These were my initial comments having read through the papers initially and I just wanted to jot down queries in my own mind as to whether I had some relevant information.

Q. And then you've noted down:

"Query severity of vomiting c/f fluid chart but Sister Millar and nurse notes, 9 June."

A. Yes.

Q. So you seem to be there very quickly looking at the competing evidence as it were for vomiting?

A. I recognised very quickly that there seemed in my mind to a tension there that had to be elucidated.

Q. Even a contradiction, perhaps?

A. Perhaps, yes, though this was an initial query.

Q. Then the following page, which is 172-002-002, we find actually the documents that you were provided with. We see at number 13 you get Dr Sumner's report, an autopsy report at 15, extracts from literature, and curiously a draft press statement. Would you normally be sent a draft press statement of an inquest before you even reported?

A. No.

Q. Did that surprise you to see such a thing?

A. I didn't really take notice of it, I saw it was in the bundle, but it wasn't something which I felt I had to pay any particular attention to.

Q. Can we just have a look at it? 172-002-043. It's dated, by fax transmission, March 2002. The first date of the inquest listing is 10 April 2002. And the draft which is for some reason sent to you, states:

"It is important to be aware that the procedures and practices put into effect in the care of Raychel following her operation were the same as those used in all other area hospitals in Northern Ireland."

Did you in the course of reviewing the papers form any view as to the appropriateness of that conclusion?

A. I certainly formulated a view that the treatment of Raychel and her management needed to be tested against standards of care and that was one of the issues I raised in my first report.

Q. Yes, of course. So on that basis it's clearly premature to draft a press release in these terms?

A. Yes.

Q. You didn't feel yourself obliged to make any response. Did you in fact advise that this was ill-advised?

A. No.

Q. You have the report of Dr Sumner.

THE CHAIRMAN: I think, before you move on, I think the unfortunate question about the inclusion of that document in the brief is whether, although you were being briefed as an expert witness, you were at the same time being given the Altnagelvin line. And if you were being given the Altnagelvin line at the same time as being asked to produce an objective, independent expert's report, do you agree that would be inappropriate?

A. Yes.

THE CHAIRMAN: Thank you.

A. But I can say that I did not take any notice of that in preparing my report.

THE CHAIRMAN: Yes.

MR STEWART: Can we have a look at 172-002-028? And 029. These are pages from Dr Sumner's report and you've clearly gone through it with your pen, marking everything you think of interest, of note, as you work through it, thinking, as it were, with your pen on the page. We can see therefore what you thought was important. On the left-hand side at the top of the second paragraph, you have underlined:

"Vomiting plus plus. At 2300 hours there were a few more small vomits. Raychel had been able to walk during the day."

In the paragraph after that you go through the fluids and you total up the fluids there so you're interested in the quality and the rate of fluid administration. In the next paragraph you're circling the times because you are working through the progression of 8 June through to 9 June, working out what's happening.

On the next page, more of the same detailed attention to Dr Sumner's observations, at paragraph 2 you have underlined:

"Suffered very severe and prolonged vomiting."

On the right-hand page, can we enlarge that to its full size, please? You'll see that you have actually put an asterisk beside:

"Suffered very severe and prolonged vomiting."

Why did you mark that passage out for particular reference?

A. Because it was one of the things in my analysis of the papers that had been sent to me, including Dr Sumner's report, that I felt needed to be looked at in more detail as a particularly important aspect.

Q. Thank you. The next page is 172-002-030. And again, on this you've been highlighting by underlining. In relation to the central paragraph there, you've underlined his final conclusion:

"I believe that the state of hyponatraemia was caused by a combination of inadequate electrolyte replacement in the face of severe post-operative vomiting and water retention always seen ..."

Was that a comment that you believed that you had to address your comments to?

A. It was mainly just, as you've said, I went through the whole document underlining the bits that I felt were most important, and obviously I felt his conclusion was a very important part of his report.

Q. And you had been asked to prepare your report in the light of his report?

A. Yes, that's one of the factors that I needed to be aware of in preparing my report.

Q. And then you did produce a report and we find it at 022-010a-040. And can we perhaps see 041 beside it? This is your 12 November 2002 report. You head it "Raychel Ferguson deceased. Inquest". This is eight months after your Lucy report, which we recall was clearly headed with the title of the action, the clinical negligence action.

You say at the top:

"This report is prepared at the request of the Directorate of Legal Services."

Then at the comments section on the left-hand side,

the first sentence there:

"Solution No. 18 has been routinely used in paediatric medical practice for a very long time and is rarely associated with any acute electrolyte disturbances such as were seen in this tragic case."

In your report in Lucy's case, you had drawn attention to death and cerebral damage and so forth. Why did you not make that caveat to this comment?

A. I just need to read through the rest of it so that that sentence can be taken in the context of the whole of my report.

THE CHAIRMAN: Take your time, doctor. (Pause).

A. I think what I was trying to do was to make the distinction between paediatric medical practice and the surgical environment, and particularly the post-operative period, and that was why I was emphasising that point.

MR STEWART: You do make reference to deaths later on and we'll come to those. But in your report for Lucy, you have simply said that:

"Concerns have been expressed regarding the use of No. 18 Solution as a standard solution for intravenous use in young children. A number of cases of symptomatic hyponatraemia have been identified, some resulting in death or cerebral damage."

You don't attempt to make that distinction there.

A. Not in this, no.

Q. Then you go on to the next paragraph to indicate the problem of hyponatraemia and hypotonic solutions:

"This was well described in an editorial in the Journal of Paediatric Anaesthesia in 1998 by Dr Arieff, but it did not receive widespread publicity in journals likely to be read by most paediatricians or surgeons caring for children at that time."

Why did you not make reference to the 1992 Arieff article in the British Medical Journal?

A. Because I was still unaware of the existence of that article.

Q. But you were aware of the 2001 lesson of the week article in the BMJ?

A. Yes.

Q. And it footnotes, right at the very end, "Arieff".

A. Yes, but I hadn't picked that up.

Q. Then you go on:

"Many paediatric units were still using their traditional regimes based on Solution No. 18 until further concerns were raised in Northern Ireland in September 2001 as a result of two deaths."

You were there when the concerns were raised, you were on the working group in September 2001; what two

deaths were those?

A. Well, the two deaths that I'm referring to here were Raychel and Lucy. Although in retrospect, I believe that Lucy's death was not known to the department, certainly not to me, at the time the working group was undertaking its --

Q. Hang on a second. You're saying you didn't know about Lucy in September 2001 and the department didn't know about Lucy in September 2001. How can you explain you writing:

"Until further concerns were raised within Northern Ireland in September 2001 as a result of two deaths"?

Who raised those concerns?

A. I think I was quoting here from the chief medical officer's covering letter in issuing the guidance in March 2002, where she had specifically referred to two deaths.

Q. Yes. What she says is something quite different. She says:

"Hyponatraemia can be extremely serious and has in the past few years been responsible for two deaths among children in Northern Ireland."

She doesn't link those deaths to steps taken to convene a working group.

A. I'm sorry?
Q. She doesn't link those to steps taken to convene a working group; she merely says that in the past few years hyponatraemia has been responsible for two deaths.
A. But surely she makes that comment in the context of explaining how the working group came to be set up.
Q. No, what she says is -- and we can go to 012-064c-328. She, in the initial paragraph, describes the guidance that is going to be forthcoming, it's going to be in posters, it's been developed by the multidisciplinary working group and supported and endorsed by CREST. Then she goes on in the second paragraph to describe hyponatraemia and what it is:

"Hyponatraemia can be extremely serious and has in the past few years been responsible for two deaths among children in Northern Ireland. Hyponatraemia is a problem of water balance and most often reflects a failure to excrete water. Pain, stress and nausea are all potential stimulators of the antidiuretic hormone ADH, which inhibits water excretion."

So the comment there in relation to deaths is in relation to a description of hyponatraemia, not the establishment of a departmental working group.
A. Well, I took it this that whole letter was in relation to how the working group had been set up so that the

guidance could be produced. If the working group is not specifically mentioned, it is implicit.
THE CHAIRMAN: Okay, thank you.
MR STEWART: Can we go back then to the report at 022-010a-040.
MS GOLLOP: Sorry, I hesitate to interrupt, but on the page we've just looked at, it does specifically mention the working group.
MR STEWART: It does, yes.

022-010a-040. The bottom of the left-hand page:

"While it is possible in retrospect to form the opinion reached by Dr Sumner that Raychel must have suffered severe and prolonged vomiting, this does not seem to have been the assessment of her condition by experienced staff at the relevant time."

And then you go on to describe what Sister Millar said.

What was your intention when you wrote that passage, that it was possible to agree with Dr Sumner but that doesn't seem to have been the view taken at the time?
A. Well, as represented by my annotations on the letter of instruction, I had recognised that this was an area which required clarification. Dr Sumner had reached a view which differed from that of the staff who'd been providing care, so I was pointing out that it was

important that this was something which needed to be elucidated.
Q. Indeed, and those are exactly the words you use down in the conclusion paragraph on the right-hand side, third line down:

"It is, however, important that further details are obtained of relevant nursing and medical procedures, in particular information needs to be obtained ..."

And so forth. In response to this specific note by you of the importance of additional information, did you receive any additional information?
A. No.
Q. How relevant to your view of the case was the absence of information?
A. Well, the conclusions in my first report were all that I believed I could adduce on the basis of the information that was available to me. And I was not in a position to formulate any more clear conclusion in respect of the issues that I believed that I was addressing. And as you will see, I perhaps misunderstood the purpose of this document because I do talk about the issue of negligence.
Q. Yes.
A. And my understanding was that this was a report which had been requested by DLS for the trust, though in the

context of the coroner's inquest.
Q. Yes. What was your experience of appearing at inquests?
A. I had only, I think, ever been at one coroner's inquest, and that was as a very junior doctor, basically where I'd been involved in a road traffic accident and had to go along as a witness of fact.
THE CHAIRMAN: So a completely different scenario to this?
A. Absolutely.
MR STEWART: And likewise, did you have experience in drafting reports for inquests or coroners?
A. None.
Q. Can I ask you about the final part of your report, about four lines from the bottom?

"In the circumstances relating to this incident, it was only the tragic deaths of two children in Northern Ireland which alerted the wider clinical community to these concerns. These have subsequently been assessed and relevant guidance prepared and disseminated as outlined above."

Was it the deaths that were assessed or the concerns?
A. The concerns. The two deaths that I refer to there are again Raychel and Lucy.
Q. 160-097-001. This is an internal DLS note of 18 November. So that's really very soon after your

opinion has been received. It is noted at the bottom:

"Phoned Therese. Advised re Dr Jenkins' report. Explained I was still trying to get a paediatric anaesthetist, explained it would be necessary to consult with Altnagelvin and Dr Jenkins in due course and get Dr J to fill out his report. TB to revert re availability of consultants."

MR STITT: Can I just interrupt? I appreciate it's in the middle of a sentence and no discourtesy is intended, but we've discussed the question of the DLS inquest file. There were two letters which were submitted to the inquiry, one with a long list of documents in which privilege was claimed. Then a meeting took place, which I have some personal knowledge of, and the second letter was sent a few days later with a much shorter list of documents, to which privilege was claimed. We've been there and I'm slightly surprised that this document, which is one of the documents in the second letter, is being opened.

MR STEWART: I'm surprised as well. I thought this was --

MR STITT: If I'm wrong about that, I will apologise.

MR STEWART: We'll pull it down now. I did not think that was --

MR STITT: If I'm wrong about that, I'll accept the criticism. My understanding from my nomenclature, which

is not as straightforward, it's a complicated nomenclature for various reasons, tells me that's one of the documents. I am just making the point, not specifically because of the document, but in principle lest we trawl through others --

THE CHAIRMAN: Well, can we go on without that, Mr Stewart?

MR STEWART: Yes, of course.

If we might look, please, at 172-003-001. This is a letter -- I'm on safer ground now -- written to you by the DLS, in which you are in fact sent a copy of Dr Warde's report:

"Enclosed herewith a copy received from Dr Warde, a consultant paediatric anaesthetist retained to advise the trust. I would be gratefully obliged if you could consider Dr Warde's report and provide me with any further comments which you have which might assist the trust."

That's a curiously worded letter, isn't it, or is that straightforward to you?

A. Well, that was one of the points picked up, I think, in one of my witness statements, where I explained that I understood this as assisting the trust in considering what the expert views were as opposed to assisting the trust in any way, you know, in any particular direction.

Q. You're quite clearly asked to give comments which you

have, which might assist the trust, but you ignored what might look like a steer?

A. I didn't read it that way. But I did see this letter again in the context of the trust because the heading, as you will notice, no longer refers to the coroner's inquest at all. And although there is a reference in the body of the letter to the inquest, it seemed to me that this again was information for the trust, specifically in relation to this report which they'd obtained.

Q. Yes, but you're retained in relation to the inquest.

A. In the context of the inquest.

Q. Yes:

"I refer to the above matter."

THE CHAIRMAN: Sorry, doctor, you're asked for your comments as a matter of urgency in view of the imminent date of the hearing of the inquest. This letter must be inquest-related rather than medical negligence-related, surely.

A. Yes, I accept that, but it was in my mind still focusing on providing information to the trust as opposed to the coroner.

THE CHAIRMAN: Yes, but it was information you were providing to the -- sorry, so you didn't necessarily expect whatever information you provided to go before

the coroner?

A. That's correct.

THE CHAIRMAN: So that as far as you were concerned it wasn't clear that you were going to be used as a witness at the inquest?

A. That hadn't been made clear to me.

THE CHAIRMAN: Okay.

MR STEWART: If we go back, please, to 172-002-001. This is your initial letter of instruction on behalf of Altnagelvin Trust. At the second part of the main paragraph:

"The coroner is to hold an inquest into her death, Belfast Coroner's Court, Victoria Street, Belfast, on 26 and 27 November 2002."

Surely that's an indication to you what you are required for, isn't it?

A. Well, I think in my mind -- again, I have to accept that I may well have misunderstood this because of the previous context in which I had prepared reports, but my understanding was that I was preparing a report for the trust in the context of the inquest, but not directly for the coroner.

Q. Not for the coroner?

THE CHAIRMAN: I'm sorry, doctor, there's one point I don't quite understand. When you provide a report as an

expert, you typically sign an appended note, which is to the effect that you're giving your evidence independently and impartially; isn't that right?
A. I certainly have in more recent years. I'm not aware that I did on this occasion.
THE CHAIRMAN: Does that mean that the report that you would provide if it was going to the coroner would be different to the report you would provide if it was going to the trust?
A. Well, in the sense that I would want to be full and frank with the information that I had, no, it wouldn't, but the way in which I formatted my initial report was quite different. I didn't start off in the way that I subsequently discovered I should have started it off.
THE CHAIRMAN: It's not the format I'm more concerned about, it's how frank you are in it.
A. Yes.
THE CHAIRMAN: And in the first report you were saying in terms "I need more information". But when you were by then provided with Dr Warde's report -- and then when you ultimately do a report, the report which does go to the coroner, it's a report which is going to the coroner with you being proffered to the coroner as a trust witness; is that right?
A. I certainly understood my third report in a different

way, and that's why it is formatted in a different way.
THE CHAIRMAN: Okay.
A. And I understood that I had been asked to comment on one particular aspect of the issue of hyponatraemia in the report that was going to the coroner.
MR STEWART: Let's just remind ourselves --
MR STITT: May I just come in on that point raised by the chairman? That may not be particularly relevant, but you had said, sir, do you not sign the normal acknowledgment at the end of a report that I am aware of this, that and the other thing. It's my understanding that that is a fairly recent invention in and around the order of 2009. Your underlying point of course is still valid.
THE CHAIRMAN: Thank you.
MR STEWART: On the issue of the formatting, your first report was headed:
"Raychel Ferguson deceased. Inquest at Belfast Coroner's Court, 26 and 27 November 2002."
And indeed, your final report is, likewise, headed:
"Raychel Ferguson, deceased. Inquest at Belfast Coroner's Court, February 2003."
So all along your reports are headed "inquest".
A. The heading, but the content and the format of the first paragraph is completely different.

Q. That's to your final deposition, which appears on the coroner's own deposition heading.
A. Which is exactly, as I understand it, the same as my report of 30 January.
Q. We'll come to that in just a moment. What we do have from you is your response to the letter asking you for comment in relation to Dr Warde's report, and that comment is provided by you at 022-004-013 and 014.
In the first paragraph there, you make reference to the documents you've received and Dr Declan Warde's report:
"My initial impressions are that in many respects Dr Warde's report does not differ significantly from previously available information."
And of course, his conclusion was that Raychel had suffered prolonged and severe vomiting. His actual words were:
"Severe and protracted post-operative vomiting."
And in the second paragraph you go on then to actually refer to Dr Warde's report, and Dr Warde again makes reference to the significance of the vomiting:
"I pointed out in my report of 12 November 2002 [you almost mention this with irritation] the importance of seeking further information regarding the frequency and severity of Raychel's vomiting, given the comments in the report by Sister Millar. I have also not been

provided with any further details of the relevant procedures and management in relation to fluid administration and post-operative monitoring of fluid intake, urine output and other losses."
Were you surprised that they hadn't come back to you to supply you with the information that you had sought?
A. Well, I understood it to be entirely within the remit of the trust and its advisers as to what information they wished to provide to me and what information they wished me to comment on. So I was just pointing out that they had not responded to that request.
Q. Were you surprised?
A. Well, there was no sense of annoyance, as you perhaps suggested, in that I had an open mind on whether this was an aspect on which they wanted me to provide any further advice or not.
Q. Yes, but they want you to go and give a report at an inquest and they're not giving you the information; that's hobbling you, isn't it?
A. As I say, at this point in my mind, I was continuing to provide advice for the trust in order to enable them to make up their mind as to how they were going to proceed.
Q. And if we look at the final paragraph on the right-hand side, you confirm your availability for the date of the inquest, 5 February 2003. So it's pretty clear to you,

you're going to the coroner's court?
A. At this point, yes.
MS GOLLOP: I'm not sure that's right. If you read the end of that paragraph, you'll see:
"I will therefore be grateful if you can confirm details of my expected involvement as a matter of urgency, as I have heard nothing further regarding this, despite the request in my letter of November."
So it exactly reads differently to the way it's just been put.
MR STEWART: He's asking for confirmation of his understanding. He confirms his understanding, available for 5 February, but asks for confirmation of it.
A. I think what was in my mind, if I may, is that I was confirming my availability, so I understood that I needed to go to the inquest, but I was still unclear as to what my role was going to be.
Q. Can we go back, please, to the document that my learned friend Mr Stitt thought was privileged? I'm now informed that it wasn't, and we've got the correspondence here. Perhaps we could go through it at lunchtime, but it doesn't seem, I'm told, to be part of that list.
MR STITT: If that's the case, as I've indicated before, I'll acknowledge that. I have got the letter of

11 March 2013, which is the letter -- I don't have the exact reference for it. But one of the documents is document number 206. But that could refer to a different index.
MR STEWART: My instructing solicitor clearly notes that number 97, which must be this document, is not included --
MR STITT: That's the nomenclature problem to which I referred and I apologise for that, sir.
THE CHAIRMAN: If we need to go back to that, we will after lunch.
MR STEWART: Thank you, sir.
So we come then, in fact, to your third and final report on Raychel, which is at 022-004-010. This has, of course, a number of changes to it from your first report. Can I ask you why you decided to change it?
A. As I indicated in my witness statement, I had no documentation which enables me to answer that question with certainty. But I believe that I must have been contacted because otherwise I wouldn't have known to change, for example, the contents of the first paragraph. Up to that point this was something which I had not understood, so in order for this to be suitable for submission to the coroner, I know understood that I had to at least introduce myself

in the way that I now do in this paragraph.
Q. Can I ask who might have contacted you to give you that information?
A. It must have been someone from the legal adviser side. It certainly wasn't the trust.
Q. And the document I was looking at a moment ago was the internal DLS memo, suggesting that a consultation be arranged and that Dr Jenkins fill out his report. Did you have a consultation?
A. I have no record of having attended a consultation. I think if I'd travelled to Belfast to attend a consultation, I would have kept a record of that. But whether or not there was a telephone conversation, I'm unable to say.
Q. Did you receive any advice apart from the introductory paragraph about your report?
A. Yes. I was asked to deal with the issues relating to the guidance in my report.
Q. And who would have asked you to deal with those issues?
A. My best guess is that this was in the same conversation that explained to me about the format of my report and so would have been, in all likelihood, the same individual.
Q. Did it surprise you that somebody from a legal services department should be advising you, an independent

expert, what to put in your report?
A. My understanding was that it was within their rights to advise me as to what aspects of the matter I should provide a report on for the coroner. I wasn't concerned about leaving out some of the material in my first report, simply because I hadn't been provided with the further information which would have enabled me to have formed a firmer view on those issues, and I knew that within a matter of days I was going to hear Dr Sumner presenting his report, and I was going to be able to formulate my view on those issues.
Q. Were you asked not to refer to Dr Warde's report?
A. I don't know. I don't have a recollection of that.
Q. Why otherwise would you delete all reference to Dr Warde and his report from your report?
A. Well, there was no reference to Dr Warde in my first report, obviously. And my second letter had simply been dealing with the issues raised in Dr Warde's report, and as I said in that letter, I did not see those of being of any significance. I did not believe that Dr Warde had raised any additional issues or provided any additional information to what was already contained in Dr Sumner's report.
THE CHAIRMAN: But to put it very broadly, he confirmed that he agreed with Dr Sumner's view.

A. I agree.
THE CHAIRMAN: And if the coroner's going to be hearing expert evidence, would you agree that it might appear to be relevant to the coroner that this is not just the view of one expert, it's actually the view of another expert who's looked at the issue?
A. I accept that, and as I've seen from elsewhere in the inquiry, I think that I had, in my mind, expected that Dr Warde's report would have appeared to the coroner. But I cannot say whether that was specifically mentioned to me or not as to whether I should include that in my report. It wasn't that I took anything out because, although I saw this report as being a new report for a different purpose, it was based on my first report.
MR STEWART: Yes. You've noted the importance and the relevance of vomiting from the outset. Why is it that your third report omits all reference to vomiting?
A. In my mind, I was unable to take that issue any further, and I think the best way I can describe it is that I saw this as a division of expertise, that I was being asked to comment on areas that Dr Sumner couldn't comment on and Dr Sumner had already commented on the areas where I didn't have the information to assist the coroner.
Q. But if you couldn't take the matter any further and if there was relevant information that you hadn't seen,

surely it was relevant to say that?
A. Well, I knew I was going to hear Dr Sumner present his report at the inquest and I was going to be there.
Q. But you're an independent expert, providing a report. What is the point of an independent expert if you don't actually give an opinion?
A. Well, I had given an opinion on those aspects on which I'd been asked to give an opinion.
Q. Did you have a conversation with anyone informing you of what you should give an opinion on?
A. My best guess of what happened is that I was asked to reformat my report and to concentrate on the aspects of the development of guidance.
Q. Asked to concentrate on aspects of the development of guidance. In other words, you were asked not to concentrate on Raychel's case but on a much broader picture?
A. Yes.
Q. And did you see that as properly your role?
A. Yes.
Q. But if your observations in relation to Raychel were relevant to the coroner's enquiries, surely you should have brought them to his attention?
A. In retrospect I can see that that would have been a very sensible thing for me to do, but that was not how it

appeared to me at the time.
Q. Not just sensible but the proper thing for you to do?
A. As I've explained, or sought to explain, I understood that all of the relevant information in relation to those aspects was contained in Dr Sumner's report, and that, in the absence of further information having been provided to me, I had nothing which I could usefully add to that, but would have the opportunity to hear him present that evidence and, if necessary, to comment on that evidence at the inquest.
Q. There was also relevant information contained in Dr Warde's report.
A. Relevant, but in my mind not anything new or anything that needed to be added or addressed.
Q. When you read Dr Warde's report, did you see in it that he actually noted down all the reports that had been furnished to him so that it was perfectly clear what expert evidence had come to him, what paperwork he had?
A. Yes.
Q. Did you not think that that was an approach that you could have adopted? Because what you write in this first paragraph is:
"This report has been prepared following a review of a photocopy of material from the case notes relating to the admission of this girl to Altnagelvin Hospital,

together with other material."
A. Yes.
Q. Why did you deliberately not set out what that material was, as Dr Warde had done?
A. That was not my practice in the limited experience I had at that time.
Q. You have also deleted from the end of the second paragraph there your four-line discussion and analysis of the quantities of fluid given, the rates. Why did you decide to delete that?
A. It was part of the same thought process that my third report, the report for the coroner, was specifically addressing the broader issues.
Q. But if we look at the second paragraph, it's not addressing broader issues, it's addressing Raychel:
"Raychel was admitted with abdominal pain suggestive of acute appendicitis ..."
A. Yes, it includes the background that I felt I needed to give to addressing those broader issues.
Q. But it's not just background, it's detail. On the next page it goes on for another paragraph about closely observed detail from Raychel's case and her collapse and so forth. So you're not dealing with the big, broad picture that you can paint in a background way for the coroner, you're dealing with this case, and out of your

dealing of this case you've omitted things which you've previously thought relevant.

A. Yes, but which I also knew were in Dr Sumner's report.

Q. But if you thought they were relevant, then you should recognise their continuing relevance and retain them.

A. I recognise in retrospect that that would have been a more sensible thing to do, but that was not how I thought at the time.

Q. Why would that have been more sensible?

A. I think as you're pointing out, to have included that information would not in any sense have diminished the impact that I've wanted to have in the main thrust of my report.

Q. Because when you came to deliver that report to the coroner, you had an obligation under the GMC's Good Medical Practice to offer all relevant information to the inquest, didn't you?

A. Yes, and I believed that all relevant information was provided to the coroner at the inquest.

Q. Let's just have a look at the duty, which appears at 314-014-014. This starts off with "Formal enquiries" at paragraph 30:

"You must cooperate fully with any formal enquiry into the treatment of a patient."

At paragraph 32:

"Similarly, you must assist the coroner by responding to enquiries and by offering all relevant information to an inquest ... Only where your evidence may lead to criminal proceedings being taken against you are you entitled to remain silent."

It's a terribly clear duty. Do you think now, looking back, that perhaps you did not fulfil that duty?

A. I believe that all relevant information was offered to the coroner at the inquest.

Q. But not by you?

A. Well, I concurred with Dr Sumner's views, so I supported what he had said.

Q. But you didn't in your report, because at page 022-004-011, after that first paragraph in your initial report, the first report, after the first paragraph you have the passage where it was possible to form the same opinion as Dr Sumner, and whilst it is recognised that you didn't dissent from Dr Sumner's opinion at the inquest, what you have done is delete your view that it might be possible to agree with him from your report. Why was that?

A. It was part of the same thought process that I've sought to explain to you. It was when I heard Dr Sumner explain his views and answer questions at the inquest that I was able to consolidate in my mind my

understanding and my conclusion particularly in respect of the vomiting issue. I had not been able to do that prior to hearing him at the inquest.

Q. May I ask what it was he said at the inquest that allowed you to see for the first time with clarity that the vomiting had been severe and prolonged?

A. Yes, yes, and I'm not sure whether, it's a sheet of the handwritten notes, they could be referred to. I can quote it, but I don't know the page number.

Q. Ah, right. This is the handwritten transcript of Dr Sumner's oral evidence?

A. The coroner's handwritten --

Q. The coroner's? I don't have it to hand.

MS GOLLOP: I expect the document that the witness is referring to is the Therese Brown handwritten notes, which start at page 160-010-001. The pages that contain her record of Dr Sumner's evidence start on page 160-010-008. I don't know the best way to do this, either we flick through the pages until Dr Jenkins finds the part to which he wishes to refer, or if somebody hands him the hard copy document he can do the same from the witness box.

MR STEWART: Here's a hard-copy document. This is, I ought to say, not Mrs Brown's handwriting, rather the solicitor from Brangam Bagnall & Co.

THE CHAIRMAN: It's 1.05. I presume there's some more questioning beyond this, is there?

MR STEWART: Yes, sir.

THE CHAIRMAN: We'll give you the document over lunch, doctor.

Mr Stitt?

MR STITT: May I just tidy up one point before we break for lunch?

THE CHAIRMAN: Let me tidy this point up with the doctor, have a look at this document over lunch, we'll start again at 2 o'clock, we'll finish your evidence and we will finish Dr McCord's evidence this afternoon as well. Okay? So we'll start again at 2 o'clock.

Mr Stitt?

MR STITT: Sir, could I ask if the witness could stay? It's the first preliminary report, as I recall it, could it be pulled up, 022-010a-040? This is the first page of that first report and I'm making the point in the light of Mr Stewart's questioning that the witness had effectively chosen to erase any reference to the Dr Sumner. I wonder could it be put through you, sir, to the witness that -- and I'll read it and ask the question:

"While it is possible in retrospect to form the opinion reached by Dr Sumner that Raychel must have

suffered severe and prolonged vomiting, this does not seem to have been the assessment of her condition made by experienced staff at the relevant time."

I wonder could the witness be asked what he meant by "retrospect" and did he expect to be enlightened further when he heard the actual evidence of Dr Sumner as to how he reached that conclusion, albeit apparently in retrospect?

THE CHAIRMAN: Can you help with that, doctor?

A. My intention in the use of the words "in retrospect" means following the events. Following the time at which the events occurred.

THE CHAIRMAN: Okay, thank you. Thank you very much. We'll pick it up at 2 o'clock.

(1.10 pm)

(The Short Adjournment)

(2.00 pm)

MR STEWART: Dr Jenkins, before lunch you told us that whilst you couldn't remember the detail, you felt that you had been asked, in relation to your final report, to concentrate on the broader picture, aspects of the drafting of the guidelines, and so forth. You don't recall the identity of the individual who asked you to do that, but you think it was at least a member of the DLS or a member of the trust.

A. It was definitely not a member of the trust. I had no direct contact with any member of the trust during this period.

Q. Can we therefore conclude it was likely to be a member of the DLS?

A. Someone on --

MR STITT: Before the question is asked -- and I don't know the answer to it -- but, in my respectful submission, it's clearly a matter of privilege what discussions took place between legal advisers and the independent expert in relation to his report.

THE CHAIRMAN: That's right, but Mr Stewart isn't asking the content of the legal discussions, he's asking if any discussions took place, who did they take place with. Dr Jenkins has said he's sure it wasn't anybody from the trust and in fact I think the only alternative is that it's somebody from the legal team, whether it's a solicitor or counsel. That's the point. Or were you going somewhere else?

MR STEWART: That's fine. I'm not sure that I was waiting for a response from Dr Jenkins to that, but ...

A. I think the chairman has summarised my view.

Q. Thank you. Were you aware going into the inquest that it was the trust's stated position that it took issue with Dr Sumner and believed that the vomiting was

neither severe nor prolonged?

A. No, I hadn't seen any of the other material that had led the trust to take that position.

Q. But were you aware of that position?

A. I'm trying as best I can to recollect what happened on the morning when I went to the inquest. In all honesty, I can't remember what was said to me, but certainly I have no recollection of that being said, and even if it had been said, it had no impact on my views. My view, as I think I've said earlier, was that I needed to hear Dr Sumner explain his position in relation to the vomiting.

Q. Indeed, and you said just before lunch that you would like an opportunity to go through the handwritten note of the evidence to draw to our attention Dr Sumner's evidence and the evidence that caused you to revise your opinion.

A. It's very brief, it's on page 15 of the document 160-010-015.

Q. Thank you.

A. In the second section which starts:

"Re fluid balance situ. Anything in test results to indicate severe and prolonged ..."

Well, I presume that's "severe prolonged and severe vomits".

THE CHAIRMAN: Yes.

A. It was his response to that which, for me, was what I described as the light bulb moment when he said, "In my opinion, grossly ..." -- and I don't think he used the word "inflated", but it was in respect of the abnormal electrolyte results, were, in his view, clear evidence that the vomiting must have been of a severe degree. And that to me took away the whole issue about who said what about the vomiting. This was the evidence, the electrolytes showed -- and I was happy with that.

MR STEWART: In particular it was not only the sodium, but also the magnesium levels.

A. Potassium. Magnesium may also, I can't remember, but potassium was also ...

Q. And that was, of course, information that you had all along?

A. Yes. But that's why I describe it as a light bulb moment. It was just when he said it that it suddenly made sense. If you like, the final piece of the jigsaw fell into place.

Q. We looked this morning at your underlinings and annotations on Sumner's report and so forth and we can see that you were very interested in the severity of vomiting, you were very interested in the timings, the

fluid amounts and so forth. How could you not have incorporated the U&Es into your overall consideration?
A. I think I was focusing on the debate and the disagreement in relation to the issue of the vomiting, and it just didn't occur to me that the electrolytes themselves were independent evidence in that respect. For whatever reason, this was the moment at which I suddenly realised that Dr Sumner, and indeed Dr Warde, had evidence to support their conclusion, and I was content with that evidence.
Q. Because if we follow on this note and we come to page 021 and 022, there is a record of your evidence to the coroner. If we put alongside 022:
"Taught in medical school ..."
Presumably that's fluid balance or hyponatraemia:
"... but not widely understood by the general medical practice."
The coroner asks:
"Can knowledge be accessed? Knowledge can be accessed, but you have to go looking for that piece of information. Are you aware of non-fatal hyponatraemia? Don't have a figure. Northern Ireland is now in enviable position, should happen in England and Wales. Should happen and will continue to happen."
Then:

"[19]96 death, not disseminated. Dr S [Sumner] felt if Dr C [may be Dr Campbell] brought to attention of CMOs in England and Wales, two-pronged approach."
So there was much reference to Adam Strain's case at the inquest?
A. Yes, the dots there --
MS GOLLOP: Sorry to interrupt. I don't think one reference could be described as "much reference". I've looked through this and there are, as far as I could see, two references.
THE CHAIRMAN: Okay. Let me rephrase it. There's specific reference.
MS GOLLOP: Here's one specific question being put to the witness by the coroner here.
MR STEWART: If you allow me two minutes, I'll find you other references and there are plenty of them. In fact, Mr Brangam writes back to Mr Walby at the Royal Group of Hospitals Trust to say that he cross-examined at length to differentiate the cases of Adam Strain and Raychel Ferguson, and in three particular respects he sought to differentiate them, so there was a significant discussion of Adam Strain's case, and if you'd like I will find the reference to that for you.
MS GOLLOP: If that's a question being put to the witness as to whether he remembers there being a -- sorry, what are

the words? -- "significant discussion" of the Adam Strain case, I am happy for that to be put as a question and --
MR STEWART: Do you remember a discussion about --
THE CHAIRMAN: I'm sorry, when you intervened, Ms Gollop, it was on the basis that I don't think that one reference could be described as "much reference". Mr Stewart is now saying that in fact the totality of the document shows that the then solicitor for the trust, Mr Brangam, made a point of cross-examining Dr Sumner about the difference between Adam's case and Raychel's case. That would appear to be significant specific reference to Adam as against Raychel. Yes?
MS GOLLOP: I have to say perhaps I'm missing something in my reading of this document, but I haven't seen extensive --
THE CHAIRMAN: Mr Stewart isn't just referring to this document; Mr Stewart is referring not just to a single document from a bundle of documents, but he's also referring to what Mr Brangam said after the event that he had done on behalf of the trust, which was at pains to distinguish Adam's case from Raychel's. Unless Mr Brangam was misleading in his own report to his client then it seems fair to conclude that what Mr Brangam was asking this witness would have involved

significant reference to Adam's case.
MS GOLLOP: Sir, three points. First of all, I'm certainly not suggesting that anybody has mislead anybody else. The next point: my reading of this document, which runs to 59 pages, is that it was an accurate, insofar as a handwritten contemporaneous document -- and none of us write quite as speedily as we would like to, but within the parameters of those constrictions, as reliable a note as it could be.
And the third point is that I think I'm right in saying that this part of the note that's being put is the coroner's questions to Dr Jenkins, and of course, as you will be aware -- and perhaps Mr Stewart is going to come on to this -- Dr Jenkins was present on Day 1 of the inquest only. So it may well be that Mr Brangam put matters to others witnesses on days 2 and 3 of the inquest, but this witness will not have been here to have heard those questions being put.
MR STEWART: Very well.
THE CHAIRMAN: I'm not quite sure where we're going with this, but ... Continue, Mr Stewart.
MR STEWART: In any event, there was discussion there, and it's noted:
"[19]96 death -- not disseminated. Dr S felt if Dr C brought to attention of CMOs in England and Wales."

So presumably that's the coroner pointing this out to you, and asking really what you thought about that as a proposition.

A. Well, when he referred to it as "the '96 death", it went completely over my head that he was referring to what I later found out to be Adam Strain because at this stage I was still completely unaware of Adam Strain in any respect.

Q. So he starts asking you a question about a death and his reference means nothing to you. Do you turn round and say, "I'm awfully sorry, sir, I don't understand what you're talking about"?

A. Well, my understanding was that he was not talking to me about a death, he was talking to me about dissemination of guidance. He mentioned a death in respect of the topic which I then responded to because my response was about the dissemination of guidance.

Q. So he took it as read that you would know about this death and you didn't disabuse him of that notion?

A. No, I took it as read that he was talking about -- in all of the references to two deaths at this point in time, I only knew of two deaths. And it may be the coroner only knew of two deaths. One of them we were in common, we both knew about Raychel's death, but it appears that we were on different tracks. I thought

that I was talking about the same death that he was talking about and he probably thought he was talking about the same death that I was talking about. My references were to Lucy.

Q. I see. So when you heard that there was another death, the 1996 death, did you take note of that mentally?

A. No, my focus was on -- and I mean, this was in the process of being examined in an inquest, so I was seeking to focus on what I understood to be the point of his question, and that was what I responded to, and this -- it was only when I read these notes subsequently that I saw that in fact there was a date mentioned at all.

Q. But in your response you go on to say:

"I was on the working group and I've also prepared an article with colleagues which has been submitted."

So you were talking about deaths and you were talking about the working group, but you knew that the working group had not considered a 1996 death.

A. Yes. As I say, that was not something which rang any bells with me at all at the time. But I didn't understand that to be an issue and so I continued in the discussion which I thought I was having with the coroner about what had changed in Northern Ireland because the previous comment that he'd made was about

Northern Ireland now being in an enviable position.

Q. So he thought your reference in your report to two deaths was to Adam Strain and Raychel, and you thought his referral to another death -- what?

A. I assumed that that must have been Lucy. But at this point this time --

Q. Sorry, that's a 1996 death; you know Lucy's not 1996.

A. That wasn't something which registered in my consciousness that the date didn't match.

Q. But what we do know is you do know about a death that he doesn't know about, Lucy's --

A. I didn't know he didn't know about it.

THE CHAIRMAN: Sorry, Mr Stewart, we're getting -- I have got your point. We're getting into knowns and not knowns and so on. It's not going to take us anywhere.

MR STEWART: You didn't refer Lucy's death to the coroner.

A. No, no, I understood that because she had died, a sudden and unexpected death, that her death would have been notified to the coroner.

Q. But you had no reason to believe that?

A. Well, I think that's the standard practice, so I assumed that that would have taken place.

THE CHAIRMAN: So in fact, it's very obvious that it should have been referred to the coroner because it's a sudden and unexpected death of a child in hospital.

A. Yes. And I assumed that that had taken place, and in fact, as I later understood it --

MR STEWART: Notwithstanding the papers that you got in relation to Lucy's case, none of which might have led you to suppose for a moment that there had been an inquest or a coroner's case, you nonetheless persisted in the belief that it would have gone?

MS GOLLOP: First of all, that's interrupting the witness so he didn't get a chance to finish, and second of all, I'm sorry, sir, but I'm not sure that's a fair extrapolation from the Lucy papers.

MR STEWART: We've been over this ground before: he was not instructed to appear at an inquest, he was not briefed with a verdict at inquest; he was asked to give opinion on a medical negligence claim. There was nothing on the papers to suggest it had gone anywhere near the coroner. On what basis was he to suppose that it had?

A. Because I know that to be standard practice.

THE CHAIRMAN: So your basis for supposing that it had gone was that it should have gone?

A. Yes.

THE CHAIRMAN: Thank you.

MR STEWART: If we go across the page, at the top of the right-hand side, at the end of that exchange, the coroner asks:

"Is there any aspect, further aspect, you take issue with?"

And you then describe how helpful you found it to have an explanation of why Dr Sumner felt it was prolonged vomiting, and that was because of the U&Es. The coroner asks you:

"Any instruction re degree of vomiting?"

Which I assume to mean:

"Did you receive any instructions, Dr Jenkins, about the degree of vomiting in this case?"

And there you say:

"Difficult to tie down. If in toilet, can't know. Plus is estimate; plus plus is usually large, but not v large; three pluses very large. Most people don't use more than four pluses. Seems staff made judgment not so severe to get medical assistance."

We know that you thought it was important that you get further information about all that. This was your opportunity to turn to the coroner and say, "Instructions? I've been trying to get instructions but they won't tell me"; why didn't you?

A. I don't know whether the word "instruction" is an accurate transcription of what the coroner said. It was certainly not how I interpreted his question because my response to his question was that he had asked me could

I shed any further light on the issue about the recording of the amount of vomiting and that was the question I answered and he did not come back to me and say, "That's not what I was talking about; I was talking about your instructions".

THE CHAIRMAN: I'm not sure, Mr Stewart, that any "instruction re degree of vomiting" means had the witness received any instructions from his solicitors about the degree of vomiting.

A. It was certainly not my interpretation.

THE CHAIRMAN: It might be: are there any instructions which were given to record the degree of vomiting? And that's how you get into the plus, plus plus, and so on.

MR STEWART: Did you get any further instructions after that?

A. Instructions in what sense?

Q. In relation to vomiting. Did you see any further reports after that time?

A. No.

Q. And it was simply what Dr Sumner said that led you to firmly agree with his conclusion?

A. Yes. And the coroner had just, before this, as you see at the top of the page, asked me if there was any aspect or further aspect that I took issue with, and if there had been anything within my knowledge at that point in

time that I felt needed to be brought to the attention of the coroner and which might influence the outcome of the inquest, I would have taken that opportunity.

Q. Could you have said, "I completely agree with Dr Sumner and, in my view, not only did she have vomiting, but there's no doubt she had severe vomiting"?

A. I could have said that, but this, I assume, records how I chose at that point in time to answer his question. But I did subsequently, in response to his further question, as you know, concur with the evidence that Dr Sumner had given.

Q. Yes. Over the page to 023. The bottom of the page there, we have:

"Further episode at 9. Would you make assessment?"

And your answer is:

"Judgment call for those caring."

Question:

"Comment re fact re doctors coming early AM without any other medical intervention for rest of day."

Answer:

"Not uncommon. Doctor would return if concerns. Would see same time next morning."

Question:

"Would expect to be notified re prolonged vomiting?"

Answer:

"Up to clinical staff to assess."

Did you tell the coroner at that time that you'd been asking for the protocols and for the regimes from the hospital --

A. No.

Q. -- and that you hadn't got them? Would it have been relevant to tell him that in that context?

A. I didn't think then and I don't think now that that would have altered his opinion or his conclusion in any way.

Q. But you're obligated to proffer, to offer relevant information, not to second-guess what the coroner might think is relevant.

A. I offered the information which I felt was relevant.

Q. There is a transcript of the judgment as delivered by the coroner at 161-066-016.

When did you learn for the first time more detail about the Adam Strain case?

A. Sometime late in 2004. And that wasn't just more detail, it was my first awareness of the case and that was some time later in 2004 after my interview with Trevor Birney.

Q. But you had been alerted to it there at the inquest?

A. No.

THE CHAIRMAN: The witness doesn't accept that he picked up

the significance of the date on which the coroner is said to have referred to.

MR STEWART: Very well.

You have been following the evidence, and doubtless you have read what the coroner, Mr Leckey, thinks about the practice of having, say, three reports and producing the third of them. He doesn't expect that in his court. Have you read that?

A. I have seen the transcript.

Q. When you came to Lucy's inquest, you produced a second report, which went to the coroner as, just in this case, you changed them. I take it in Lucy's inquest you didn't draw the coroner's attention to that fact either, did you?

A. No, it was my understanding that it was up to the trust and their legal advisers to decide what information should be shared with the coroner. I did not understand myself to have any responsibility in that regard.

MR STEWART: I see. Thank you, Dr Jenkins, I have no further questions?

THE CHAIRMAN: Mr Quinn? Do you have any?

MR QUINN: No questions.

THE CHAIRMAN: Any questions from the floor? Mr Stitt, have you something?

MR STITT: I don't have a question, but I have a point which

I have already alluded to.

THE CHAIRMAN: Ms Gollop, do you have any questions?

Questions from MS GOLLOP

MS GOLLOP: Just a few, Dr Jenkins. You've been asked questions about Dr Warde's report; were you aware before the inquest started that a decision had been made by the trust and/or DLS not to call Dr Warde to give evidence?

A. No.

MR STITT: Just for the record, I made it clear yesterday in my submissions that if a decision was taken in relation to such a matter, it will be taken by a client either accepting or rejecting legal advice given by the legal advisers.

THE CHAIRMAN: Thank you.

MS GOLLOP: Were you told when you wrote your report, dated 30 January, that Dr Warde was not coming to the inquest?

A. No.

Q. As I understand it, doctors Warde and Sumner were paediatric anaesthetists and you were a consultant paediatrician. Which of those disciplines would be most relevant to the matters touching on Raychel Ferguson's death?

A. Well, I believe that both had a contribution, but that in respect of the management and the issues that had arisen in the post-operative period, it was much more

relevant to the paediatric anaesthetist than to the paediatrician. There were broader aspects of the diagnosis and management of hyponatraemia which I felt would have been equally relevant to my expertise.

Q. You've been taken to the list of documents that you were sent for you to look at before you prepared a report. Did you get any documents in addition to those on that list?

A. No.

Q. Were you at any time, before you gave evidence to the inquest, told that there had been a critical incident review meeting about Raychel's death on 12 June 2001?

A. No.

Q. Were you told that there had been a meeting between the doctors and nurses who cared for Raychel and Mrs Ferguson in September 2001?

A. No.

Q. And just so that we're clear about this, you attended the inquest on the first day; is that right?

A. That is correct.

Q. And you listened to Mrs Ferguson's evidence?

A. I did.

Q. And then you listened to Dr Sumner's evidence?

A. Yes.

Q. And then you gave evidence?

A. Yes.

Q. And did you attend any further part of the inquest?

A. No. If I can just clarify, both Dr Sumner and I had arranged to give evidence on that day because we both had prior engagements on the subsequent days and the coroner had agreed to that.

Q. In your 30 January report, you referred to two deaths. Did the coroner ask you to identify the other death?

A. No.

Q. Did anyone at the trust ask you to do so?

A. No.

MS GOLLOP: I don't have any more questions, sir.

THE CHAIRMAN: Thank you very much.

Doctor, let me ask you two slightly different areas of questioning, moving away from Raychel and moving forward in time. There has been something of a debate, partly raised by Dr Scott-Jupp, who gave evidence from England, about a development there in some but not all hospitals, which is that in hospitals which are perhaps similar to Altnagelvin, where there are children who are on the ward for medical reasons and a smaller number of children who are there for surgical reasons, that the lead is taken in their care by paediatricians, but with the support of surgeons where there are surgical children.

I think other witnesses have said, well, we're not very keen on that idea, and I think I'll hear soon from Dr McCord, who I suspect wasn't very keen on that idea. What's your view on that?

A. Certainly at the time these events took place it was quite clear in Antrim Hospital that surgical children were under the care of the surgeons.

THE CHAIRMAN: I understand that and Dr Scott-Jupp is saying that in his hospital, in Salisbury, the situation which now exists did not exist in 2001, but it came in maybe five or six years ago, which might be not far short of your retirement. But as a system, what do you see the strengths and weaknesses of that are?

A. I think what did happen after these events was, first of all, there was much clearer guidance so that whoever was taking responsibility for caring for children in these circumstances had clear guidance on which to base their management and clear instructions as to the type of monitoring that should take place. Whether or not that was being done by the junior staff on the medical side or on the surgical side, at least they were working to a common guidance. There was also, in my experience, a much closer communication between the two teams, so that whereas in history it would have been unusual for the surgical team to seek the advice of the medical

team, in recent years it has been much more common for the two teams to talk to each other and to jointly address issues that might arise in the day-to-day management.

THE CHAIRMAN: Sorry, when you say that, are you talking about your experience in Antrim and experience beyond that? That's a general trend, is it?

A. I can't say because I wasn't involved, but my impression was that that improved communication and improved clarity was certainly something that was widespread. Although the rate at which it was implemented, I think, has varied enormously, as has been demonstrated, for example, by some of the publications that the inquiry is aware of, going as far forward as 2006, 2008, and still demonstrating very high levels of, in some cases, inappropriate use of the No. 18 Solution.

Whether or not that has in most recent years meant that the medical paediatricians take primary responsibility for the care of those surgical children, it was not the case up to my point of retirement, but I can't answer subsequently to that.

THE CHAIRMAN: Okay. If I could ask you about one other issue. When you were asked, just after the break this morning, by Mr Stewart about the Royal Children's Hospital moving away from Solution No. 18,

you said you weren't aware of it, you would like to have been told about it, but the systems which are now in place were not in place then for letting us know.

What better systems are now in place or were in place at the time of your retirement so that if the regional specialist hospital changed something quite significant in its practice it would let other hospitals know?

A. Well, in the latter years of my practice I was concentrating entirely on neonatal care, so I can really reply to you best in that context, which was where a much more active communication group was established within the neonatal community across Northern Ireland, which met a regular basis and exchanged this type of information, but still, informally, if you like. So they weren't formal links with, for example, the Department of Health.

There is now, certainly in process -- whether it is yet in place or not I'm unable to say -- a development of a managed clinical network, which would be a formal arrangement to ensure that communication does take place with all those centres who are providing particular types of care.

THE CHAIRMAN: And then there's a bigger issue. Within Northern Ireland, where more people know each other

there is a comparatively small medical and local population, it might be easier to get the word out if there are changes afoot, but we're also part of the UK Health Service. It seems it could become impossibly large to try to spread lessons around, but up to the point of your retirement was there a better system of learning significant lessons from developments elsewhere?

A. Well, I think some systems had improved. I mean, part of my contribution was to publish articles in literature that I hope will be read by people in the relevant specialties. For example, at the end of 2002 when we sought to publish something in the Archives of Disease in Childhood, which would be read by all paediatricians, but in fact the journal didn't see this as a high enough interest topic, and they did not accept the article we submitted, but did subsequently publish a letter, albeit in 2004, so in the interim we published in the Ulster Medical Journal, which would have had a limited distribution. So the literature, I think, is one of the areas which can be taken to do this.

The second thing, which I think and hope has been more effective, was the NPSA safety alert, and there's certainly in my experience, prior to my retirement, a much greater attention being paid to those types of

communications, which are generated centrally, but are then distributed through a formal network to all trusts. In the case of NPSA, of course, not necessarily involving Northern Ireland, but within the context of GB, which was, I think, where you asked me the question.

THE CHAIRMAN: Yes. Okay, thank you very much for that. Thank you for coming today. Unless there's anything that you want to add to anything you have said, you're now free to leave.

A. Could I just say something very briefly?

THE CHAIRMAN: Yes.

A. From the outset of my contribution to this area in September 2001, I sought to assist with the positive aspects to develop guidance, to try to prevent this happening again. However, I have become aware, not at least through the work of the inquiry, that in doing so I may have inadvertently and unintentionally caused hurt or distress to some. If that has been the case, then I am deeply sorry and I hope that they can accept my apology.

THE CHAIRMAN: Thank you very much indeed, doctor. Thank you.

(The witness withdrew)

THE CHAIRMAN: Mr Stitt, was there a point that you wanted to make to me?

MR STITT: If I may, Mr Chairman. It's touching on the last witness and the three Jenkins reports. I did mention this to Mr Stewart. It's very brief, but it's simply this. You observed or you put to -- I think it was Dr Nesbitt -- last week, or it might have been this week -- I can't recall exactly where and I couldn't find the reference, but it was simply this.

In relation to providing the third report and not providing the first two reports, the trust/DLS/trust legal team were not even acting in the manner which would be appropriate for a clinical negligence action in the High Court. You remember that, do you?

THE CHAIRMAN: Yes.

MR STITT: And I made no response as I had no response to make, and my colleague made a short response. I thought it important to just have a look and to refresh my memory because time can sometimes be abridged in one's memory, and this isn't the sort of thing which is often found in the textbook or in case law. So what I'm saying is my research, my best endeavours to try and assist you, sir, in putting this into perspective.

The time that we're talking about is early 2003. Going back in time, you will be intimately familiar with Order 25.

THE CHAIRMAN: Yes.

MR STITT: Order 25 was amended in 2009 to include -- I will call them, broadly speaking, medical negligence actions, and that was coming into effect on 7 September 2009. Before that, we had the, what I will call the old Order, the former Order 25, paragraph 1 of which -- it's short and I'll just read it if I may:

"This Order applies to all actions for damages in respect of personal injury or death, except while liability remains an issue for actions grounded on an allegation of medical or surgical negligence."

The logicality of that is that if in a medical -- I'll call it for short a medical negligence case. If in a medical negligence case, liability is still an issue, clearly the liability evidence is going to come from a medical expert. If it was a factory accident and liability was in dispute, it is most unlikely that the medical evidence would come from a medical expert, probably an engineer or somebody else and there was no rule to the contrary that I am aware of.

The actual practice was, in 2003, that in a medical negligence action, the first time that either side would probably be aware of the contents of a medical report dealing with liability as opposed to a quantum report would be when the plaintiff's expert went into the witness box. And the format would often be -- and I can

speak with some experience -- that the plaintiff's counsel would, after the swearing of the witness, have the witness introduce himself or herself, and then the question often was: my Lord, the witness has compiled a report; would it be helpful if that report was shared and could be read into the evidence?

And the judge almost invariably agreed to that and time was not taken for all parties to read that report, and that was the first time that the defence would have seen the plaintiff's report and either at that stage or later in the hearing, the defence would make a similar application and often hand over its reports.

There are cases when, in fact, reports were not handed over, but as the years progressed it became more common for that to be the case, but not before the morning of the hearing. That was the accepted practice in 2003.

One has to fine-tune that to some degree to look at the question of whether or not, when that report was handed in, there was an obligation, a duty or a requirement on that counsel to hand in any previous report. And in this case, for instance, we have the report of November 2002, the second report, that's 12 November 2002, the second report is 27 January 2003, and the final report is 30 January 2003.

My first general observation is that there was no obligation to refer to or to hand in any earlier report. If that witness adopted that report as his or her evidence, they would give their evidence within the four corners of that report but could not go outside the report because that's what was contained in the report. They would then be subject to cross-examination, which may or may not ask whether they had ever taken a different view or whether they'd ever given a different opinion.

But that's the case generally speaking, no matter what any earlier report might have dealt with. But when one comes to the actual reports in this case -- and we're dealing not with the High Court, but we're dealing with a coroner's court -- and we know from the report from Ms Dolan -- which has been commissioned by you, sir, by the inquiry team -- the current position in relation to the requirement to disclose reports before a coroner in Northern Ireland as of today. But dealing with these three reports, if I may ask that -- the first report. If I could very briefly --

THE CHAIRMAN: Yes, please, very briefly, because Dr McCord is waiting to give evidence and I didn't expect this to turn into a significant, lengthy submission, Mr Stitt. Keep it very tight indeed.

MR STITT: I won't call it up then, but for the record it's 022-010a-041. That's the second page of his first report. It says:

"If it can be confirmed that the frequency and severity of the vomiting was not outwith the degree expected by experienced staff, then it would appear that there has been no negligence in the treatment."

That's obviously a preliminary view and he's asking for this further information, which has been referred to.

The second document which has been called a report, which is in fact a different format, it's a letter, and it clearly deals with one issue and he's been asked to comment on Dr Warde's report and does so, and in my submission that is a specific, free-standing letter dealing with a specific subject and that is his view on another report.

The final report, if I may respectfully suggest, is a free-standing report. He does not venture comments on the degree of vomiting, and in my submission, he has left that because he hasn't received -- well, you've heard his evidence. And in my submission, the decision to put forward to the coroner the final report should not be criticised because, firstly, it was entirely compatible with procedure in the High Court; secondly,

it was entirely compatible with procedure in the coronial area; and thirdly, even in those days, there was no requirement to put forward or to give any report.

In my submission, it's not accurate to suggest that in withholding that report, that wasn't adhering to the standards then applying in 2003 in the High Court.

THE CHAIRMAN: I'll consider that. I will also consider -- and I'll put you on notice that I'll also consider this -- the fact that he's briefed with a misleading press release. How that finds its way into an expert's brief is entirely beyond me. Dr Jenkins thinks it's inappropriate to be briefed with a press release and then he's written to later on and is asked if he has any further points which he thinks can assist the trust. There's nothing independent about an expert being asked for a report and if he can think of anything more which will assist the trust to go to an inquest, but we can deal with this in submissions. I'm putting you on notice that I am very concerned about this morning's evidence.

MR STITT: I am not in a position to deal with the first of those points, but in relation to the second of those points, that was to help the trust in relation to a view in relation to the Warde report.

THE CHAIRMAN: Well, we'll see.

Mr Reid?

MR REID: Thank you, Mr Chairman. If I can call Dr Brian McCord, please.

DR BRIAN McCORD (called)

Questions from MR REID

THE CHAIRMAN: Doctor, thank you for coming back. When you were here in February/March, your evidence went beyond the strict clinical areas and into some of the governance areas, so you can take it that that evidence is available to me and I have re-read my notes on your evidence already. So I think Mr Reid will cover some of those areas in a little more detail, but we don't need to go through all of those points again. That's subject, of course, to you being free to add any further thoughts or anything that has occurred to you.

A. Thank you.

MR REID: Thank you, sir. Thank you, Dr McCord.

As the chairman's just said, you gave evidence on 13 March 2013 in the clinical hearings before the inquiry. Since then, you have made two witness statements, and if I could just get you to adopt those witness statements. The first was WS032/3, and that was a collection of governance-based questions. Do you recall that statement that you made?

A. I cannot see it.

Q. It's not going to be called up, doctor. Your witness statement dated 15 July 2013, do you remember making that?
A. Yes, I do.
Q. And the fourth was WS032/4, which was your water-bottle example statement. Do you wish to adopt those two statements?
A. That was in June.
Q. Yes.
A. Yes.
Q. Thank you, doctor.
I don't intend to go through your CV because Ms Anyadike-Danes did it on a past occasion, but is it correct to say that at the time of Raychel's admission you had been a doctor for 22 years and a consultant for 12 years?
A. That's correct.
Q. Thank you. The inquiry's heard from Mr Gilliland, as regards surgery at Altnagelvin, and Dr Nesbitt as regards anaesthetics. To some extent, you are here as the paediatric representative of Altnagelvin in Raychel's case.
A. Okay.
Q. Can I ask you just about teaching and education, firstly? How, in general, would new teaching, new

issues, be brought into the practice of paediatricians at Altnagelvin?
A. Changes to practice would in part -- at each changeover we'd get trainees who would be coming through from the regional centre having spent some time there. Sometimes they would bring novel treatment regimens with them, which had been altered from the previous. An example would be management of bronchiolitis, for example. A variety of treatments have been changed over the years from nebulised adrenaline to hypertonic saline, and we would alter those in part, not at the insistence, but having been exposed to the juniors who had come through and had experience in the regional centres. So that was one way.
Q. Let's split that into two parts. Firstly you said about the training they would have received at the regional centre. Is it correct to say then that the paediatricians coming up to Altnagelvin would have spent some time, would have had to spend some time, at the Royal as the regional centre?
A. There are broadly two trainees types of paediatrician: the very junior ones, who may be GP-focused or the early stage of their training, but there would be a middle band, a middle-grade group, who would have had prior experience, often in the regional centre, before they

would be sent out to the peripheries then to practice there and get an experience of what peripheral practice might be like.
Q. So we have the junior ones who are GP-focused and then the ones in the middle who might have trained at the regional centre?
A. Yes.
Q. To what extent did new information from the regional centre -- was it through that avenue of new paediatricians?
A. That would have been a prominent one. I'm not aware of any formal linkages, you know, unless there was something ... I'm thinking perhaps -- but these would be more national. I'm thinking about the withdrawal of aspirin and the association with Reye's syndrome, going way back to the mid-80s, that kind of thing.
Q. So that's at the junior level how information might be brought across from the regional centre.
A. Mm-hm.
Q. At the senior level you say there's no formal links, but how, as a consultant paediatrician, for example, would you have heard about new information or new guidance or new issues coming from the regional centre?
A. Well, it probably would have been from personal reading or discussion with colleagues --

Q. So just --
A. -- within your hospital. Occasionally you will have reason to contact a colleague in the regional centre and it may have been divulged from that or discussed at that level and then following up with reading you may have changed after that.
Q. So to a large degree it was an ad hoc system?
A. It was loose, a loose system.
Q. As a consultant paediatrician in a district general hospital like Altnagelvin, say in 2001, what did you see the Royal's role as a regional centre as being?
A. For regional specialties and for provision of intensive care. And the regional specialties would have been such things as neonatology, which would be in the Royal Maternity, and then within the Children's Hospital you would have the paediatric intensive care and then endocrine, cardiology, gastroenterology, and renal specialties. That would have been part and parcel of that.
Q. So you mainly saw it as a referral centre?
A. Referral centre, yes.
Q. Which is kind of a one-way street in some ways.
A. Mm-hm.
Q. In what ways was it a two-way street, so to speak?
A. Optimistically, you'd hope you'd get information back

for any referral you had made and that might include information that was relevant and might change your practice to some extent. You know, if you had a child with a gastroenterology concern, you might be advised by the regional centre to do this, do that, prescribe this, prescribe that, and you would have learnt to some degree that way.

Q. Let's look at a real example. Let's look at, for example, the case of Adam Strain. As you might have been aware, there was a statement --

A. No, I'm not aware of Adam Strain at all.

Q. Let me explain to you. There was a statement made by the Children's Hospital following Adam Strain's inquest in 1996, and if we can pull that up. It was a statement made at the inquest, following the inquest, regarding the use of intravenous fluids. In areas such as that, would you expect statements such as that where the Royal is making a statement about intravenous fluids, would you expect that to be disseminated to the district general hospitals?

A. It depends what the statement was.

Q. We'll get you a copy and we'll come back to that.

A. Thank you. You know, it's hypothetical.

Q. You have told us what you thought the Royal's place as a regional centre would entail. What would you, as

a consultant paediatrician at Altnagelvin, like the role of the Royal to entail?

A. Again, it was a regional centre, it functioned very well as that, somewhere where you could approach for specialist advice or for intensive care. By way of education dissemination, the experience with No. 18 Solution being withdrawn, that caught me by surprise that they had withdrawn. I think it depends on the reason for changing practice, if it was for a progressive reason in terms of modified treatment, but if there was health and safety issues around a modification I would have anticipated and hoped that that would have been more widely disseminated than it seems to have been.

Q. Let's bring up that statement I was referring to. I have got a reference now. It's 011-014-107a, please. I'll just give you a moment to read that, Dr McCord. (Pause).

A. I don't recognise the signature.

Q. Okay. The signature is Dr Robert Taylor's, I believe.

A. Right. I get the impression that it is being directed towards anaesthetic rather than general paediatric, either medical or, on a more wider context, surgical.

Q. That's correct. But would you, as a consultant working in a district general hospital, expect something like

that to be disseminated out to the district general hospitals or not?

A. It's a very general document, you know. It's lacking in detail or specifics, you know, and it deals with specifics of anaesthetics. So it probably wouldn't have had that much meaning to me just coming across my desk on day one. I would have noted it because of the tone of the letter, but with the lack of specifics, whether it would have had any effect on my practice because I have very little contact with surgical and anaesthetic matters.

THE CHAIRMAN: It might not be for you, but it might be for an anaesthetist or for a surgeon?

A. [OVERSPEAKING] yes, and that might lead to a follow-up query: what's the issue here?

MR REID: Also, you've said it might not have affected your practice, but would you have liked a statement like that to have been sent out, just in the first place?

A. I think it'd be a good idea because of the tone of it and the issues, the safety issue, safety.

Q. You mentioned during your evidence there as well about the change in policy as regards Solution No. 18 at the Children's Hospital.

A. Mm-hm.

Q. And how you would have liked to have known about

a policy such as that? When did you first become aware of the change in policy as regards Solution No. 18 at the Children's Hospital?

A. I think around the time of the critical incident review, but I am not sure it was at the review; I think it may have been a short time later, through my colleague Dr Nesbitt, who had made an enquiry and had discovered it and revealed that then to us. It came as a surprise and a shock.

Q. Okay. We've looked at the Royal's position in terms of training. What particular training did you do of paediatricians just within Altnagelvin to alert them to new issues and new guidelines?

A. I didn't have that much to do, I had a little more to do with undergraduate teaching at that time rather than the post-grad. That was undertaken by other colleagues, both within our specialty. But there was a lot of ward round teaching, and that would have been teaching on the job rather than formalised, although there were some formalised sessions. I can't remember any particularly off the top of my head in relation to electrolyte imbalance, but there may have been. I'm not totally sure.

Q. Were you aware of, for example, lecture series or training sessions that were held for JHOs or SHOs at

Altnagelvin?
A. JHOs would have been a fairly regular feature and the SHOs, because they were general medical, there would have been teaching for those, and then in-house within the paediatric department we tried to organise regular weekly teaching sessions on various topics, often picked by the juniors themselves, and then read up and then presented. And sometimes following a case, as an example, leading on to discussion about a particular condition.
Q. Can I just ask you, in 2001 how many paediatric consultants were there?
A. Five.
Q. And who was in charge of the paediatric consultants?
A. Nobody was in charge in terms of -- probably, seniority, Dr Quinn would have been the most senior, and followed by my next colleague, and I would have been third. That kind of thing. If you like, that kind of seniority, but nobody was in charge as such.
Q. To whom were the consultant paediatricians accountable? Who was the next level?
A. I understand. We were certainly not a fledgling, but -- previously we had been under the general medical umbrella and then there was a change to the directorate structure, you know, and then we moved into the women

and children's directorate, probably because of our neonatal work where we probably would have had contact with obstetricians through the midwives, et cetera, et cetera, and perinatal meetings more than we would have had with our adult medical colleagues.
THE CHAIRMAN: From what I was told over the last few days, when that directorate was set up Dr Quinn was the director and after he'd done it for a few years, he stepped down and was replaced by Dr Martin. Does that ring a bell?
A. I can't remember the exact order, but I remember Sally McGee was at one stage and that may have been after Denis Martin, I am not sure. But those names were the -- I can't remember their title. Clinical directors.
MR REID: In terms of Raychel's case, were any of the other consultant paediatricians involved or was it just yourself in the aftermath, because you'd been involved during her care?
A. I suppose we were all -- I was directly involved because I was there at the time of Raychel's collapse. But I suppose we were all involved to some extent in that there was talk around it, that sort of thing, what are we going to do. There was almost an immediate -- not knee-jerk, but a palpable sense that this was going to

be pushed towards the paediatric team to deal with, you know, whereas first and foremost Raychel was a surgical patient having had a surgical procedure who happened, by chance, to be on a paediatric ward because of her paediatric age range.
We felt that -- and we didn't have the facilities or the resources to be able to assist and this was a surgical problem, but we had to look at our fluids, were we happy enough with No. 18? We didn't change immediately, but there were changes on the surgical side. So there was discussion. We were all involved to some extent around that.
Q. Was there a tension amongst the consultant paediatricians because of the fact that Raychel was a surgical patient and maybe this wasn't paediatric's problem?
A. I suppose I was the one who felt most tension, being most close to it. But "tension" is not the right word. Stress, maybe, related to the events, and what would likely be the follow-up from that. But no, there was no tension between ourselves in terms of, you know, "Will we, won't we?", that kind of thing.
Q. We might get into it shortly, but was there any opposition amongst the consultant paediatricians in relation to the ideas or the decisions that were

being made about the appropriate fluids to be used with paediatric patients?
A. No, I think, you know, there was a general feeling that we didn't have to change because of the conditions we dealt with and the way we managed fluids, that we had not had an issue with this. I suppose initially we probably thought, you know, this was such a rare event and it didn't need to merit change at the moment, but take stock, wait a little while, measure the pros and cons and see what happens.
Q. But again, to the extent that the paediatricians didn't do anything wrong, but the surgeons had done something wrong here --
A. Yes.
Q. -- was that the general feeling?
A. Well, I think it was a feeling it was a surgical issue.
THE CHAIRMAN: Yes, something has gone wrong on the surgical side.
A. Yes.
THE CHAIRMAN: And the question was: to what effect should that lead to changes on the paediatric side?
A. Yes.
THE CHAIRMAN: If it needs to lead --
A. If it needs to change all. That kind of thing. And we didn't feel there was enough worry or concern at that

point.

MR REID: Let's just look at the involvement of surgeons in the paediatric ward, Ward 6. This was touched on somewhat during your previous evidence. If we call up pages 22 and 23 of your evidence on 13 March 2013, please.

Ms Anyadike-Danes asked you:

"Were you aware there was a bit of concern from the nurses [this is at line 10, page 22] that the surgeons perhaps just weren't as accessible as they might want them to be for their patients?"

You answered:

"I did get, you know, that impression, yes and you know, it was mentioned from time to time and it seemed to flare and then quieten, improve for a while and then it would come to the surface again. But it did seem to be an issue for the nursing staff."

Would it be fair to say this was a source of tension between the nursing staff and the surgeons that kept bubbling up?

A. Tension, again, I'm not sure ... I think an annoyance, an irritation might be a more appropriate term. Because things didn't generally get done, just maybe not as quickly as everybody would have liked them. I wasn't aware of any issue of patient safety and these were just

niggles that people weren't available when you would like them to be or as soon as you would like them to be.

Q. How often did that issue keep raising its head?

A. It'd only be a guess, I'm sorry, I couldn't put any figure to that at all.

Q. Was it a regular issue that --

A. Not regularly, it was an intermittent phenomenon.

Q. But it did come round more than twice?

A. It did come round from time to time.

Q. Because I think you might be aware of what Sister Millar has said on behalf of the nurses.

A. Mm-hm.

Q. If I can actually just drop page 23 for the moment and bring up the 1 March 2013, page 58, please. If we can start at line 7:

"I said that I thought it was totally unfair that the nurses had such responsibility for the surgical children. I felt it was unfair. I felt that we had to be the lead all the time in looking after the surgical children. We are nurses, we're not doctors, and whilst we do our very best, I don't think we should be prompting doctors. We would now maybe, but 12 years ago ... Or I don't think we should be telling a doctor to do electrolytes. It's different now: we're more knowledgeable, we've had quite a bit of education. But

in those days, really, we were leading the care, I feel, in looking after children."

Does that feeling of Sister Millar's reflect what the situation sometimes was in 2001 on Ward 6?

A. I think I would have some sympathy towards that view. My own context earlier on was thinking of the paging system that doctors weren't -- surgical doctors weren't immediately available. In terms of check electrolytes, certainly all I can comment is on the fact that on the medical side we did them a lot more regularly. I don't know what structures in detail were available or advice was available from the surgical doctors to the nurses or whether ... Are they in part a prompt? I suppose one of the reasons why a child is in a paediatric ward is for nursing, is for paediatric nursing expertise. Does the day-to-day management, the electrolyte checks -- is that part and parcel of that? It could be argued either way. Technically, it is a medical decision to do, but where nurses are there continuously, prompting for doctors who are a little forgetful, or surgical doctors who are forgetful and are not available ...

Q. This is an issue between the surgeons and the nurses?

A. It is, yes.

Q. But it's happening on paediatric Ward 6?

A. Yes.

Q. What did you or the other consultant paediatricians do about that issue that was there?

A. Again, it was a surgical in-house problem, but I think Sister Millar did mention it at one sisters' or consultant meeting, and we advised -- certainly I think I advised to speak to Mr Bateson, who would have been the surgical lead at that time, to take that issue through that way.

Q. You said it was a surgeon's in-house issue and you said to Sister Millar, "Speak to Mr Bateson about it"?

A. Yes.

Q. Did you speak to Mr Bateson about it?

A. I did not.

Q. Did you give Mrs Millar or the nurses any support or encouragement to back them up?

A. I'm just wondering what form -- I tried to be there, you know, sort of thing, with a friendly aspect. I didn't do any formal thing in terms of that particular request about Mr Bateson. I suppose, had Sister Millar come back to me and said, "I have approached Mr Bateson, I didn't get any satisfaction", I hope I would have had the sense to say, "Look, gather information", the way Sister McKenna had done about the staffing issue, gather actual examples and go back to Mr Bateson at that stage. It would be unusual, because of the different

directorate, for one directorate to point out issues in another, unless there were specific details about a patient-harm issue or something.

Q. Doctor, you say it would be unusual for one directorate to involve themselves in another directorate --

A. Yes.

Q. -- and you have said it's an in-house issue --

A. Yes.

Q. -- but these are patients that are on your ward; isn't that right?

A. It doesn't belong to me, it's the hospital ward --

Q. Yes, but --

A. -- where I happen to practise as well.

Q. It's a paediatric ward.

A. It's a ward where children under 14 tend to be nursed, both surgical and medical.

Q. But ostensibly it's the paediatric ward and ostensibly the paediatricians are in charge of the paediatric ward?

A. Not at all. Not at all.

THE CHAIRMAN: That's the debate, Mr Reid.

A. For paediatric medical children we look after a different set of conditions. I have no experience in post-operative child management. I have never had experience -- I have had no training in it, and that's been part of the issue, you know.

MR REID: All I'm saying is you see there's this issue there. Do you not think that it's incumbent on you or the other consultant paediatricians to do something?

A. It's incumbent upon the practitioner themselves if they see paediatric -- to see paediatric patients that they have to be responsible. And children are not mini-adults; it does require a certain degree of training and expertise. We provide advice if requested, but we do not take responsibility. We can't. We do not have the resources and we do not have the training.

Q. Can I ask you about another aspect of that, which is of course how the paediatricians step in if the surgeons are unavailable. To what extent was that an issue or a problem for the paediatricians as opposed to the nurses?

A. I think it was based on goodwill, you know, it was done with a "Oh, let's do it and get on with it", that kind of thing. So it was really the practical things, re-erecting cannulas, writing up IV fluids, what Dr Butler did, that sort of level.

Q. Dr Scott-Jupp has commented on this. If I can bring it up, it's 20 March 2013. Pages 44 and 45, please. Dr Scott-Jupp is the inquiry's expert consultant paediatrician, and like you, he works in a district general hospital. If we look at the very last line on

page 44:

"The majority of patients on any children's ward in a hospital like this, where there's only one children's ward, will be medical. The paediatric staff will be there virtually the whole day. The nurses will know them as well. The surgical teams will be much less involved."

And later on at line 12:

"Surgical doctors can sometimes be difficult to get hold off for very good reasons because they may be in theatre, but even if they're not in theatre they'll be tied up with adults in a different part of the hospital, which may be a long way away and they may be extremely busy dealing with very sick adults and the children's ward is often quite a long way down their list of priorities."

Is that a reality that you also experienced as a consultant paediatrician?

A. Well, paediatricians are often off the ward too because they have clinics, they have neonatal intensive care, they have day care units, they have A&E resuscitation calls. So it's not 100 per cent strictly true that there's a paediatric presence there 24/7. We are there more of the time because our throughput is much higher. We would see many, many more patients, short stay in,

out, you know, that kind of way, than what the surgeons would. By virtue of that then we are around and do get to know the nurses better. But again, the same applies, on goodwill we will help if asked, but not as a matter of routine. But we have stretches on our resources too.

Q. As you know, obviously one of the issues in Raychel's case was the availability of the surgical staff as opposed -- and because of the fact that Raychel wasn't seen by any senior doctor throughout the main day --

A. Yes.

Q. -- after she'd been seen in the morning and it was only junior doctors who were in to see her. What has been done since 2001, doctor, in order to solve or at least try and address the issue of the responsibility for surgical patients on Ward 6?

A. I don't know in detail because, again, we run side by side rather than concurrent. But a formal ward round done, post-take ward round, AM ward round is done. There have been guidelines issued about the electrolyte checks, and I think to date I have not heard any significant issues from the nursing staff in recent times, but things have changed for the better in terms of the regularity of assessment and regularity of review of intravenous fluids, et cetera, especially the intravenous fluids.

Q. Just before we leave the point, I'll assist you by bringing up reference 021-044-091, please. This is a memorandum, it's referred to in your witness statement, and this is provided to all surgeons and consultant paediatricians from the medical director. Do you recognise that memo?
A. Yes, indeed.
Q. It's dated 2 May 2003, so almost two years after Raychel's death. It starts:
"As a result of some uncertainty regarding the management of surgical paediatric patients ..."
What uncertainty is the memo referring to, as far as you are aware?
A. I'm not aware of what the uncertainty is. I commented on that before. I'm not sure whether Dr Nesbitt has commented or given you his answer, but he is one of the authors. I think there were some presumptions related about who was responsible for IV fluids, i.e. surgeon, anaesthetist or paediatrician. It may have been related to that, although that's two years after Raychel's collapse, so I'm not sure if that's a historic comment or whether that relates to events between 2001 and the setting of that.
Q. Can I ask you about the fourth bullet point down:
"The paediatric nursing staff will bleep the surgeon

or nominated deputy and inform them of the results when available. If the named consultant is not available, then the on-call surgeon should be bleeped."
A. Mm-hm.
Q. Does that mean that the on-call surgeon should always be contacted before any of the paediatricians should be contacted?
A. I'm not sure that, you know, whether that means that or not. That was something that I wouldn't feel competent enough to comment on because it didn't involve me directly. And we would always be available ad hoc any time, no matter who rung us or spoke to us. But I'm not sure if there was any order of calling there. I don't know.
Q. Is the same system in place now effectively as it was in, to some, extent in 2001 where paediatricians offer just ad hoc advice?
A. Nothing has changed, that still applies to today and still -- what we operated in 2001 in terms of paediatric and medical and surgical is the same.
Q. Do you think, as a consultant paediatrician, there's anything to be gained from having more certainty as to the relative responsibilities of the surgeons and the paediatricians on Ward 6?
A. Not without additional resources. I mean, you could

argue "If it ain't broke, don't fix it", but it obviously was broken in terms of Raychel. That was fixed. You could argue "If it ain't broke, don't fix it". But certainly in terms of paediatric medical people, I'm aware of what Dr Scott-Jupp -- and that is maybe a foreboding of what will come in the future given time. It may be what society or the medical community at large would prefer. I can see advantages to it, but not on the current situation, staffing wise or training wise. It would be something that could be taken forward, but would require staffing, resources and education.
THE CHAIRMAN: When you say "training wise", do you mean if paediatricians are going to have overall responsibility not just for medical patients, but for surgical patients, then you need to receive further training in, bluntly, what it is --
A. In management of surgical children, yes. Because there are subtleties, and I've hinted at this before, that surgical vomiting and medical vomiting may be slightly different. They may not be the exact same thing. That's a case in point: get some familiarity.
MR REID: Just in terms of responsibility for IV fluid management, immediately following Raychel's death, am I correct in saying that there was an attempt to

transfer responsibility to paediatric medical staff?
A. Mm-hm.
Q. But that that simply didn't work because of --
A. Resources, we didn't have the staffing, we didn't have the experience, and we weren't comfortable taking that on board. In addition, you could argue that might encourage surgeons to undertake more risk-prone surgery so the surgical contact would end at the theatre door -- surgical responsibility would end at the surgical door -- theatre door rather than at discharge from hospital. So I could see that we weren't ...
Q. And as far as you're concerned, is the delineation of responsibility for IV fluid management now a straightforward matter or are there still gaps?
A. I'm not aware of any deficiency. I think in the last two or three years I've only been asked twice to comment on fluid electrolyte results in surgical children, so it's not happening very often and usually it's a sicker child.
I should add maybe that the junior doctors would have been approached more, or the middle-grade doctors were maybe being asked a wee bit more frequently than would come up to my level. But it's not frequently to consultant level.
Q. Just one last question about this area. This memorandum

is mainly directed towards surgeons. Would you have expected these sort of issues in regards to responsibility to have been addressed prior to 2001?

A. We weren't aware there was a problem until 2001, and again, if it ain't broke, don't fix it. Everybody -- nobody had any indication that there was any issue with No. 18 or the surgeons -- as I say, there was irritation but not aware of anybody coming to harm.

THE CHAIRMAN: You knew there was an occasional problem, but what happened in June 2001 was a combination of that occasional problem, issues about who was responsible for fluid prescription for a child coming out of an operation, issues about the accurate recording and measuring of vomit and a whole combination of issues.

A. It opened up a whole can of worms and I think up until 2001 we were probably just fortunate. You know, luck was on our side that nobody had come to harm by it.

THE CHAIRMAN: Thank you.

MR REID: If I can ask you then about the critical incident meeting of -- this might a good opportunity for a break.

THE CHAIRMAN: Doctor, we'll take a short break. The stenographer's been going since 2 o'clock so we'll take a few minutes.

(3.27 pm)

(A short break)

(3.37 pm)

MR REID: Dr McCord, if I can refer now to the critical incident meeting of 12 June 2001. You touched on this briefly in your evidence with Ms Anyadike-Danes in March. Can I just ask you, as a preliminary question, how much can you recall of the meeting itself?

A. It is fading with time. When I looked at my rota, relatively recently, I had been working nine consecutive days with four overnight on call periods during those days, so I must have been pretty tired by the end of that Tuesday afternoon. That may be in part responsible for the memory.

What I do recollect is -- I'm not sure whether I volunteered or I was asked to produce the fluid chart, which I did eventually do, and which was displayed in the ward. And a few other pieces and parts like that. I remember Dr Nesbitt mentioning about fluids and particularly he felt initially at that stage that it had been an over-perfusion of fluids over and above maintenance, but I think that was later rescinded when he cooled down a wee bit.

I don't think No. 18 in terms of the Children's Hospital issue was -- I don't have a clear recollection of it being discussed at that meeting. And other than that, I felt it was a relatively -- although

critical incident review was what it was titled, it was relatively less officious than that. It was critical with a small C rather than -- if you understand what I mean. Maybe that's the style of the management team, but certainly it wasn't -- it has been hinted that people were interviewed. It wasn't really an interview situation, it wasn't as official as that. It was more everybody setting out their stall, their experience and what their contact had been with Raychel and a chronology continued on that way with then some discussion around points.

Q. So it was a round table discussion more than an interview process?

A. That's probably a fair comment in the way it was.

Q. Can you remember being in the room and those who attended the meeting?

A. I have a fair recollection. Do you want me to name individuals?

Q. I think we're okay at the moment.

THE CHAIRMAN: No, I think you did that as best you could in March.

A. One point in my answer would be there had been an explosion in job titles. I can remember who the clinical effectiveness coordinator, but I now know the individual it was.

Q. Is there anyone you would expect to be there that wasn't?

A. There was no startling absence that I can think of. Myself and my registrar were there. I don't think Dr Johnson, who was on the paediatric medical team, was there. I can't remember a reason, whether it was duties or anything like that. I wouldn't have known enough about the surgical establishment, but Mr Gilliland was there and Dr Nesbitt was there.

Q. From what you now know of Raychel's case, would you have expected doctors Curran and Devlin to have been there?

A. Mm ... Very junior doctors. Would they have added anything? If it was to be a critical incident review, then by [inaudible word] sake they should have been there, but I wasn't surprised that they weren't because, again, their duties may have been contributing, but they were also very, very junior.

Q. You said --

THE CHAIRMAN: Sorry, I understand that, but in a sense they would contribute to the story of what happened as the day had gone on.

A. Yes.

THE CHAIRMAN: So if part of the reason for the review is to piece together what happened and then either later in the meeting or subsequently you can speak to people and

say, "This is what you need to do differently or better in the future", it's easier to do that if you have the --

A. I rescind that comment. Chairman, that does make sense.

THE CHAIRMAN: The fact that they are there doesn't mean they have to be criticised, but they can piece together the story.

A. Thank you, yes. I concur with that, apologies.

THE CHAIRMAN: Not at all.

MR REID: In answer to Ms Anyadike-Danes in March, you stated -- and this is at page 144 of 13 March, line 4 -- that you thought there was a general acceptance that things could have been done better.

A. Yes.

Q. What did you mean by that?

A. That we'd failed Raychel and if we had dotted all the Is, crossed all the Ts, that there might have been a better outcome.

Q. And at that meeting on 12 June, what did you identify as the major failings?

A. "Failings" is probably not the right word, but there were problems. The electrolytes not being checked. Timing wise, most commonly they're done first thing in the morning, on the ward round. Would that have predicted it? A possibility it might not. It probably

would be more meaningful in early evening, mid-evening type electrolyte, where there might have been opportunities because there had been medical contact on the basis of the nurses having concerns. That would have been probably an ideal time to have had an electrolyte check, but it wasn't.

Q. You said that things could have been done better. Was it accepted that in the same way that errors had been made, if I can draw a distinction between those two things --

A. I don't understand the ...

Q. Things were okay but they could have been done better, is one scenario. The other is that errors were made as in something wasn't done properly or there was a mistake made.

A. Right. I don't think there was that air to it. I don't think it was critical, you know, of what an individual did or did not do. It was sort of a group admission, if you like, you know: these weren't done as such, but no particular individual faulted.

Q. There was no attribution of blame?

A. Not that I picked up on, no.

Q. Can you recall what the discussion was as regards Raychel's vomiting at the critical incident meeting on 12 June?

A. I cannot remember in detail. I'm unsure whether there was discussion because, as it turns out, as you know, there is a disparity between the nurses' view and mum and dad's view. I'm not sure whether that was highly discussed at that meeting. I cannot remember. And being a nursing issue, it may have gone over my head. I didn't make a big conscious note of it. What I did take away from it, from the nursing point of view, that you've heard many, many times, is that they didn't appreciate a significant concern -- it didn't generate a significant concern with them, the degree of vomiting that there was.

THE CHAIRMAN: I think more fundamentally, they thought that if Raychel was on Solution No. 18 she was going to be okay. So they didn't correlate the vomiting to the continued infusion of Solution No. 18, nor did they connect either of those to the fact that she should have been up and about, as the day went on, and when she wasn't up and about, instead of thinking it was a vomiting problem, they didn't also then think "Well, could it be more than a vomiting problem? What's the root of the vomiting problem?"

A. Yes.

THE CHAIRMAN: It's easy for me to --

A. Maybe I went blindly into it in the sense that

I respected the experience of the nurses involved. The cumulative experience of the nursing staff that were seeing Raychel from time to time was phenomenal. I'd never had any concerns or issues about the nursing practice in my contact with them. And there's one sure thing that's probably saved many a paediatrician along the way is that a good nurse will alert you, no matter what the blood tests or the observations are, a good nurse knows a sick child. I have often gone on that premise, that nurses would alert me.

THE CHAIRMAN: I think, unfortunately, doctor, it's almost exactly the problem here that the nurses didn't spot the sick child.

A. Exactly, that's where the system failed.

MR REID: Let's look at your reaction to what happened at the meeting. If we bring up the action points following the meeting. 022-108-337, please. There's the action points there, and you will see at point 5 your action point is:

"A chart for IV fluid infusion rates to be displayed on Ward 6 to guide junior medical staff."

A. Mm-hm.

Q. And I believe that you made a chart and supplied that somewhere between July and September of that year.

A. Yes. There should be a copy.

Q. I think there's a copy, yes, at 026-009-010.
A. Yes.
Q. Is that a copy of the chart you produced afterwards?
A. Yes. Indeed, I think that is even Sister Millar's writing there on the top.
Q. Is that Sister Millar's addition at the top?
A. I think so. It looks like her ...
Q. For how long did that chart stay up in Ward 6?
A. I have no idea.
Q. Would it have been years, months?
A. It would have to be years because fluid regimes changed after that, so it could have been the order of some months until the proper -- not the proper, until the Department of Health changed the process.
Q. You said Sister Millar added the section at the top. Did those suggested rates only apply for surgical patients?
A. Oh no, this was a general for paediatric -- but specifically with the surgical doctors in mind because of what Dr Nesbitt had brought to light about the higher-than-maintenance fluid rates for Raychel.
Q. Whenever it was put up around the ward, did it have that annotation at the top of it?
A. "For surgical patients"? When produced by me, I don't know. Did it have that? I'm sure there was more than

one copy around, you know.
THE CHAIRMAN: When you produced these guidelines, did you produce them only for surgical patients or --
A. No, this chart is a free-standing thing. That was for all children.
MR REID: Is that the Holliday-Segar rates on that chart?
A. Yes.
Q. I think the question I'm asking is: was that put up with "for surgical patients only"?
A. No, no, but with them in mind I suppose because we had been dealing with Raychel.
Q. It would be used for paediatric patients as well?
A. Yes, and these would be maintenance rates which would be across the age range or weight range.
Q. There has been suggestion that some junior doctors or surgeons weren't asked to go into Ward 6 following Raychel's case; is that correct as far as you're aware?
A. I think JHOs, the very junior house officers, the doctors in training who had just completed their university course, were left or restricted to the adult wards only.
Q. Was that as a direct result of Raychel's case or was it something else?
A. I'm not sure whether the staffing levels would have allowed it to have happened immediately, but probably

the next batch or the next intake at the very least, maybe sooner than that.
Q. Was the reason behind it the facts of Raychel's case or was this an issue that was always there?
A. I'd imagine that Raychel's case weighed heavy on the minds of the rostering people, whoever was doing it. Certainly in my JHO year I did paediatrics, but that is increasingly -- general medical paediatrics, but that was rare, and certainly wouldn't be routine nowadays that you'd have JHOs dealing with children because they are a special case.
Q. In your witness statement you stated that for a time there was:
"A distinct divergence between IV fluid management between post-operative surgical children and paediatric medical inpatients --
A. That's right.
Q. -- with blanket use of Hartmann's solution for the former [as in the post-op surgical patients] and continued use of Solution No. 18 for the latter, unless indicated otherwise by clinical condition."
How long did that continue for?
A. That would have continued until the Department of Health produced their suggested fluid regime and they encouraged us to provide local guidelines. That seemed

a reasonable time. Because of the divergence, it meant there was No. 18 and Hartmann's being used on the ward, that maybe a common solution might be useful and at that stage then half-normal saline, 0.45 per cent saline with dextrose, then was picked up as probably the solution that would cover all bases.
Q. Would I be correct to say that until the 2002 hyponatraemia guidelines came in then that the changes to fluid management that were instituted following Raychel's death only applied then to paediatric surgical patients?
A. Only to the surgical patients, yes. Paediatric surgical ones.
Q. Was there any opposition amongst the consultant paediatricians to bring that in before the guidelines came in for paediatric patients, just normal paediatric intensive care patients?
A. No, I don't think we had any indication to use Hartmann's. It wouldn't have been a solution that we'd have had a great deal of experience with. An issue, I suppose -- I think I brought up at one of those meetings, or at a meeting, was because there's a lack of any dextrose that glucose BM sticks, capillary blood glucose, should be monitored until we knew that the children were safe and didn't develop hypoglycaemia.

But no, there was no resistance. I don't think it was ever countenanced by us to use Hartmann's; it wouldn't be a commonly used paediatric solution in the medical sense.

Q. If we move to the meeting with the parents on 3 September 2001 now. Mrs Ferguson gave her evidence on 26 March of this year. If I can bring it up on screen, it's 26 March, page 177, lines 11 to 19.

Would it be correct to say, Dr McCord, that following your giving of evidence that you went and spoke to Mrs Ferguson; is that correct?

A. I can't remember the incidence of that now.

THE CHAIRMAN: It was after you gave evidence here in March.

A. Oh yes.

THE CHAIRMAN: I think we understood that you had then spoken to Mr and Mrs Ferguson.

A. Yes. I thought you were referring to September 2001. I do beg your pardon.

MR REID: In March of this year after you gave your evidence, you went and spoke to Mr and Mrs Ferguson; is that right?

A. Yes, we spoke outside.

Q. Mrs Ferguson in her evidence said at line 11:

"By September, they all knew full well [she's speaking here about the September meeting] what had

happened and I make no apology for it that I still feel so angry reading the notes of the September meeting. Dr McCord has told us personally that that meeting was a disaster."

Doctor, can I ask: is that what you said to Mrs Ferguson following your giving of evidence in March?

A. It is a flippant comment that I have been known to use, you know. It was perhaps inappropriate in the setting.

THE CHAIRMAN: Doctor, don't misunderstand. In fact, I think Mr and Mrs Ferguson welcomed that. They don't regard your comment as flippant. In fact, if I understand correctly, they're welcoming the fact that you have acknowledged that however you thought the meeting went at the time, that on reading more about it and reading their understanding and their recollection of events, that whatever the meeting was supposed to achieve to help the Fergusons, it didn't go anywhere near it.

A. Just in terms of the word "disaster", it was not a good meeting.

THE CHAIRMAN: I don't want to trawl through all this, but do I understand it that that's not the impression that you had when you left the meeting in September 2001, or --

A. I was unhappy. Unhappy. It was a meeting -- I'm not

sure what it set out to do in terms of -- there was no agenda, no plan, no prior thought as to who was going to speak. The setting wasn't good, we arranged ourselves, you know, in a cold, blue-coloured room, it was an echoey Portakabin.

Only a few of the relevant clinicians were there, myself, Dr Nesbitt, you know, who had been there towards the end of Raychel's hospital episode. There was no surgeon. It would have been nice to have had a radiologist there. There were nursing staff there and from the trust point of view, Mrs Burnside, senior member, was there. But even with that, I think it was still incomplete. I'm not sure what it started out as, but at the end of it, as it progressed, it really slipped away into a question-and-answer session. And at the end of it, there was no structure to it, no order, no sense that we'd achieved anything at the end of it that was going to help.

My abiding memory is speaking to mum briefly afterwards, because she wore a little lapel badge with Raychel's face, and the most striking thing was I spoke to mum -- and she reminded me of it recently -- despite the events of June, I couldn't remember Raychel's face. I could see the body, I could see Raychel lying there, but I couldn't see her face and that has still haunted

me to this day, that thing, you know. So it did have an impact, it wasn't a good meeting, I didn't enjoy it. It could have been done better, I think.

THE CHAIRMAN: And had you come subsequently to realise from the perspective of the Fergusons just how hugely unsatisfactory it was for them?

A. Oh, absolutely.

THE CHAIRMAN: Do I take it from what you're saying that you are not surprised by their reading of the meeting because you yourself weren't happy with it?

A. Yes. I have no direct experience of one case where it's been spread across many specialties. That hampered us. I'm much more used to dealing in an ordered, structured way, after a neonatal death, you know, where you would have a post-mortem there. So I'm not sure if mum and dad were totally aware of what this meeting was going to avail them of, that kind of thing, and it kind of got away from us, if you like, and didn't do anybody any good, I thought. But again, that's a personal opinion.

THE CHAIRMAN: Okay.

MR REID: If I could ask you as a final issue, doctor, just about the inquest. The coroner's inquest comes round in February 2003. You give a statement to the trust, dated 12 June 2001, just a week or two after Raychel's death, a week after Raychel's death. And that is the

statement that you effectively adopt at the inquest; is that right?

A. Yes, it's less than a week. It was actually the weekend of the happening. It was typed up on the 12th by my secretary, but I'd worked with a previous colleague some years ago with North American experience and he always reminded me, after any unexpected death, get something down on paper, it'll stand you in good stead and make it as contemporaneous as you can. There didn't seem any point -- I didn't think I had any more to add for the coroner's statement when it did come round.

Q. Looking back at that coroner's inquest, are you satisfied that you said everything that you think you should have said to the coroner?

A. My understanding of the coroner's inquest, it would be -- it was to be an outline plan of my clinical involvement with Raychel, which I think I did in fairly chronological order.

Q. Because if we bring up your deposition -- it's 012-036-170 and 171, firstly, please. Do you recognise that as the main deposition that you gave?

A. Yes.

Q. We'll look in a moment just at the other evidence that you gave in answer to questions.

Would you accept, Dr McCord, that that's generally

a quick history, as you saw it, of Raychel's medical history during her care at Altnagelvin?

A. It was a brief précis, but the detail would have been mainly on that two-hour, two to three-hour period where I would have had clinical contact with Raychel, which I thought was what the coroner required of me.

Q. Do you consider that any of the elements that you discussed at the clinical incident meeting of 12 June should have been brought out at the coroner's inquest as well?

A. At the time, no. I have learned substantially with the reading and questioning that that is an issue that would make me probably change my practice if I was involved in a coroner's case tomorrow of a similar type and nature. But at the time, I had no inkling to go beyond what I did there, and then answer the questions that were offered to me appropriately, or as best as I could.

Q. If I can bring up 098-034-108, please, and 109. This is counsel's note of your evidence, Dr McCord. It started on the previous page, 107, but if we look at the last paragraph on the left-hand side:

"Mr Foster began by inviting the doctor [Mr Foster was the counsel for the Ferguson family] to reconsider his description of some vomiting in paragraph 2 of his deposition. He declined, saying it was a fair

reflection of his perception at the time. He agreed it was concerning, now that he had the full picture in retrospect, but said he relied on those below him, including the nurses, to bring it to his attention. He had no access to medical notes. He concurred that 'some vomiting' was not appropriate, but only in hindsight."

Can I ask you about just what you meant that you found it concerning just in retrospect as opposed to previously at the time?

A. At the time of my writing of my report --

Q. Yes.

A. -- which was 12 June, I did not inspect the fluid balance sheets. This was written, not freehand, but freely without access to clinical notes. Verbally, it had had some mention from the nursing staff about vomiting. I think "some vomiting" in retrospect was an inappropriate term. I should either have said -- it probably would have been better to say vomiting without qualifying it. "Some" implies small, I would have thought, and just left it as "vomiting".

Q. Was it the case that once you saw the medical notes, you realised "some vomiting" was an inappropriate term?

A. It was an inappropriate term, you know, or the discussions thereafter.

Q. Were you aware -- and we had Dr Jenkins giving evidence earlier -- of Dr Jenkins' report?

A. Not in detail, only recently in terms of the content. I was aware that there were reports around, you know, and Dr Jenkins had been asked.

Q. Let me be more clear. Were you aware at the time of the inquest that Dr Jenkins had produced a report for the trust?

A. Yes, indeed.

Q. Had you seen a copy of that report?

A. No.

Q. You simply knew that he'd produced a report. And then did you see that report then at the inquest?

A. I'm not sure whether it was at the inquest or afterwards.

Q. Did you see, other than the report from the inquest, any other versions of Dr Jenkins' report?

A. No.

Q. Were you aware of a report from Dr Warde?

A. I heard the name mentioned with some rumouring that there was a report by an anaesthetist, which I presume is Dr Warde, and that it had offered some slight criticism of my junior colleague, Dr Trainor. That was the context of the rumour. There seems to have been some veracity in it, you know, when I subsequently did

hear that.
Q. Do you know who you heard that rumour from?
A. No, I can't remember.
Q. And were you surprised whenever Dr Warde didn't appear at the inquest?
A. I wasn't there for every day and I didn't know -- and I didn't know the formalities of the legal process. It was the very first time, if memory serves me, that I'd ever been in a coroner's court. I simply gave my evidence and, as far as I was concerned, that was my responsibility over.
Q. Just as a final point, Dr McCord. You're a consultant paediatrician at a district general hospital. You dealt with paediatric patients on a regular basis. What, as far as you're concerned, still can be done better or could still be done in order to improve areas of fluid management or patient safety? If you were, for example, to name one thing that you think could be done better, what would you say?
A. Education, education, education. Go back to the medical school, you know, ensure that there is training for doctors there. Induction, you know, make sure that the paediatric induction is specifically aimed at or has a specific section on fluid management and electrolyte problems. Things which I think are taking process at

the moment and continuing, and have been for some time now. We can never be 100 per cent safe. Always be prepared to expect the unexpected because that's the way it'll creep up and bite you. Auditing. But again, you know, we have to keep doing it, keep doing it and keep doing it. But I can't think of any single thing that's going to reassure the public by my doing it or other medical staff doing it. Just be on your guard.
MR REID: Nothing further, Mr Chairman.
THE CHAIRMAN: Any questions from the floor?
MR QUINN: I have a question, sir.

Questions from MR QUINN

MR QUINN: You said that you only became aware of Dr Warde's report because it contained some rumour that may affect a junior colleague, who you thought was Dr Trainor.
A. Mm-hm.
Q. Can you tell us when you first became aware of Dr Warde's report?
A. That would have been around the inquest time, around the coroner's inquest time.
Q. Can you recall how that came to your notice, how that information came to you?
A. No, I have no idea. It was a rumour I head. I'm sorry.
Q. I wonder could we have up WS032/3, page 10, please. In question 28 you have been asked about Dr Warde and

you will see under sub-paragraph (e) you were asked when you became aware of the content of the following: the report of Dr Warde, and you say you're unable to recollect. What has jogged your memory today?
A. Hearing the chat of Dr Warde's report, you know, that Dr Jenkins --
Q. I'm sorry, I didn't pick that up.
A. Hearing the mention of Dr Warde's report here in Dr John Jenkins' appearance.
MR QUINN: Thank you.
THE CHAIRMAN: Any more? Mr Lavery, anything?
MR LAVERY: No, Mr Chairman.
THE CHAIRMAN: Doctor, thank you for coming back again. You were kind enough when you finished last time to say some words and I don't expect you have anything more to say today.
A. May I though?
THE CHAIRMAN: Absolutely.
A. Thank you, Mr Chairman, for the opportunity. It's not lost on me that it's 12 years and three months today since Raychel's death. She would have been a 21 year-old, independent, free-spirited girl now. But we can't bring Raychel back; you can't bring her back, I can't bring her back. The purpose of the discussions today and in the weeks and months that have gone before

are that there are two absolutes: Raychel was admitted and Raychel died. Between those two points there are many if onlys, buts and presumptions and otherwise. Nothing can bring Raychel back. However, I think a fitting tribute to her memory would be that since Raychel's death, things have changed, that has precipitated a whole lot of changes and I would be hopeful that this will be a fitting tribute to her memory, knowing that others have gone forward and are safer than they would have been before 2001. Thank you.
THE CHAIRMAN: Thank you very much, doctor.
Tomorrow morning at 10 o'clock with Dr Crean.
Thank you.
(4.10 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X