

1 Tuesday, 10 September 2013

2 (10.00 am)

3 Timetable discussion

4 THE CHAIRMAN: Good morning. Just before we start,

5 Mr Stewart, I want to go over some housekeeping. This  
6 will just take a moment or two, doctor.

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

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

25 In this context I should mention that there is some

1

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

3 So it's almost exactly the same timetable as I set  
4 out before save that we'll start on Wednesday  
5 16 October, instead of Monday the 14th, and we will also  
6 take the week of Monday the 11th to finish. Okay?

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

15 Mr Stewart?

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

18 DR JOHN JENKINS (called)

19 Questions from MR STEWART

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

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

3

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

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

15 The result of that is that the historic segment of  
16 the department's involvement will start on Monday  
17 28 October and will run for the two weeks beginning  
18 28 October and 4 November. That will then lead us  
19 directly into the final week, which is Monday  
20 11 November, in which the Belfast Trust and the  
21 department will come here with panels to bring us  
22 up-to-date with what happens now and how those  
23 procedures and practices have evolved and improved since  
24 the periods that we're talking about, ten and more years  
25 ago. That will be the final week of the public hearings

2

1 that's acceptable.

2 THE CHAIRMAN: Yes.

3 MR STEWART: Yes, thank you.

4 You have also provided us with your CV, which  
5 appears at 317-044-001. It runs to several pages. On  
6 the first page, could I just draw attention to your post  
7 at the time of Raychel's admission to hospital, down  
8 towards the bottom of your record of employment? From  
9 1 November 1999 to 31 December 2010, you were senior  
10 lecturer in child health at Queen's University and  
11 consultant paediatrician at Antrim Hospital. Below  
12 that is noted your retirement in 2010, from both  
13 clinical practice and teaching.

14 A. That's correct.

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

19 A. Yes, correct.

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

25 Below that, in 2005, you were appointed chairman of

4

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

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

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

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

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

9

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

11

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

10

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

12

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

4 Q. I wonder, can I ask for page WS008/1, page 15, please?  
5 This is not something with which you were personally  
6 engaged, but I hope it will set the scene for  
7 a chronological run through the events of 2001. This is  
8 a meeting of the Sick Child Liaison Group on  
9 26 June 2001; this is really very soon after Raychel  
10 died. And your colleague, Dr Jarlath McAloon, was  
11 there, as indeed was Dr Taylor, and you'll see running  
12 down the page:

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

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

13

1 on the screen is my annotated copy of the memo.

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

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

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

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

21 Q. I wonder can I ask for page 068b-036-247? This is from  
22 a transcript of an interview you gave to UTV on  
23 7 June 2004. I wonder can the previous page, 246, be  
24 shown next to it so we might read the question? That's  
25 the bottom of the left-hand page. The questions are

15

1 28 June. You can see that Dr McAloon writes:

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

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

8 A. No.

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

11 A. Yes.

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

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

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

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

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

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

14

1 slightly hard to follow:

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

7 And you answer:

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

19 So you were asked:

20 "Who was that in the Royal did that?"

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

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

16

1 Lucy Crawford and Raychel Ferguson, within 14 months of  
2 each other?  
3 "That's my understanding; it's certainly how  
4 I became aware of it and how the process started to try  
5 to bring something good out of these two tragedies, if  
6 we can do a little in that respect."  
7 Is that an accurate transcript of that interview?  
8 A. I cannot recall the interview, but I had seen it shortly  
9 after the time, and I have no reason to say that it is  
10 not an accurate record of what I said.  
11 Q. Is it correct to say that Bob Taylor made contact and  
12 was telling you and your fellow paediatricians that  
13 there had been a second death in the Children's Hospital  
14 in Belfast?  
15 A. Well, I cannot now reflect exactly why I used that form  
16 of words in 2004. This was in May 2004, I think, when  
17 I --  
18 Q. June, yes.  
19 A. -- when I was interviewed. And at that time, this was  
20 what I had in my mind as being the sequence of events,  
21 but as I have looked over all of the paperwork, which  
22 I still have, and my best recollection of all that  
23 happened, I certainly was not aware of a second child at  
24 that time. So I'm unclear as to whether I'd simply  
25 confused my timings whenever I gave that response to

17

1 contact had not been with me, so I -- in retrospect  
2 I can see that I was unclear in the way in which I spoke  
3 to Mr Birney because I was reflecting a contact which  
4 had been made through a colleague and I was speculating  
5 unwisely as to exactly what information had been  
6 provided at that time because of what I then had later  
7 learnt.  
8 Q. Well, with respect, it doesn't sound like speculation;  
9 it sounds like a clear recollection. And furthermore  
10 you do say there:  
11 "Well, the contact that I'm aware of was from  
12 Dr Bob Taylor."  
13 Who was the contact with?  
14 A. With Dr McAloon.  
15 Q. And furthermore, it seems to be your understanding that  
16 there were two deaths that were 14 months apart.  
17 A. Yes, yes, I can see that, but what I'm attempting to  
18 explain is that as I now look at it, my understanding  
19 is that I had put the information together  
20 retrospectively, and incorrectly, as to the timings and  
21 the identities of those two children.  
22 Q. I'm struggling to understand how you can have put it  
23 together incorrectly because what you say is so clear  
24 there. So what you're saying now is that contact was  
25 made by Dr Taylor with Dr McAloon in June 2001,

19

1 Mr Birney.  
2 Q. How could you have confused it? Because you're saying  
3 here that there are two deaths -- Lucy Crawford is one,  
4 Raychel Ferguson the other -- and within 14 months of  
5 each other:  
6 "That's my understanding. It's certainly how  
7 I became aware of it and how the process started."  
8 How could there be a misunderstanding?  
9 A. Because I think I was confused in relation to the dates,  
10 and that was also the reason why, at a different point  
11 in the interview, I identified Lucy as being one of the  
12 two children.  
13 Q. This is an explanation of what you heard. You see the  
14 top paragraph there, you say:  
15 "That was where the process started, before the  
16 formality of the working group."  
17 In other words, this is put in a time frame before  
18 the CMO's working group is established, before the  
19 formality starts.  
20 A. Yes. What I intended there was that the contact from  
21 Dr Taylor had taken place before the formality of the  
22 working group had started.  
23 Q. Yes. And was that contact from Dr Taylor to say that  
24 there were two deaths or there had been?  
25 A. Well, that is what I'm now unable to recall. The

18

1 probably, before the formality?  
2 A. At the time that Dr McAloon then sent the memo, in which  
3 he only mentioned the death of one child.  
4 Q. Yes. But it seems that, at least in 2004, it was your  
5 understanding that two deaths had been referred by  
6 Dr Taylor to Dr McAloon.  
7 A. That was what I said at the interview, but I am now --  
8 I'm unable to explain why that was my understanding  
9 because certainly I was not aware of any second death at  
10 that time.  
11 Q. Of course, your recollection then would have been  
12 fresher than it is now.  
13 A. Well, I'm quite clear in my mind that I was not aware of  
14 any second death for a considerable period after that.  
15 Q. Can we go on to page 251 of this document? It's the  
16 bottom paragraph, and you say:  
17 "It may be that in looking back, we could see ways  
18 in which this could have been recognised more quickly,  
19 although I have to say that the two cases out of the  
20 thousands of children who are treated in this way and  
21 while there were common factors in the two cases, i.e. the  
22 hyponatraemia, there were also different situations: one  
23 child had an operation, one didn't; one was older, one  
24 was younger; so there were differences as well."  
25 So you're discussing there with your interviewer the

20

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

21

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

23

1 saying is that, notwithstanding this transcript, you  
2 weren't aware of Lucy's death in 2001 and what then  
3 happened, by the time you were interviewed by UTV in  
4 2004, was that you were aware of Lucy's death by then,  
5 you were obviously aware of Raychel's death, and you  
6 were aware of Adam's death?  
7 A. No, I was not. At the time of my interview I was not  
8 aware of Adam's death.  
9 THE CHAIRMAN: So in reading this, we can disregard Adam  
10 completely?  
11 A. In my mind, there were two children, and they were the  
12 two who I have become aware of at different points in  
13 time and they were Raychel and Lucy.  
14 THE CHAIRMAN: Okay. So you went all the way through the  
15 working group without ever hearing or knowing anything  
16 about Adam Strain?  
17 A. That is correct. And Mr Chairman, if I can -- I think  
18 it was the previous pages that you were showing me,  
19 I said something about how it was through my involvement  
20 with the inquest that I came to my knowledge of these.  
21 So I'm seeking to explain.  
22 MR STEWART: Which page is that?  
23 THE CHAIRMAN: Can we bring back up again 246 and 247 from  
24 the same sequence? That's 068b-036-246 and 247, please.  
25 MR STEWART: Yes.

22

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

24

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

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

15 MS GOLLOP: Yes.

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

25

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

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

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

27

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

4 MS GOLLOP: Noted.

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

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

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

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

26

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

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

13 A. Yes.

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

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

25 THE CHAIRMAN: Yes.

28

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

29

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

31

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

30

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

32



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

33

1 A. No.  
2 Q. Were you sounded out and approached before you got the  
3 formal letter of invitation?  
4 A. No. I mean, again, if I had to speculate, it might have  
5 been related to my membership of the specialist advisory  
6 committee, the paediatric specialist advisory committee,  
7 but I don't know, and I just received the letter along  
8 with every other member of the working group, I assume.  
9 Q. And that was 21 August 2001, the letter won't come up on  
10 the screen, sadly, but it is a pro forma round-robin  
11 letter.  
12 At that stage, when you received the invitation to  
13 join the working group, did you know who else might  
14 serve on that group?  
15 A. Unless it was -- unless there was a circulation list on  
16 the letter, I would have had no way of knowing who else  
17 was going to serve on the group.  
18 Q. But you might have been on the phone to some of your  
19 good chums to ask, what's happening, is this Bob Taylor,  
20 who else is on it?  
21 A. I certainly didn't do so.  
22 Q. You didn't do so? Do you sit on so many committees that  
23 you're not interested in who else might be with you or  
24 what you can do?  
25 A. Well, I'm interested in what the group is being set up

35

1 to you on that grapevine. This is Dr Carson writing to  
2 the CMO at the end of July 2001, and he's been talking  
3 to Bob Taylor, and he informs the CMO and he also  
4 informs Raymond Fulton at Altnagelvin that the  
5 anaesthetists in the RBHSC would have approximately one  
6 referral from within the hospital per month:  
7 "There was a previous death six years ago in a child  
8 from Mid-Ulster. Bob Taylor thinks there have been five  
9 to six deaths over a ten-year period of children with  
10 seizures."  
11 Was that the sort of information that was coming to  
12 you?  
13 A. No.  
14 Q. Do you know Dr Fulton? Did you know him then?  
15 A. Only by name.  
16 Q. Do you know Dr Carson?  
17 A. Yes.  
18 Q. And you knew Dr Campbell, the CMO?  
19 A. Yes. Primary communication, as we saw from the memo  
20 of June, was between Dr Taylor and Dr McAloon as the  
21 lead from the Antrim team on this liaison group.  
22 Q. I'm asking what might have been available to you on the  
23 grapevine, not primary, formal communications. Do you  
24 know how it was you came to be selected and included on  
25 the CMO's working group?

34

1 to do, but I'm quite happy to wait until I either attend  
2 the meeting or see minutes of the meeting to find out  
3 who else is involved.  
4 Q. All right.  
5 A. I certainly don't try to prejudge meetings by phoning  
6 round in advance to see who else is involved.  
7 Q. I wasn't suggesting you prejudge a meeting, but you  
8 might be curious to know who your colleagues were  
9 serving on the group.  
10 A. I was -- I made no such contact.  
11 Q. Can we please see 007-048-094. This is the first  
12 meeting. This is the first meeting, 26 September 2001,  
13 that's the meeting in Castle Buildings that you referred  
14 to that you couldn't attend. Also on the committee  
15 we can see, apart from Dr Darragh who you have  
16 mentioned, Dr Taylor, Dr Nesbitt from Altnagelvin,  
17 Mr Marshall from the Erne, and Dr Loughrey from the City  
18 Hospital, who wrote the chemical pathologist's report in  
19 Raychel's case, and of course Dr Crean and yourself.  
20 Why was Mr Marshall there, do you know?  
21 A. No.  
22 Q. Dr Lowry, what was his expertise?  
23 A. Dr Lowry, as far as I understand it, was an  
24 anaesthetist. My understanding was that this was  
25 a group who had been selected to represent the breadth

36

1 of units in which paediatric care was provided across  
2 the Province.  
3 Q. Yes, but they also may have been selected at least in  
4 part because of their knowledge of some of the more  
5 recent cases of hyponatraemia. Certainly Dr Taylor knew  
6 of Adam, he knew of Lucy, he knew of Raychel. Obviously  
7 Dr Nesbitt --  
8 MR UBEROI: I rise for clarification on a point I raised  
9 last week. There is some uncertainty about that and  
10 I think it needs to be trodden around more carefully  
11 than my learned friend has demonstrated there.  
12 MR STEWART: I did not say Claire Roberts. I said  
13 Adam Strain, Lucy and Raychel.  
14 MR UBEROI: Even for example in the case of Lucy, one of the  
15 chairman's interventions during that part was to the  
16 effect that there was significant doubt as to whether  
17 that death was ever presented at a mortality meeting, so  
18 I think there is uncertainty about it and I think it  
19 needs to be trodden around more carefully than that.  
20 MR STEWART: I'll come back to that if I may.  
21 Dr Nesbitt certainly knew about Raychel's case.  
22 Dr Loughery knew about Raychel's case. Dr Crean knew  
23 about Adam's case, he knew about Lucy's case, he knew  
24 about Raychel's case. So it might look as though some  
25 members had been selected because of their specific

37

1 A. Yes, and it may well have been the case. I'm not in  
2 a position to say when I received the minutes.  
3 MR STEWART: You see there Dr Taylor informs that meeting of  
4 the incidence of cases seen at the RBHSC. And we know  
5 that Dr Taylor prepared a bar chart, which purported to  
6 show the incidence of hyponatraemia in the RBHSC. We  
7 know that Dr Taylor shared that with Dr Darragh, who is  
8 there, and we know he shared it with Dr Nesbitt, who is  
9 also there. Did you see the bar chart?  
10 A. I'm not aware that I did.  
11 Q. Perhaps we'll just have a look. It's at 321-020a-034.  
12 Have you seen that before?  
13 A. I have seen it more recently as part of the inquiry  
14 papers.  
15 Q. Did you see it at the time you were serving on the  
16 working group?  
17 A. That's not my recollection. I have no record of having  
18 seen it at that time.  
19 Q. Can we go, please, to page WS059/2, page 16? We have  
20 a letter sent to your colleague, Dr Jarlath McAloon, and  
21 it's from Bob Taylor, and it seems to have been received  
22 by 1 October 2001 by Dr McAloon, and he forwards a copy  
23 to you, and in fact to all consultants, and your receipt  
24 is signified by the stamp in the bottom right-hand  
25 corner, 2 October 2001.

39

1 knowledge of specific cases.  
2 A. You would have to ask those who decided on the  
3 membership of the group as to why they selected  
4 individuals.  
5 Q. Dr Taylor is then noted at paragraph 2 as:  
6 "... informing the meeting about the background,  
7 incidence of cases seen in the RBHSC, and patients who  
8 are particularly at risk of hyponatraemia."  
9 He is noted as having said that this is a problem  
10 that's been present for many years. Were these notes  
11 sent to you immediately after the meeting?  
12 A. I have no recollection of when I received them, but  
13 I did definitely receive them.  
14 Q. Well, may we assume that it was shortly after the  
15 meeting?  
16 A. No, I don't think so. It's quite common for minutes not  
17 to be circulated until sometime after a meeting takes  
18 place.  
19 Q. How long a gap might intervene?  
20 A. Up to a month.  
21 THE CHAIRMAN: That might well be right, but in a group  
22 which is not going to have regular meetings because of  
23 the urgency of bringing in guidelines, one would hope  
24 and expect that there might be some greater urgency to  
25 it than that.

38

1 If you look to the third paragraph down, the final  
2 sentence:  
3 "Dr Taylor states I have also audited our incidence  
4 of admissions to PICU with hyponatraemia."  
5 When you received that, you were a serving member of  
6 the working group for the CMO and you receive  
7 notification there that Dr Taylor's gone to the trouble  
8 of auditing the incidence of hyponatraemia in PICU.  
9 What do you do when you learn there's an audit of  
10 admissions?  
11 A. I didn't take any action in respect of that.  
12 Q. What did you think when you received that information?  
13 A. I don't think that any particular thought process took  
14 place.  
15 Q. Might it not have occurred to you that this was useful  
16 information for your work on the group and that perhaps  
17 you should find out what the incidence was?  
18 A. No.  
19 Q. Why didn't that occur to you?  
20 A. Well, I can't say. All I can say is that the focus of  
21 the working group was on developing guidance. And I saw  
22 my role as being part of that process, not undertaking  
23 an audit of cases.  
24 Q. Well, Dr Taylor thought it was part of the process and  
25 he thought Dr McAloon would be interested in that too.

40

1 A. Well, he had done this audit because he worked in the  
2 unit where the specialist care was being provided.  
3 Q. Yes. And for that reason, he had some figures which he  
4 thought relevant to the work of the working group.  
5 A. He may have done, but it was not brought to the  
6 attention of the working group.  
7 Q. If you go down to the final sentence in this letter,  
8 Dr Taylor says:  
9 "I think you may be getting a few letters on this  
10 topic as I have discussed the subject with as many  
11 colleagues as possible."  
12 You're a colleague who's serving on the same working  
13 group. Did he discuss this topic with you?  
14 A. As far as I understand it, the topic that he mentions  
15 in that sentence is the topic of hyponatraemia and the  
16 development of guidance and not specifically the audit.  
17 Q. Well, he does mention specifically the audit and he  
18 mentions it in the context of people who might be  
19 interested in it for the purposes of the working group.  
20 There must have been discussions. Quite clearly here he  
21 refers to "discussions with as many colleagues as  
22 possible".  
23 THE CHAIRMAN: If I take your point, doctor, that one  
24 interpretation of this letter is that there's a debate  
25 which has emerged about whether, if you move away from

41

1 with some children, moving to 0.45 would be acceptable;  
2 it might mean that in other children that might be an  
3 improvement, but there's more that could be done. But  
4 you won't know that, and the group won't know that, if  
5 everybody's working at this point on their individual  
6 knowledge rather than a collective knowledge.  
7 A. Yes. Well, the collective knowledge was the knowledge,  
8 as I've described it, of the underlying physiology and  
9 the principles and the literature and the added value  
10 that the group brought at that point was to draw  
11 together the different areas of expertise, if you like,  
12 from the anaesthetic side, the paediatric side, the  
13 chemical pathology side and try to draw that together  
14 into a draft guideline which could then be tested  
15 against whatever cases people were aware of.  
16 If I can also point out that at the beginning of the  
17 third paragraph Dr Taylor specifically mentions the  
18 death of only one child.  
19 THE CHAIRMAN: Yes. Well, I have to say that's unfortunate,  
20 because there was more than one child's death known  
21 about.  
22 A. But certainly in my mind, I was only aware of one death  
23 and he only mentioned one death.  
24 THE CHAIRMAN: Thank you.  
25 MR STEWART: Can we move on? Did you attend any meetings of

43

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

42

1 the working group?  
2 A. I looked through my papers and I have no record or  
3 recollection of having any further face-to-face  
4 meetings. In fact, any, because I wasn't at the first  
5 meeting.  
6 Q. Okay. Can we go to 007-038-072 and 073? It's not  
7 available.  
8 This is a two-page, handwritten memo of a meeting of  
9 the working group, which took place on 10 October 2001  
10 and is referred to by Dr McCarthy in her witness  
11 statement WS080/1, page 5. It deals, as indeed you were  
12 indicating a moment ago, with much of the debate about  
13 the nuts and bolts, as opposed to the incidences, of  
14 hyponatraemia. But of interest to me, the individual  
15 participants are noted by their initials. "JJ" I take  
16 it is you?  
17 A. Yes. It's unfortunate I can't see the document.  
18 Q. Yes, I'm sorry about that. (Pause). There's a copy for  
19 you and I hope by lunchtime it can be on the screen.  
20 (Handed).  
21 A. Thank you.  
22 THE CHAIRMAN: Could we just try it one more time so that  
23 the public can see this? Okay, the reason why it's not  
24 available yet is it's part of the departmental papers,  
25 which are not yet available publicly. So when this

44

1 becomes publicly available, it will be 007-038-072, but  
2 we'll try to put this one up as the morning goes on.  
3 MR STEWART: Perhaps I could read into the record what  
4 Dr McCarthy says about this meeting and of the meetings  
5 in general. She says:  
6 "The first meeting was chaired by Dr Darragh, after  
7 which I chaired a subgroup responsible for drafting the  
8 guidance. In addition to the original members of the  
9 group Dr Maurice Savage, RBHSC, was invited to  
10 participate and a second meeting was held on  
11 10 October 2001, at which it was agreed that further  
12 communication would be via e-mail."  
13 And she gives the reference from these pages as  
14 007-038-072.  
15 MS GOLLOP: Sorry to interrupt, but we've got two pages of  
16 073 and I just want to check that the witness has 072  
17 and 073. A copy of 072 would be appreciated if someone  
18 could hand a copy back.  
19 MR STEWART: I do apologise. We may come back to this and  
20 we'll supply it in due course.  
21 A. Can I just say that I stand corrected? There must have  
22 been a second meeting. I had no record of it. I also  
23 haven't seen Dr McCarthy's witness statement, so I have  
24 no knowledge of that.  
25 Q. Yes. Can I ask, I take it the initials "PC" is Peter

45

1 A. I'm not sure. At that time, I'm not sure. I'm not on  
2 the copy list.  
3 Q. You do make reference to it in your witness statement at  
4 059/1, page 2.  
5 THE CHAIRMAN: This is the alert or the yellow card,  
6 Mr Stewart? Is this the yellow card?  
7 MR STEWART: Yes, this is the yellow card that Dr Taylor  
8 reported.  
9 You see the second page, second paragraph:  
10 "Dr Bob Taylor [you advise], consultant paediatric  
11 intensivist to the RBHSC, informed the Committee on the  
12 Safety of Medicines of his concerns in October 2001. He  
13 received an initial reply in November 2001, followed by  
14 an substantive reply dated 26 November 2001 from the  
15 Medicines Control Agency, copy enclosed for information.  
16 No amendment was made to the product information  
17 relating to this solution."  
18 We do know that Dr Taylor copied Dr Nesbitt of the  
19 working group into this correspondence, and we also know  
20 that he copied Dr McCarthy of the working group into  
21 this correspondence. I can take you through those  
22 references if you want. And I take it from your  
23 reference to the correspondence in your first witness  
24 statement that you were aware of it and you were  
25 probably also copied into it.

47

1 Crean and "JMCA" is Jarlath McAloon?  
2 A. I have no memory of this meeting, but yes, I suspect  
3 you're correct in those assumptions.  
4 MS GOLLOP: Sir, can I suggest that we do come back to this  
5 when everybody has the document? I'm finding myself  
6 somewhat handicapped.  
7 THE CHAIRMAN: Okay.  
8 MR STEWART: There's no great point arising out of this  
9 document, so please don't be concerned.  
10 I wanted to ask you merely this one question, that  
11 Dr McAloon does not appear at the first meeting of the  
12 working group as being a member of the working group,  
13 and yet he appears to be e-mailed in to some of the  
14 correspondence and he appears here at the second  
15 meeting. Do you know how that was?  
16 A. No, I wasn't aware of that, but I don't understand that.  
17 He certainly was an active member of the drafting  
18 subgroup.  
19 Q. He was?  
20 A. Yes.  
21 Q. Perhaps the list of membership is incomplete.  
22 I wonder can we now move to 012-071e-412. This is  
23 a letter from Dr Bob Taylor to the Medicines Control  
24 Agency. Part of this correspondence was sent to you;  
25 is that correct?

46

1 A. No, I certainly accept that I was aware of it, because  
2 Dr Taylor had agreed to do that and reported back  
3 subsequently that he had done so.  
4 Q. Yes.  
5 A. But I have no recollection -- and in fact I do not  
6 believe that I received a copy of this, of the letter  
7 itself.  
8 Q. And you were able to pick up the letters and their dates  
9 from the inquiry website or what?  
10 A. At the time I was doing my report in -- I think in  
11 2005 -- I could have picked them from the website or  
12 I could have picked them up from the discussions that  
13 had taken place when Dr Taylor had reported back to the  
14 working group, particularly in terms of the response.  
15 Because I remember discussing this response with  
16 Dr Taylor in the context of our preparation of the paper  
17 for publication, in which we wanted to refer to his  
18 communication with the MCA and their response.  
19 Q. The letter on the left, on 23 October 2001, he has sent  
20 in the yellow alert to them, it may have come back and  
21 they've asked:  
22 "Could you please give us some information about  
23 this patient RF?"  
24 Raychel, and he does so in ten numbered paragraphs.  
25 The part I wish to refer to is the last sentence, in

48

1 which he advises Dr Cheng:  
2 "I am also conducting an audit of all infants and  
3 children admitted to the PICU with hyponatraemia. My  
4 initial results indicate at least two other deaths  
5 attributable to the use of Solution No. 18."  
6 He brought this letter to the attention not only of  
7 Dr McCarthy and Dr Nesbitt, but also to the coroner at  
8 that time, and to Dr Herron, who wrote the post-mortem  
9 report, who of course was working with Dr Loughery on  
10 the post-mortem report, and she sat on the working  
11 group. Was this letter discussed to the working group  
12 or the content discussed?  
13 A. No. This letter, of course, post-dated the second  
14 meeting of the working group which you've now made me  
15 aware of.  
16 Q. Was information exchanged by e-mail then in relation to  
17 this correspondence?  
18 A. Certainly not to my knowledge. And not in the e-mails  
19 that I have made reference to, which I understand to be  
20 the record of all of the e-mails that were exchanged.  
21 Q. But we know that at the very first meeting Dr Taylor  
22 more or less opened the discussions of the group by  
23 referring to the incidents and we saw the reference to  
24 him circulating information about incidents at RBHSC.  
25 And here's correspondence which is also circulating the

49

1 committee on paediatrics, upon which you sat. And it  
2 seems that such a meeting of that took place very soon  
3 after this letter was written on 30 October. Can we go,  
4 please, to 320-055-001?  
5 This looks like it has been corrected to date it as  
6 at October 2001. I draw this to your attention -- you  
7 in fact were present at this meeting because, if one  
8 reads through the minute of the meeting, your name  
9 appears on numerous occasions as having made  
10 contributions, confirmation, summaries and so forth.  
11 But you're not actually mentioned in the list at the  
12 top.  
13 I draw this to your attention because this is an  
14 occasion during the course of the working group  
15 deliberations where the chief medical officer,  
16 Dr Campbell, met with no fewer than seven members of her  
17 working group on hyponatraemia. And apart from  
18 yourself, there's Dr Crean on the left-hand side. On  
19 the right-hand, Dr McAloon, Dr Taylor as  
20 a representative and, on the bottom left, Dr Kennedy was  
21 part of the working group. We've got Dr Darragh and  
22 Dr McCarthy and yourself.  
23 The issue of hyponatraemia and your work was  
24 referred to at that meeting, and it's at 320-055-006.  
25 In "Any other business":

51

1 working group, in which again he comes back to his  
2 audit.  
3 A. Well, I don't believe it was circulated to all the  
4 members of the working group and I certainly have no  
5 record of receiving it.  
6 Q. Do you recollect any discussion, exchange or reference  
7 to it in your e-mails with other working group members?  
8 A. No.  
9 Q. Or any discussions with working group members  
10 individually or collectively?  
11 A. Not in relation to the content of this letter. There  
12 was discussion in relation to what we perceived as the  
13 lack of responsiveness of the MCA to the concerns that  
14 had been raised about this solution.  
15 Q. In October 2001, how many deaths were you aware of from  
16 hyponatraemia in Northern Ireland?  
17 A. One.  
18 THE CHAIRMAN: And that was still in a general way, it was  
19 a child in Altnagelvin?  
20 A. Yes.  
21 THE CHAIRMAN: You still weren't aware of Lucy?  
22 A. That's correct.  
23 THE CHAIRMAN: And you weren't aware of anybody else?  
24 A. That's correct.  
25 MR STEWART: You mentioned earlier on the specialty advisory

50

1 "Dr McCarthy refers to hyponatraemia and summarises  
2 the brief guidelines on the prevention of hyponatraemia  
3 in children receiving intravenous fluids. Members  
4 welcomed the guidelines, which will be published soon."  
5 So that would suggest that the drafting is well  
6 advanced.  
7 A. At the end of October, we were certainly in the process  
8 of drafting. I'm not sure how I can distinguish what  
9 well advanced was because there was still a lot of  
10 debate which went on until the end of the year. But,  
11 yes, there was a draft at that point, which, as  
12 I understand it from these minutes, was what Dr McCarthy  
13 referred to, but this would have been a very short issue  
14 which she raised briefly under any other business at the  
15 very end of the meeting.  
16 Q. Would the chief medical officer perhaps have taken the  
17 opportunity of you all being in the same room to  
18 mutually discuss the incidence figures that she'd had  
19 e-mailed to her in July 2001, we looked at it earlier,  
20 the five to six deaths, the death in the Mid-Ulster, and  
21 perhaps discussed it with you, with Dr Taylor, who might  
22 have contributed his own audit figures?  
23 A. That was not what happened.  
24 Q. So when people meet to discuss hyponatraemia in  
25 Northern Ireland, they never mention the victims of

52

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

53

1 e-mail from me to Dr McCarthy on 21 December.  
2 Q. I'd be grateful if we could find that.  
3 On 8 November, you go to a meeting of the CREST at  
4 Castle Buildings in Belfast. That's at 075-066-210.  
5 There you are, about the seventh name down, I think,  
6 "Dr J Jenkins". And in attendance, Dr McCarthy, for  
7 item 5, and item 5 appears at 075-066-213.  
8 MR UBEROI: Sorry to interrupt my learned friend's flow, but  
9 just for assistance, in case it does assist, picking up  
10 on his last comment about finding the e-mail, which the  
11 witness has referred to, I do have a reference for that,  
12 which is 007-012-025.  
13 MR STEWART: Thank you.  
14 THE CHAIRMAN: Thank you, Mr Uberoi.  
15 MR STEWART: Again, that's another one which is not yet  
16 live.  
17 THE CHAIRMAN: Thank you anyway. If Mr Uberoi has it, it  
18 should be live, but we'll come back to it later.  
19 MR STEWART: This is the CREST meeting, and it's  
20 8 November 2001, and you are there and Dr McCarthy is  
21 there, and Dr McCarthy is there in order to report to  
22 CREST on the guidelines for the prevention of  
23 hyponatraemia in children receiving intravenous fluids.  
24 We see that from the third line down, Dr McCarthy is  
25 introduced, and she states that:

55

1 THE CHAIRMAN: But it's the bare details you have --  
2 A. Yes.  
3 THE CHAIRMAN: -- not the greater details?  
4 A. That's correct.  
5 THE CHAIRMAN: Thank you.  
6 MR STEWART: I'm trying to chart a chronological course  
7 through the events, so please, if there were events or  
8 things that happened in the course of this narrative,  
9 please let us know.  
10 Can I refer, please, to -- maybe this is another of  
11 these pages, 007-028-053. Again, the problem, sir, is  
12 I've been quarrying a file, which isn't online.  
13 This was -- and we'll get copies for you, I assure  
14 you -- an e-mail of 5 November 2001 from Dr McCarthy to  
15 members of the working group, and it is forwarding  
16 a draft of the guidelines as they were at  
17 5 November 2001. And they are clearly a draft, but  
18 really a very advanced draft and close to the final  
19 guidelines. So we'll come back to that document, it's  
20 just to mark in your mind that at the beginning  
21 of November the guidelines were well advanced in their  
22 preparation.  
23 A. I would certainly accept that they were well advanced,  
24 but it was not until, in my mind, immediately prior to  
25 Christmas when, I think, we will find in that file an

54

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

56

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

6 (11.28 am)

7 (A short break)

8 (11.48 am)

9 MR STEWART: Thank you, sir. I wonder might we, for the  
10 sake of completeness, go back and have a look at the  
11 documents I was unable to call up. The first is at  
12 007-038-072 and 073.

13 This, to remind you, was the minute of the  
14 10 October 2001 meeting, and I described to you how  
15 Dr McCarthy indicated that that is what it is and the  
16 initials down the left-hand side are given as "JJ",  
17 which I assume is yourself, "PC", and "JMCA", and you'll  
18 see the discussion is a fairly technical one and not  
19 related to any particular incident or patient.

20 A. Yes.

21 Q. The next one we looked at briefly --

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

57

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

6 A. I don't know.

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

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

13 A. Yes, the pages are reversed obviously.

14 Q. Of course, yes.

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

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

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

59

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

3 Q. Indeed.

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

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

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

10 Q. Yes.

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

17 Q. Well, you will recall that that drafting subgroup was  
18 going to be formed after the initial meeting of  
19 26 September. So it would seem logical to assume that  
20 this meeting is of the subgroup, but as you correctly  
21 point out, there are some names which are missing, which  
22 would underline the importance of e-mail as the channel  
23 of communication between the members of the group?

24 A. Yes, that was the agreed way forward.

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

58

1 paediatricians/anaesthetists at the PICU RBHSC."

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

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

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

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

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

17 A. I was certainly not aware of that.

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

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

60

1 their responsibility. I certainly had examples of where  
2 they had changed their practice in my area of  
3 specialism, which was neonatal care, and where we would  
4 not have been formally notified by them of those changes  
5 in practice, but we would usually have heard fairly  
6 quickly, particularly because of the rotation of our  
7 junior doctors who tended to come out to work in the  
8 peripheral hospitals having spent time in the regional  
9 centre.  
10 Q. Would you have expected such information to be discussed  
11 at one of the specialty advisory committees in  
12 paediatrics?  
13 A. No, that wouldn't have been the forum that would have  
14 been used.  
15 Q. Would there have been other fora?  
16 A. The one which you described earlier, with Dr McAloon,  
17 the day before Dr McAloon's memo.  
18 Q. Yes, that was the Sick Child Liaison Group.  
19 A. That's the type of forum in which this sort of  
20 information would normally have been shared.  
21 THE CHAIRMAN: I think there's one more. Dr Jenkins has  
22 raised one other document which we couldn't turn up,  
23 Mr Stewart. It was 007-012-025, I think you wanted to  
24 refer to this, doctor. It was a December 2001 e-mail.  
25 A. It was simply because we had been asking about my

61

1 that the Department of Health, as in Dr McCarthy, was  
2 aware of this information that she had become aware of.  
3 But I think it's quite clear that she didn't copy this  
4 to the other members of the working group; it was an  
5 e-mail specifically to Dr McCarthy.  
6 Q. Yes. She got it from the coroner and he was keen that  
7 she receive that information because she was working on  
8 the working group. Did she draw this to the attention  
9 of the members of the group?  
10 A. No.  
11 Q. That's the end of November. But meanwhile, on  
12 15 November, and perhaps unbeknownst to you, the Sperrin  
13 Lakeland Trust had decided to commission a report from  
14 you in relation to Lucy's case. That appears at  
15 047-104-234.  
16 You can see the top:  
17 "Clinical negligence claim, Lucy Crawford deceased,  
18 against the Sperrin Lakeland Trust. Chronology of key  
19 steps. 15 November [at the very bottom] case discussed  
20 at the trust's scrutiny committee. Independent expert  
21 identified and agreed. Report to be requested from  
22 Dr J Jenkins."  
23 Had you previously provided reports for the Sperrin  
24 Lakeland Trust?  
25 A. Not to the best of my knowledge. I have no recollection

63

1 contribution and this was an e-mail -- I think  
2 Mr Stewart had said he wasn't aware of any e-mails -- of  
3 my contribution within the e-mail chain, and I was just  
4 pointing out that at least on this occasion I had  
5 contributed comments.  
6 MR STEWART: I'm grateful for that, yes.  
7 THE CHAIRMAN: Thank you.  
8 MR STEWART: Perhaps we could go then to 30 November 2001 at  
9 007-025-048. This is November 2001, and we have an  
10 e-mail from Dr Clodagh Loughrey, who's on the working  
11 group, who Dr McCarthy, and she starts it "Dear Miriam"  
12 and if we go to the final paragraph of it, she is  
13 e-mailing her fellow working group members to say:  
14 "Were you aware of the death of a four-year-old  
15 child in what sounds like very similar circumstances in  
16 Northern Ireland in 1996? I was speaking to the coroner  
17 about it today and he is to send me a copy of his report  
18 in that case. Let me know if you'd be interested in  
19 seeing it. Perhaps you're already aware of it. Best  
20 wishes, Clodagh."  
21 So it looks as though at least among two members of  
22 the working group, there is an interest in sharing  
23 information about individual cases of deaths from  
24 hyponatraemia.  
25 A. Well, Dr Loughrey obviously felt that it was important

62

1 of having done so.  
2 Q. Or indeed for Altnagelvin --  
3 A. Well --  
4 Q. -- before Raychel's case.  
5 A. Reports which I had previously prepared had been on the  
6 instructions of DLS or CSA, as they were, in relation to  
7 a number of trusts in Northern Ireland. And I have no  
8 specific recollection of either of these two trusts, but  
9 it's quite possible that I had done a report on  
10 a medical negligence case in respect of them because  
11 I had done that on other occasions.  
12 Q. How many previous occasions might you have provided  
13 reports for the DLS, CSA?  
14 A. In medical negligence cases, this averaged at about  
15 roughly four a year.  
16 Q. And how many years had you been offering this service?  
17 A. I had first been asked to do this within five years of  
18 my appointment in 1982, so mid-1980s, and had certainly  
19 not sought this work, but those legal advisers were  
20 approaching me from time to time and so if a matter,  
21 I felt, was within my area of expertise, I was prepared  
22 to provide an expert report.  
23 Q. Yes. I think Ms Gollop said that you received a letter  
24 of instruction in respect of which privilege is claimed,  
25 in February of 2002.

64



1 A. That's correct.  
2 Q. And can you recall in what terms that letter was  
3 couched?  
4 A. It was in relation ...  
5 MR STITT: I have to rise to that one.  
6 THE CHAIRMAN: I think if the trust has claimed privilege,  
7 Mr Stewart, you can't ask the witness for the terms in  
8 which the privilege letter was couched.  
9 MR STEWART: Very well, sir, thank you.  
10 Can I ask, please, that we have a look at your  
11 report that you did furnish on 7 March, which is  
12 013-011-037 and perhaps 038 beside it? Of course, Lucy  
13 had died in April of 2000, and this was a liability  
14 report that you prepared in relation to the clinical  
15 negligence action, and we can see you have headed your  
16 report with the title of the case "Lucy Crawford,  
17 deceased, against the Sperrin Lakeland Health and Social  
18 Care Trust". It's dated 7 March 2002. And of course at  
19 that stage, the CMO had yet to publish the working  
20 group's guidelines and so you were still then, I take  
21 it, a member of the working group prior to the final  
22 publication of your deliberations?  
23 A. As far as I was concerned, the working group had  
24 completed those deliberations in January. There's no  
25 further communication back and forward in any further

65

1 intravenous use in young children and a number of cases  
2 of symptomatic hyponatraemia have been identified, some  
3 resulting in death or cerebral damage."  
4 Can I ask you what cases you were referring to?  
5 A. I was referring to cases -- the one case that I had  
6 previously been aware of and cases reported in the  
7 literature.  
8 Q. So at that time, you say you still had no knowledge of  
9 Adam Strain's case?  
10 A. Correct.  
11 Q. You had knowledge, of course, of Lucy's case and you had  
12 knowledge, of course, of Raychel's case.  
13 A. Yes.  
14 Q. In the course of the working group meetings, was  
15 reference made to victims of hyponatraemia suffering  
16 brain damage as opposed to death?  
17 A. I would have seen that in the literature that I had  
18 reviewed as part of the guideline development.  
19 Q. Did the working group not discuss the consequences of  
20 hyponatraemia?  
21 A. I'm sorry, I'm not sure what it is that you're asking  
22 me.  
23 Q. Well, hyponatraemia can presumably finish with a range  
24 of outcomes.  
25 A. Yes.

67

1 drafting that took place after the middle of January.  
2 THE CHAIRMAN: Yes. In fact it was so far advanced, as  
3 we've just seen, in December that you were making  
4 a suggestion about the appearance of the poster.  
5 A. Yes.  
6 THE CHAIRMAN: So if they weren't technically complete, they  
7 were effectively complete?  
8 A. Yes. I'm not aware that the working group was ever  
9 formally stood down, but as far as the members were  
10 concerned we had completed our work in January, if not  
11 by Christmas.  
12 MR STEWART: The work was over, but the product had yet to  
13 be delivered?  
14 A. It was in the process of being prepared for publication  
15 and the poster had to be -- there was some artwork had  
16 to be done in relation to the wall poster.  
17 Q. I wonder can I take you, please, to the bottom of the  
18 second page there, the paragraph commencing "over recent  
19 years", and I wonder can we take down the page on the  
20 left, 037, and put up 039 beside 038?  
21 013-011-038 and 039. It's the bottom sentence on  
22 the left-hand side:  
23 "Over recent years concerns have begun to be  
24 expressed regarding the use of 0.18 per cent saline in  
25 dextrose [Solution No. 18] as a standard solution for

66

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

68

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

69

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

71

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

70

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

72

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

73

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

75

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

74

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

76

1 in Raychel's inquest and then in Lucy's. Would it have  
2 been helpful, do you think, to the working party to have  
3 had Dr Sumner's public document, his report in Adam's  
4 case, before it?  
5 A. Yes.  
6 THE CHAIRMAN: Thank you.  
7 MR UBEROI: Might I rise, sir, for a small point, just  
8 picking up on a detail inherent to the first point.  
9 I am not actually sure we have factually established all  
10 those people were in the room at the same time for  
11 a meeting, but of course your succeeding points about  
12 e-mails, et cetera --  
13 THE CHAIRMAN: I accept that query because there's a degree  
14 of uncertainty, but I don't think it detracts from the  
15 main issue. I'll accept that.  
16 MR UBEROI: Thank you.  
17 A. Is this an appropriate moment for me to make a further  
18 comment on the point that you raised earlier this  
19 morning and have just repeated in respect of the method  
20 of working of the working group or would you prefer me  
21 to leave that?  
22 THE CHAIRMAN: It's okay, if it's in your mind, let's not  
23 lose it again.  
24 A. Simply, I referred this morning to two circumstances in  
25 which I had been in a working group producing this type

77

1 an internal note from the DLS, the solicitors for  
2 Altnagelvin, and it's in relation to commissioning  
3 a report from you in respect of Raychel's case. The  
4 note is:  
5 "Dr Jenkins has heard of the case. He will be  
6 prepared to look at the papers and do a report."  
7 Can I ask you about this? You are being  
8 commissioned to do a report, you've heard of the case,  
9 you've sat on a working group which was convened as  
10 a response, in a sense, to the death. You have sat on  
11 it with Dr Nesbitt, who was from the hospital where the  
12 death came from. Did you feel in any sense that you  
13 weren't sufficiently independent to do a report on this  
14 case?  
15 A. No.  
16 Q. Did you feel that perhaps even though you might be  
17 yourself confident of independence, that you might not  
18 appear completely independent?  
19 A. No.  
20 Q. That never crossed your mind?  
21 A. No.  
22 Q. The brief you received appears at 172-002-001. We can  
23 see, I think, some of your own annotations, on this;  
24 is that correct? Is that your handwriting?  
25 A. That's correct.

79

1 of guidance, the one that we're discussing today and the  
2 NPSA working group. I had said my experience was that  
3 other group had worked in a similar way. There is  
4 a third example, which has been more recent, and  
5 that is, as reported in my CV, I have recently been  
6 a member of a working group set up by the chief medical  
7 officer looking at group B streptococcal disease in the  
8 newborn. That working group has also worked in the same  
9 way: that a group of people with expertise have been  
10 brought together, have discussed and formulated  
11 guidelines without reference to individual cases.  
12 I just simply provide that as another example.  
13 I understand the points you've made about that way of  
14 working, but that has been my experience.  
15 MR STEWART: May I take you back to something you said  
16 a moment ago? It was in relation to the Altnagelvin  
17 response to Raychel's death, and you said that Dr Fulton  
18 went to the meeting and he learnt of another death.  
19 A. No, sorry. If I said that, that was not what  
20 I intended. I said he learnt of something else that had  
21 happened in the Erne Hospital. Because I understand  
22 that there's some debate as to whether it was reported  
23 as a death or not.  
24 Q. Thank you. Can we please go to 160-113-002? This is  
25 a note, the bottom of the page, 31 October. This is

78

1 Q. And at the top you've underlined several times that you  
2 were to look at these papers on behalf of the trust.  
3 And then further down you're informed that the coroner  
4 is to hold an inquest into the death and you're asked to  
5 prepare a report on the matter, having been told that an  
6 independent report has been obtained from Dr Sumner.  
7 And you have noted on it a number of things. First of  
8 all, on the left-hand side:  
9 "BJHM article 1985."  
10 What's that?  
11 A. That was simply for my own recollection of a paper that  
12 I had been involved in publishing in 1985 in relation to  
13 cerebral oedema in a different condition, a condition  
14 called Reye's syndrome. But cerebral oedema was  
15 a common feature of severely -- of adverse outcomes in  
16 both of these conditions.  
17 Q. That's another metabolic disorder, is it?  
18 A. Yes, it just triggered a memory when I was reading this  
19 that I'd had some previous experience of cerebral oedema  
20 leading to adverse outcomes, but in a different set of  
21 circumstances.  
22 Q. On the right-hand side you have noted "Query". You  
23 don't seem to have got the statement from Staff Nurse  
24 McAuley.  
25 A. That's correct.

80

1 Q. And:  
2 "Query Ward 6 nursing notes for the 8th."  
3 Was that because you didn't have those?  
4 A. These were my initial comments having read through the  
5 papers initially and I just wanted to jot down queries  
6 in my own mind as to whether I had some relevant  
7 information.  
8 Q. And then you've noted down:  
9 "Query severity of vomiting c/f fluid chart but  
10 Sister Millar and nurse notes, 9 June."  
11 A. Yes.  
12 Q. So you seem to be there very quickly looking at the  
13 competing evidence as it were for vomiting?  
14 A. I recognised very quickly that there seemed in my mind  
15 to a tension there that had to be elucidated.  
16 Q. Even a contradiction, perhaps?  
17 A. Perhaps, yes, though this was an initial query.  
18 Q. Then the following page, which is 172-002-002, we find  
19 actually the documents that you were provided with. We  
20 see at number 13 you get Dr Sumner's report, an autopsy  
21 report at 15, extracts from literature, and curiously  
22 a draft press statement. Would you normally be sent  
23 a draft press statement of an inquest before you even  
24 reported?  
25 A. No.

81

1 THE CHAIRMAN: I think, before you move on, I think the  
2 unfortunate question about the inclusion of that  
3 document in the brief is whether, although you were  
4 being briefed as an expert witness, you were at the same  
5 time being given the Altnagelvin line. And if you were  
6 being given the Altnagelvin line at the same time as  
7 being asked to produce an objective, independent  
8 expert's report, do you agree that would be  
9 inappropriate?  
10 A. Yes.  
11 THE CHAIRMAN: Thank you.  
12 A. But I can say that I did not take any notice of that in  
13 preparing my report.  
14 THE CHAIRMAN: Yes.  
15 MR STEWART: Can we have a look at 172-002-028? And 029.  
16 These are pages from Dr Sumner's report and you've  
17 clearly gone through it with your pen, marking  
18 everything you think of interest, of note, as you work  
19 through it, thinking, as it were, with your pen on the  
20 page. We can see therefore what you thought was  
21 important. On the left-hand side at the top of the  
22 second paragraph, you have underlined:  
23 "Vomiting plus plus. At 2300 hours there were a few  
24 more small vomits. Raychel had been able to walk during  
25 the day."

83

1 Q. Did that surprise you to see such a thing?  
2 A. I didn't really take notice of it, I saw it was in the  
3 bundle, but it wasn't something which I felt I had to  
4 pay any particular attention to.  
5 Q. Can we just have a look at it? 172-002-043. It's  
6 dated, by fax transmission, March 2002. The first date  
7 of the inquest listing is 10 April 2002. And the draft  
8 which is for some reason sent to you, states:  
9 "It is important to be aware that the procedures and  
10 practices put into effect in the care of Raychel  
11 following her operation were the same as those used in  
12 all other area hospitals in Northern Ireland."  
13 Did you in the course of reviewing the papers form  
14 any view as to the appropriateness of that conclusion?  
15 A. I certainly formulated a view that the treatment of  
16 Raychel and her management needed to be tested against  
17 standards of care and that was one of the issues  
18 I raised in my first report.  
19 Q. Yes, of course. So on that basis it's clearly premature  
20 to draft a press release in these terms?  
21 A. Yes.  
22 Q. You didn't feel yourself obliged to make any response.  
23 Did you in fact advise that this was ill-advised?  
24 A. No.  
25 Q. You have the report of Dr Sumner.

82

1 In the paragraph after that you go through the  
2 fluids and you total up the fluids there so you're  
3 interested in the quality and the rate of fluid  
4 administration. In the next paragraph you're circling  
5 the times because you are working through the  
6 progression of 8 June through to 9 June, working out  
7 what's happening.  
8 On the next page, more of the same detailed  
9 attention to Dr Sumner's observations, at paragraph 2  
10 you have underlined:  
11 "Suffered very severe and prolonged vomiting."  
12 On the right-hand page, can we enlarge that to its  
13 full size, please? You'll see that you have actually  
14 put an asterisk beside:  
15 "Suffered very severe and prolonged vomiting."  
16 Why did you mark that passage out for particular  
17 reference?  
18 A. Because it was one of the things in my analysis of the  
19 papers that had been sent to me, including Dr Sumner's  
20 report, that I felt needed to be looked at in more  
21 detail as a particularly important aspect.  
22 Q. Thank you. The next page is 172-002-030. And again, on  
23 this you've been highlighting by underlining.  
24 In relation to the central paragraph there, you've  
25 underlined his final conclusion:

84

1 "I believe that the state of hyponatraemia was  
2 caused by a combination of inadequate electrolyte  
3 replacement in the face of severe post-operative  
4 vomiting and water retention always seen ..."  
5 Was that a comment that you believed that you had to  
6 address your comments to?  
7 A. It was mainly just, as you've said, I went through the  
8 whole document underlining the bits that I felt were  
9 most important, and obviously I felt his conclusion was  
10 a very important part of his report.  
11 Q. And you had been asked to prepare your report in the  
12 light of his report?  
13 A. Yes, that's one of the factors that I needed to be aware  
14 of in preparing my report.  
15 Q. And then you did produce a report and we find it at  
16 022-010a-040. And can we perhaps see 041 beside it?  
17 This is your 12 November 2002 report. You head it  
18 "Raychel Ferguson deceased. Inquest". This is eight  
19 months after your Lucy report, which we recall was  
20 clearly headed with the title of the action, the  
21 clinical negligence action.  
22 You say at the top:  
23 "This report is prepared at the request of the  
24 Directorate of Legal Services."  
25 Then at the comments section on the left-hand side,

85

1 You don't attempt to make that distinction there.  
2 A. Not in this, no.  
3 Q. Then you go on to the next paragraph to indicate the  
4 problem of hyponatraemia and hypotonic solutions:  
5 "This was well described in an editorial in the  
6 Journal of Paediatric Anaesthesia in 1998 by Dr Arieff,  
7 but it did not receive widespread publicity in journals  
8 likely to be read by most paediatricians or surgeons  
9 caring for children at that time."  
10 Why did you not make reference to the 1992 Arieff  
11 article in the British Medical Journal?  
12 A. Because I was still unaware of the existence of that  
13 article.  
14 Q. But you were aware of the 2001 lesson of the week  
15 article in the BMJ?  
16 A. Yes.  
17 Q. And it footnotes, right at the very end, "Arieff".  
18 A. Yes, but I hadn't picked that up.  
19 Q. Then you go on:  
20 "Many paediatric units were still using their  
21 traditional regimes based on Solution No. 18 until  
22 further concerns were raised in Northern Ireland  
23 in September 2001 as a result of two deaths."  
24 You were there when the concerns were raised, you  
25 were on the working group in September 2001; what two

87

1 the first sentence there:  
2 "Solution No. 18 has been routinely used in  
3 paediatric medical practice for a very long time and is  
4 rarely associated with any acute electrolyte  
5 disturbances such as were seen in this tragic case."  
6 In your report in Lucy's case, you had drawn  
7 attention to death and cerebral damage and so forth.  
8 Why did you not make that caveat to this comment?  
9 A. I just need to read through the rest of it so that that  
10 sentence can be taken in the context of the whole of my  
11 report.  
12 THE CHAIRMAN: Take your time, doctor. (Pause).  
13 A. I think what I was trying to do was to make the  
14 distinction between paediatric medical practice and the  
15 surgical environment, and particularly the  
16 post-operative period, and that was why I was  
17 emphasising that point.  
18 MR STEWART: You do make reference to deaths later on and  
19 we'll come to those. But in your report for Lucy,  
20 you have simply said that:  
21 "Concerns have been expressed regarding the use of  
22 No. 18 Solution as a standard solution for intravenous  
23 use in young children. A number of cases of symptomatic  
24 hyponatraemia have been identified, some resulting in  
25 death or cerebral damage."

86

1 deaths were those?  
2 A. Well, the two deaths that I'm referring to here were  
3 Raychel and Lucy. Although in retrospect, I believe  
4 that Lucy's death was not known to the department,  
5 certainly not to me, at the time the working group was  
6 undertaking its --  
7 Q. Hang on a second. You're saying you didn't know about  
8 Lucy in September 2001 and the department didn't know  
9 about Lucy in September 2001. How can you explain you  
10 writing:  
11 "Until further concerns were raised within  
12 Northern Ireland in September 2001 as a result of two  
13 deaths\*?"  
14 Who raised those concerns?  
15 A. I think I was quoting here from the chief medical  
16 officer's covering letter in issuing the guidance  
17 in March 2002, where she had specifically referred to  
18 two deaths.  
19 Q. Yes. What she says is something quite different. She  
20 says:  
21 "Hyponatraemia can be extremely serious and has  
22 in the past few years been responsible for two deaths  
23 among children in Northern Ireland."  
24 She doesn't link those deaths to steps taken to  
25 convene a working group.

88

1 A. I'm sorry?  
2 Q. She doesn't link those to steps taken to convene  
3 a working group; she merely says that in the past few  
4 years hyponatraemia has been responsible for two deaths.  
5 A. But surely she makes that comment in the context of  
6 explaining how the working group came to be set up.  
7 Q. No, what she says is -- and we can go to 012-064c-328.  
8 She, in the initial paragraph, describes the guidance  
9 that is going to be forthcoming, it's going to be in  
10 posters, it's been developed by the multidisciplinary  
11 working group and supported and endorsed by CREST. Then  
12 she goes on in the second paragraph to describe  
13 hyponatraemia and what it is:  
14 "Hyponatraemia can be extremely serious and has  
15 in the past few years been responsible for two deaths  
16 among children in Northern Ireland. Hyponatraemia is  
17 a problem of water balance and most often reflects a  
18 failure to excrete water. Pain, stress and nausea are  
19 all potential stimulators of the antidiuretic hormone  
20 ADH, which inhibits water excretion."  
21 So the comment there in relation to deaths is  
22 in relation to a description of hyponatraemia, not the  
23 establishment of a departmental working group.  
24 A. Well, I took it this that whole letter was in relation  
25 to how the working group had been set up so that the

89

1 important that this was something which needed to be  
2 elucidated.  
3 Q. Indeed, and those are exactly the words you use down  
4 in the conclusion paragraph on the right-hand side,  
5 third line down:  
6 "It is, however, important that further details are  
7 obtained of relevant nursing and medical procedures, in  
8 particular information needs to be obtained ..."  
9 And so forth. In response to this specific note by  
10 you of the importance of additional information, did you  
11 receive any additional information?  
12 A. No.  
13 Q. How relevant to your view of the case was the absence of  
14 information?  
15 A. Well, the conclusions in my first report were all that  
16 I believed I could adduce on the basis of the  
17 information that was available to me. And I was not in  
18 a position to formulate any more clear conclusion in  
19 respect of the issues that I believed that I was  
20 addressing. And as you will see, I perhaps  
21 misunderstood the purpose of this document because I do  
22 talk about the issue of negligence.  
23 Q. Yes.  
24 A. And my understanding was that this was a report which  
25 had been requested by DLS for the trust, though in the

91

1 guidance could be produced. If the working group is not  
2 specifically mentioned, it is implicit.  
3 THE CHAIRMAN: Okay, thank you.  
4 MR STEWART: Can we go back then to the report at  
5 022-010a-040.  
6 MS GOLLOP: Sorry, I hesitate to interrupt, but on the page  
7 we've just looked at, it does specifically mention the  
8 working group.  
9 MR STEWART: It does, yes.  
10 022-010a-040. The bottom of the left-hand page:  
11 "While it is possible in retrospect to form the  
12 opinion reached by Dr Sumner that Raychel must have  
13 suffered severe and prolonged vomiting, this does not  
14 seem to have been the assessment of her condition by  
15 experienced staff at the relevant time."  
16 And then you go on to describe what Sister Millar  
17 said.  
18 What was your intention when you wrote that passage,  
19 that it was possible to agree with Dr Sumner but that  
20 doesn't seem to have been the view taken at the time?  
21 A. Well, as represented by my annotations on the letter of  
22 instruction, I had recognised that this was an area  
23 which required clarification. Dr Sumner had reached  
24 a view which differed from that of the staff who'd been  
25 providing care, so I was pointing out that it was

90

1 context of the coroner's inquest.  
2 Q. Yes. What was your experience of appearing at inquests?  
3 A. I had only, I think, ever been at one coroner's inquest,  
4 and that was as a very junior doctor, basically where  
5 I'd been involved in a road traffic accident and had to  
6 go along as a witness of fact.  
7 THE CHAIRMAN: So a completely different scenario to this?  
8 A. Absolutely.  
9 MR STEWART: And likewise, did you have experience in  
10 drafting reports for inquests or coroners?  
11 A. None.  
12 Q. Can I ask you about the final part of your report, about  
13 four lines from the bottom?  
14 "In the circumstances relating to this incident, it  
15 was only the tragic deaths of two children in  
16 Northern Ireland which alerted the wider clinical  
17 community to these concerns. These have subsequently  
18 been assessed and relevant guidance prepared and  
19 disseminated as outlined above."  
20 Was it the deaths that were assessed or the  
21 concerns?  
22 A. The concerns. The two deaths that I refer to there are  
23 again Raychel and Lucy.  
24 Q. 160-097-001. This is an internal DLS note of  
25 18 November. So that's really very soon after your

92

1 opinion has been received. It is noted at the bottom:  
2 "Phoned Therese. Advised re Dr Jenkins' report.  
3 Explained I was still trying to get a paediatric  
4 anaesthetist, explained it would be necessary to consult  
5 with Altnagelvin and Dr Jenkins in due course and get  
6 Dr J to fill out his report. TB to revert re  
7 availability of consultants."  
8 MR STITT: Can I just interrupt? I appreciate it's in the  
9 middle of a sentence and no discourtesy is intended, but  
10 we've discussed the question of the DLS inquest file.  
11 There were two letters which were submitted to the  
12 inquiry, one with a long list of documents in which  
13 privilege was claimed. Then a meeting took place, which  
14 I have some personal knowledge of, and the second letter  
15 was sent a few days later with a much shorter list of  
16 documents, to which privilege was claimed. We've been  
17 there and I'm slightly surprised that this document,  
18 which is one of the documents in the second letter, is  
19 being opened.  
20 MR STEWART: I'm surprised as well. I thought this was --  
21 MR STITT: If I'm wrong about that, I will apologise.  
22 MR STEWART: We'll pull it down now. I did not think that  
23 was --  
24 MR STITT: If I'm wrong about that, I'll accept the  
25 criticism. My understanding from my nomenclature, which

93

1 have, which might assist the trust, but you ignored what  
2 might look like a steer?  
3 A. I didn't read it that way. But I did see this letter  
4 again in the context of the trust because the heading,  
5 as you will notice, no longer refers to the coroner's  
6 inquest at all. And although there is a reference  
7 in the body of the letter to the inquest, it seemed to  
8 me that this again was information for the trust,  
9 specifically in relation to this report which they'd  
10 obtained.  
11 Q. Yes, but you're retained in relation to the inquest.  
12 A. In the context of the inquest.  
13 Q. Yes:  
14 "I refer to the above matter."  
15 THE CHAIRMAN: Sorry, doctor, you're asked for your comments  
16 as a matter of urgency in view of the imminent date of  
17 the hearing of the inquest. This letter must be  
18 inquest-related rather than medical negligence-related,  
19 surely.  
20 A. Yes, I accept that, but it was in my mind still focusing  
21 on providing information to the trust as opposed to the  
22 coroner.  
23 THE CHAIRMAN: Yes, but it was information you were  
24 providing to the -- sorry, so you didn't necessarily  
25 expect whatever information you provided to go before

95

1 is not as straightforward, it's a complicated  
2 nomenclature for various reasons, tells me that's one of  
3 the documents. I am just making the point, not  
4 specifically because of the document, but in principle  
5 lest we trawl through others --  
6 THE CHAIRMAN: Well, can we go on without that, Mr Stewart?  
7 MR STEWART: Yes, of course.  
8 If we might look, please, at 172-003-001. This is  
9 a letter -- I'm on safer ground now -- written to you by  
10 the DLS, in which you are in fact sent a copy of  
11 Dr Warde's report:  
12 "Enclosed herewith a copy received from Dr Warde,  
13 a consultant paediatric anaesthetist retained to advise  
14 the trust. I would be gratefully obliged if you could  
15 consider Dr Warde's report and provide me with any  
16 further comments which you have which might assist the  
17 trust."  
18 That's a curiously worded letter, isn't it, or  
19 is that straightforward to you?  
20 A. Well, that was one of the points picked up, I think, in  
21 one of my witness statements, where I explained that  
22 I understood this as assisting the trust in considering  
23 what the expert views were as opposed to assisting the  
24 trust in any way, you know, in any particular direction.  
25 Q. You're quite clearly asked to give comments which you

94

1 the coroner?  
2 A. That's correct.  
3 THE CHAIRMAN: So that as far as you were concerned it  
4 wasn't clear that you were going to be used as a witness  
5 at the inquest?  
6 A. That hadn't been made clear to me.  
7 THE CHAIRMAN: Okay.  
8 MR STEWART: If we go back, please, to 172-002-001. This is  
9 your initial letter of instruction on behalf of  
10 Altnagelvin Trust. At the second part of the main  
11 paragraph:  
12 "The coroner is to hold an inquest into her death,  
13 Belfast Coroner's Court, Victoria Street, Belfast, on 26  
14 and 27 November 2002."  
15 Surely that's an indication to you what you are  
16 required for, isn't it?  
17 A. Well, I think in my mind -- again, I have to accept that  
18 I may well have misunderstood this because of the  
19 previous context in which I had prepared reports, but my  
20 understanding was that I was preparing a report for the  
21 trust in the context of the inquest, but not directly  
22 for the coroner.  
23 Q. Not for the coroner?  
24 THE CHAIRMAN: I'm sorry, doctor, there's one point I don't  
25 quite understand. When you provide a report as an

96



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

97

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

99

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

98

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

100

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

101

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

103

1 11 March 2013, which is the letter -- I don't have the  
2 exact reference for it. But one of the documents is  
3 document number 206. But that could refer to  
4 a different index.  
5 MR STEWART: My instructing solicitor clearly notes that  
6 number 97, which must be this document, is not  
7 included --  
8 MR STITT: That's the nomenclature problem to which  
9 I referred and I apologise for that, sir.  
10 THE CHAIRMAN: If we need to go back to that, we will after  
11 lunch.  
12 MR STEWART: Thank you, sir.  
13 So we come then, in fact, to your third and final  
14 report on Raychel, which is at 022-004-010. This has,  
15 of course, a number of changes to it from your first  
16 report. Can I ask you why you decided to change it?  
17 A. As I indicated in my witness statement, I had no  
18 documentation which enables me to answer that question  
19 with certainty. But I believe that I must have been  
20 contacted because otherwise I wouldn't have known to  
21 change, for example, the contents of the first  
22 paragraph. Up to that point this was something which  
23 I had not understood, so in order for this to be  
24 suitable for submission to the coroner, I know  
25 understood that I had to at least introduce myself

102

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

104

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

105

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

107

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

106

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

108

1 dealing of this case you've omitted things which you've  
2 previously thought relevant.  
3 A. Yes, but which I also knew were in Dr Sumner's report.  
4 Q. But if you thought they were relevant, then you should  
5 recognise their continuing relevance and retain them.  
6 A. I recognise in retrospect that that would have been  
7 a more sensible thing to do, but that was not how  
8 I thought at the time.  
9 Q. Why would that have been more sensible?  
10 A. I think as you're pointing out, to have included that  
11 information would not in any sense have diminished the  
12 impact that I've wanted to have in the main thrust of my  
13 report.  
14 Q. Because when you came to deliver that report to the  
15 coroner, you had an obligation under the GMC's Good  
16 Medical Practice to offer all relevant information to  
17 the inquest, didn't you?  
18 A. Yes, and I believed that all relevant information was  
19 provided to the coroner at the inquest.  
20 Q. Let's just have a look at the duty, which appears at  
21 314-014-014. This starts off with "Formal enquiries" at  
22 paragraph 30:  
23 "You must cooperate fully with any formal enquiry  
24 into the treatment of a patient."  
25 At paragraph 32:

109

1 understanding and my conclusion particularly in respect  
2 of the vomiting issue. I had not been able to do that  
3 prior to hearing him at the inquest.  
4 Q. May I ask what it was he said at the inquest that  
5 allowed you to see for the first time with clarity that  
6 the vomiting had been severe and prolonged?  
7 A. Yes, yes, and I'm not sure whether, it's a sheet of the  
8 handwritten notes, they could be referred to. I can  
9 quote it, but I don't know the page number.  
10 Q. Ah, right. This is the handwritten transcript of  
11 Dr Sumner's oral evidence?  
12 A. The coroner's handwritten --  
13 Q. The coroner's? I don't have it to hand.  
14 MS GOLLOP: I expect the document that the witness is  
15 referring to is the Therese Brown handwritten notes,  
16 which start at page 160-010-001. The pages that contain  
17 her record of Dr Sumner's evidence start on  
18 page 160-010-008. I don't know the best way to do this,  
19 either we flick through the pages until Dr Jenkins finds  
20 the part to which he wishes to refer, or if somebody  
21 hands him the hard copy document he can do the same from  
22 the witness box.  
23 MR STEWART: Here's a hard-copy document. This is, I ought  
24 to say, not Mrs Brown's handwriting, rather the  
25 solicitor from Brangam Bagnall & Co.

111

1 "Similarly, you must assist the coroner by  
2 responding to enquiries and by offering all relevant  
3 information to an inquest ... Only where your evidence  
4 may lead to criminal proceedings being taken against you  
5 are you entitled to remain silent."  
6 It's a terribly clear duty. Do you think now,  
7 looking back, that perhaps you did not fulfil that duty?  
8 A. I believe that all relevant information was offered to  
9 the coroner at the inquest.  
10 Q. But not by you?  
11 A. Well, I concurred with Dr Sumner's views, so I supported  
12 what he had said.  
13 Q. But you didn't in your report, because at  
14 page 022-004-011, after that first paragraph in your  
15 initial report, the first report, after the first  
16 paragraph you have the passage where it was possible to  
17 form the same opinion as Dr Sumner, and whilst it is  
18 recognised that you didn't dissent from Dr Sumner's  
19 opinion at the inquest, what you have done is delete  
20 your view that it might be possible to agree with him  
21 from your report. Why was that?  
22 A. It was part of the same thought process that I've sought  
23 to explain to you. It was when I heard Dr Sumner  
24 explain his views and answer questions at the inquest  
25 that I was able to consolidate in my mind my

110

1 THE CHAIRMAN: It's 1.05. I presume there's some more  
2 questioning beyond this, is there?  
3 MR STEWART: Yes, sir.  
4 THE CHAIRMAN: We'll give you the document over lunch,  
5 doctor.  
6 Mr Stitt?  
7 MR STITT: May I just tidy up one point before we break for  
8 lunch?  
9 THE CHAIRMAN: Let me tidy this point up with the doctor,  
10 have a look at this document over lunch, we'll start  
11 again at 2 o'clock, we'll finish your evidence and  
12 we will finish Dr McCord's evidence this afternoon as  
13 well. Okay? So we'll start again at 2 o'clock.  
14 Mr Stitt?  
15 MR STITT: Sir, could I ask if the witness could stay? It's  
16 the first preliminary report, as I recall it, could it  
17 be pulled up, 022-010a-040? This is the first page of  
18 that first report and I'm making the point in the light  
19 of Mr Stewart's questioning that the witness had  
20 effectively chosen to erase any reference to the  
21 Dr Sumner. I wonder could it be put through you, sir,  
22 to the witness that -- and I'll read it and ask the  
23 question:  
24 "While it is possible in retrospect to form the  
25 opinion reached by Dr Sumner that Raychel must have

112

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

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

9 THE CHAIRMAN: Can you help with that, doctor?

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

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

15 (1.10 pm)

16 (The Short Adjournment)

17 (2.00 pm)

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

113

1 neither severe nor prolonged?

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

4 Q. But were you aware of that position?

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

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

18 A. It's very brief, it's on page 15 of the document  
19 160-010-015.

20 Q. Thank you.

21 A. In the second section which starts:

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

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

115

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

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

6 A. Someone on --

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

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

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

22 A. I think the chairman has summarised my view.

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

114

1 THE CHAIRMAN: Yes.

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

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

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

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

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

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

116

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

117

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

119

1 "[19]96 death, not disseminated. Dr S [Sumner] felt  
2 if Dr C [may be Dr Campbell] brought to attention of  
3 CMOs in England and Wales, two-pronged approach."  
4 So there was much reference to Adam Strain's case  
5 at the inquest?  
6 A. Yes, the dots there --  
7 MS GOLLOP: Sorry to interrupt. I don't think one reference  
8 could be described as "much reference". I've looked  
9 through this and there are, as far as I could see, two  
10 references.  
11 THE CHAIRMAN: Okay. Let me rephrase it. There's specific  
12 reference.  
13 MS GOLLOP: Here's one specific question being put to the  
14 witness by the coroner here.  
15 MR STEWART: If you allow me two minutes, I'll find you  
16 other references and there are plenty of them. In fact,  
17 Mr Brangam writes back to Mr Walby at the Royal Group of  
18 Hospitals Trust to say that he cross-examined at length  
19 to differentiate the cases of Adam Strain and  
20 Raychel Ferguson, and in three particular respects he  
21 sought to differentiate them, so there was a significant  
22 discussion of Adam Strain's case, and if you'd like  
23 I will find the reference to that for you.  
24 MS GOLLOP: If that's a question being put to the witness as  
25 to whether he remembers there being a -- sorry, what are

118

1 significant reference to Adam's case.  
2 MS GOLLOP: Sir, three points. First of all, I'm certainly  
3 not suggesting that anybody has mislead anybody else.  
4 The next point: my reading of this document, which runs  
5 to 59 pages, is that it was an accurate, insofar as  
6 a handwritten contemporaneous document -- and none of us  
7 write quite as speedily as we would like to, but within  
8 the parameters of those constrictions, as reliable  
9 a note as it could be.  
10 And the third point is that I think I'm right in  
11 saying that this part of the note that's being put is  
12 the coroner's questions to Dr Jenkins, and of course, as  
13 you will be aware -- and perhaps Mr Stewart is going to  
14 come on to this -- Dr Jenkins was present on Day 1 of  
15 the inquest only. So it may well be that Mr Brangam put  
16 matters to others witnesses on days 2 and 3 of the  
17 inquest, but this witness will not have been here to  
18 have heard those questions being put.  
19 MR STEWART: Very well.  
20 THE CHAIRMAN: I'm not quite sure where we're going with  
21 this, but ... Continue, Mr Stewart.  
22 MR STEWART: In any event, there was discussion there, and  
23 it's noted:  
24 "[19]96 death -- not disseminated. Dr S felt if  
25 Dr C brought to attention of CMOs in England and Wales."

120

1 So presumably that's the coroner pointing this out  
2 to you, and asking really what you thought about that as  
3 a proposition.  
4 A. Well, when he referred to it as "the '96 death", it went  
5 completely over my head that he was referring to what  
6 I later found out to be Adam Strain because at this  
7 stage I was still completely unaware of Adam Strain in  
8 any respect.  
9 Q. So he starts asking you a question about a death and his  
10 reference means nothing to you. Do you turn round and  
11 say, "I'm awfully sorry, sir, I don't understand what  
12 you're talking about"?  
13 A. Well, my understanding was that he was not talking to me  
14 about a death, he was talking to me about dissemination  
15 of guidance. He mentioned a death in respect of the  
16 topic which I then responded to because my response was  
17 about the dissemination of guidance.  
18 Q. So he took it as read that you would know about this  
19 death and you didn't disabuse him of that notion?  
20 A. No, I took it as read that he was talking about -- in  
21 all of the references to two deaths at this point in  
22 time, I only knew of two deaths. And it may be the  
23 coroner only knew of two deaths. One of them we were in  
24 common, we both knew about Raychel's death, but it  
25 appears that we were on different tracks. I thought

121

1 Northern Ireland now being in an enviable position.  
2 Q. So he thought your reference in your report to two  
3 deaths was to Adam Strain and Raychel, and you thought  
4 his referral to another death -- what?  
5 A. I assumed that that must have been Lucy. But at this  
6 point this time --  
7 Q. Sorry, that's a 1996 death; you know Lucy's not 1996.  
8 A. That wasn't something which registered in my  
9 consciousness that the date didn't match.  
10 Q. But what we do know is you do know about a death that he  
11 doesn't know about, Lucy's --  
12 A. I didn't know he didn't know about it.  
13 THE CHAIRMAN: Sorry, Mr Stewart, we're getting -- I have  
14 got your point. We're getting into knowns and not  
15 knowns and so on. It's not going to take us anywhere.  
16 MR STEWART: You didn't refer Lucy's death to the coroner.  
17 A. No, no, I understood that because she had died, a sudden  
18 and unexpected death, that her death would have been  
19 notified to the coroner.  
20 Q. But you had no reason to believe that?  
21 A. Well, I think that's the standard practice, so I assumed  
22 that that would have taken place.  
23 THE CHAIRMAN: So in fact, it's very obvious that it should  
24 have been referred to the coroner because it's a sudden  
25 and unexpected death of a child in hospital.

123

1 that I was talking about the same death that he was  
2 talking about and he probably thought he was talking  
3 about the same death that I was talking about. My  
4 references were to Lucy.  
5 Q. I see. So when you heard that there was another death,  
6 the 1996 death, did you take note of that mentally?  
7 A. No, my focus was on -- and I mean, this was in the  
8 process of being examined in an inquest, so I was  
9 seeking to focus on what I understood to be the point of  
10 his question, and that was what I responded to, and  
11 this -- it was only when I read these notes subsequently  
12 that I saw that in fact there was a date mentioned at  
13 all.  
14 Q. But in your response you go on to say:  
15 "I was on the working group and I've also prepared  
16 an article with colleagues which has been submitted."  
17 So you were talking about deaths and you were  
18 talking about the working group, but you knew that the  
19 working group had not considered a 1996 death.  
20 A. Yes. As I say, that was not something which rang any  
21 bells with me at all at the time. But I didn't  
22 understand that to be an issue and so I continued in the  
23 discussion which I thought I was having with the coroner  
24 about what had changed in Northern Ireland because the  
25 previous comment that he'd made was about

122

1 A. Yes. And I assumed that that had taken place, and in  
2 fact, as I later understood it --  
3 MR STEWART: Notwithstanding the papers that you got  
4 in relation to Lucy's case, none of which might have led  
5 you to suppose for a moment that there had been an  
6 inquest or a coroner's case, you nonetheless persisted  
7 in the belief that it would have gone?  
8 MS GOLLOP: First of all, that's interrupting the witness so  
9 he didn't get a chance to finish, and second of all, I'm  
10 sorry, sir, but I'm not sure that's a fair extrapolation  
11 from the Lucy papers.  
12 MR STEWART: We've been over this ground before: he was not  
13 instructed to appear at an inquest, he was not briefed  
14 with a verdict at inquest; he was asked to give opinion  
15 on a medical negligence claim. There was nothing on the  
16 papers to suggest it had gone anywhere near the coroner.  
17 On what basis was he to suppose that it had?  
18 A. Because I know that to be standard practice.  
19 THE CHAIRMAN: So your basis for supposing that it had gone  
20 was that it should have gone?  
21 A. Yes.  
22 THE CHAIRMAN: Thank you.  
23 MR STEWART: If we go across the page, at the top of the  
24 right-hand side, at the end of that exchange, the  
25 coroner asks:

124

1 "Is there any aspect, further aspect, you take issue  
2 with?"  
3 And you then describe how helpful you found it to  
4 have an explanation of why Dr Sumner felt it was  
5 prolonged vomiting, and that was because of the U&Es.  
6 The coroner asks you:  
7 "Any instruction re degree of vomiting?"  
8 Which I assume to mean:  
9 "Did you receive any instructions, Dr Jenkins, about  
10 the degree of vomiting in this case?"  
11 And there you say:  
12 "Difficult to tie down. If in toilet, can't know.  
13 Plus is estimate; plus plus is usually large, but not v  
14 large; three pluses very large. Most people don't use  
15 more than four pluses. Seems staff made judgment not so  
16 severe to get medical assistance."  
17 We know that you thought it was important that you  
18 get further information about all that. This was your  
19 opportunity to turn to the coroner and say,  
20 "Instructions? I've been trying to get instructions but  
21 they won't tell me"; why didn't you?  
22 A. I don't know whether the word "instruction" is an  
23 accurate transcription of what the coroner said. It was  
24 certainly not how I interpreted his question because my  
25 response to his question was that he had asked me could

125

1 time that I felt needed to be brought to the attention  
2 of the coroner and which might influence the outcome of  
3 the inquest, I would have taken that opportunity.  
4 Q. Could you have said, "I completely agree with Dr Sumner  
5 and, in my view, not only did she have vomiting, but  
6 there's no doubt she had severe vomiting"?  
7 A. I could have said that, but this, I assume, records how  
8 I chose at that point in time to answer his question.  
9 But I did subsequently, in response to his further  
10 question, as you know, concur with the evidence that  
11 Dr Sumner had given.  
12 Q. Yes. Over the page to 023. The bottom of the page  
13 there, we have:  
14 "Further episode at 9. Would you make assessment?"  
15 And your answer is:  
16 "Judgment call for those caring."  
17 Question:  
18 "Comment re fact re doctors coming early AM without  
19 any other medical intervention for rest of day."  
20 Answer:  
21 "Not uncommon. Doctor would return if concerns.  
22 Would see same time next morning."  
23 Question:  
24 "Would expect to be notified re prolonged vomiting?"  
25 Answer:

127

1 I shed any further light on the issue about the  
2 recording of the amount of vomiting and that was the  
3 question I answered and he did not come back to me and  
4 say, "That's not what I was talking about; I was talking  
5 about your instructions".  
6 THE CHAIRMAN: I'm not sure, Mr Stewart, that any  
7 "instruction re degree of vomiting" means had the  
8 witness received any instructions from his solicitors  
9 about the degree of vomiting.  
10 A. It was certainly not my interpretation.  
11 THE CHAIRMAN: It might be: are there any instructions which  
12 were given to record the degree of vomiting? And that's  
13 how you get into the plus, plus plus, and so on.  
14 MR STEWART: Did you get any further instructions after  
15 that?  
16 A. Instructions in what sense?  
17 Q. In relation to vomiting. Did you see any further  
18 reports after that time?  
19 A. No.  
20 Q. And it was simply what Dr Sumner said that led you to  
21 firmly agree with his conclusion?  
22 A. Yes. And the coroner had just, before this, as you see  
23 at the top of the page, asked me if there was any aspect  
24 or further aspect that I took issue with, and if there  
25 had been anything within my knowledge at that point in

126

1 "Up to clinical staff to assess."  
2 Did you tell the coroner at that time that you'd  
3 been asking for the protocols and for the regimes from  
4 the hospital --  
5 A. No.  
6 Q. -- and that you hadn't got them? Would it have been  
7 relevant to tell him that in that context?  
8 A. I didn't think then and I don't think now that that  
9 would have altered his opinion or his conclusion in any  
10 way.  
11 Q. But you're obligated to proffer, to offer relevant  
12 information, not to second-guess what the coroner might  
13 think is relevant.  
14 A. I offered the information which I felt was relevant.  
15 Q. There is a transcript of the judgment as delivered by  
16 the coroner at 161-066-016.  
17 When did you learn for the first time more detail  
18 about the Adam Strain case?  
19 A. Sometime late in 2004. And that wasn't just more  
20 detail, it was my first awareness of the case and that  
21 was some time later in 2004 after my interview with  
22 Trevor Birney.  
23 Q. But you had been alerted to it there at the inquest?  
24 A. No.  
25 THE CHAIRMAN: The witness doesn't accept that he picked up

128



1 the significance of the date on which the coroner is  
2 said to have referred to.  
3 MR STEWART: Very well.  
4 You have been following the evidence, and doubtless  
5 you have read what the coroner, Mr Leckey, thinks about  
6 the practice of having, say, three reports and producing  
7 the third of them. He doesn't expect that in his court.  
8 Have you read that?  
9 A. I have seen the transcript.  
10 Q. When you came to Lucy's inquest, you produced a second  
11 report, which went to the coroner as, just in this case,  
12 you changed them. I take it in Lucy's inquest you  
13 didn't draw the coroner's attention to that fact either,  
14 did you?  
15 A. No, it was my understanding that it was up to the trust  
16 and their legal advisers to decide what information  
17 should be shared with the coroner. I did not understand  
18 myself to have any responsibility in that regard.  
19 MR STEWART: I see. Thank you, Dr Jenkins, I have no  
20 further questions?  
21 THE CHAIRMAN: Mr Quinn? Do you have any?  
22 MR QUINN: No questions.  
23 THE CHAIRMAN: Any questions from the floor? Mr Stitt, have  
24 you something?  
25 MR STITT: I don't have a question, but I have a point which

129

1 relevant to the paediatric anaesthetist than to the  
2 paediatrician. There were broader aspects of the  
3 diagnosis and management of hyponatraemia which I felt  
4 would have been equally relevant to my expertise.  
5 Q. You've been taken to the list of documents that you were  
6 sent for you to look at before you prepared a report.  
7 Did you get any documents in addition to those on that  
8 list?  
9 A. No.  
10 Q. Were you at any time, before you gave evidence to the  
11 inquest, told that there had been a critical incident  
12 review meeting about Raychel's death on 12 June 2001?  
13 A. No.  
14 Q. Were you told that there had been a meeting between the  
15 doctors and nurses who cared for Raychel and  
16 Mrs Ferguson in September 2001?  
17 A. No.  
18 Q. And just so that we're clear about this, you attended  
19 the inquest on the first day; is that right?  
20 A. That is correct.  
21 Q. And you listened to Mrs Ferguson's evidence?  
22 A. I did.  
23 Q. And then you listened to Dr Sumner's evidence?  
24 A. Yes.  
25 Q. And then you gave evidence?

131

1 I have already alluded to.  
2 THE CHAIRMAN: Ms Gollop, do you have any questions?  
3 Questions from MS GOLLOP  
4 MS GOLLOP: Just a few, Dr Jenkins. You've been asked  
5 questions about Dr Warde's report; were you aware before  
6 the inquest started that a decision had been made by the  
7 trust and/or DLS not to call Dr Warde to give evidence?  
8 A. No.  
9 MR STITT: Just for the record, I made it clear yesterday in  
10 my submissions that if a decision was taken in relation  
11 to such a matter, it will be taken by a client either  
12 accepting or rejecting legal advice given by the legal  
13 advisers.  
14 THE CHAIRMAN: Thank you.  
15 MS GOLLOP: Were you told when you wrote your report, dated  
16 30 January, that Dr Warde was not coming to the inquest?  
17 A. No.  
18 Q. As I understand it, doctors Warde and Sumner were  
19 paediatric anaesthetists and you were a consultant  
20 paediatrician. Which of those disciplines would be most  
21 relevant to the matters touching on Raychel Ferguson's  
22 death?  
23 A. Well, I believe that both had a contribution, but that  
24 in respect of the management and the issues that had  
25 arisen in the post-operative period, it was much more

130

1 A. Yes.  
2 Q. And did you attend any further part of the inquest?  
3 A. No. If I can just clarify, both Dr Sumner and I had  
4 arranged to give evidence on that day because we both  
5 had prior engagements on the subsequent days and the  
6 coroner had agreed to that.  
7 Q. In your 30 January report, you referred to two deaths.  
8 Did the coroner ask you to identify the other death?  
9 A. No.  
10 Q. Did anyone at the trust ask you to do so?  
11 A. No.  
12 MS GOLLOP: I don't have any more questions, sir.  
13 THE CHAIRMAN: Thank you very much.  
14 Doctor, let me ask you two slightly different areas  
15 of questioning, moving away from Raychel and moving  
16 forward in time. There has been something of a debate,  
17 partly raised by Dr Scott-Jupp, who gave evidence from  
18 England, about a development there in some but not all  
19 hospitals, which is that in hospitals which are perhaps  
20 similar to Altnagelvin, where there are children who are  
21 on the ward for medical reasons and a smaller number of  
22 children who are there for surgical reasons, that the  
23 lead is taken in their care by paediatricians, but with  
24 the support of surgeons where there are surgical  
25 children.

132

1 I think other witnesses have said, well, we're not  
2 very keen on that idea, and I think I'll hear soon from  
3 Dr McCord, who I suspect wasn't very keen on that idea.  
4 What's your view on that?  
5 A. Certainly at the time these events took place it was  
6 quite clear in Antrim Hospital that surgical children  
7 were under the care of the surgeons.  
8 THE CHAIRMAN: I understand that and Dr Scott-Jupp is saying  
9 that in his hospital, in Salisbury, the situation which  
10 now exists did not exist in 2001, but it came in maybe  
11 five or six years ago, which might be not far short of  
12 your retirement. But as a system, what do you see the  
13 strengths and weaknesses of that are?  
14 A. I think what did happen after these events was, first of  
15 all, there was much clearer guidance so that whoever was  
16 taking responsibility for caring for children in these  
17 circumstances had clear guidance on which to base their  
18 management and clear instructions as to the type of  
19 monitoring that should take place. Whether or not that  
20 was being done by the junior staff on the medical side  
21 or on the surgical side, at least they were working to  
22 a common guidance. There was also, in my experience,  
23 a much closer communication between the two teams, so  
24 that whereas in history it would have been unusual for  
25 the surgical team to seek the advice of the medical

133

1 you said you weren't aware of it, you would like to have  
2 been told about it, but the systems which are now in  
3 place were not in place then for letting us know.  
4 What better systems are now in place or were in  
5 place at the time of your retirement so that if the  
6 regional specialist hospital changed something quite  
7 significant in its practice it would let other hospitals  
8 know?  
9 A. Well, in the latter years of my practice I was  
10 concentrating entirely on neonatal care, so I can really  
11 reply to you best in that context, which was where a  
12 much more active communication group was established  
13 within the neonatal community across Northern Ireland,  
14 which met a regular basis and exchanged this type of  
15 information, but still, informally, if you like. So  
16 they weren't formal links with, for example, the  
17 Department of Health.  
18 There is now, certainly in process -- whether it is  
19 yet in place or not I'm unable to say -- a development  
20 of a managed clinical network, which would be a formal  
21 arrangement to ensure that communication does take place  
22 with all those centres who are providing particular  
23 types of care.  
24 THE CHAIRMAN: And then there's a bigger issue. Within  
25 Northern Ireland, where more people know each other

135

1 team, in recent years it has been much more common for  
2 the two teams to talk to each other and to jointly  
3 address issues that might arise in the day-to-day  
4 management.  
5 THE CHAIRMAN: Sorry, when you say that, are you talking  
6 about your experience in Antrim and experience beyond  
7 that? That's a general trend, is it?  
8 A. I can't say because I wasn't involved, but my impression  
9 was that that improved communication and improved  
10 clarity was certainly something that was widespread.  
11 Although the rate at which it was implemented, I think,  
12 has varied enormously, as has been demonstrated, for  
13 example, by some of the publications that the inquiry is  
14 aware of, going as far forward as 2006, 2008, and still  
15 demonstrating very high levels of, in some cases,  
16 inappropriate use of the No. 18 Solution.  
17 Whether or not that has in most recent years meant  
18 that the medical paediatricians take primary  
19 responsibility for the care of those surgical children,  
20 it was not the case up to my point of retirement, but  
21 I can't answer subsequently to that.  
22 THE CHAIRMAN: Okay. If I could ask you about one other  
23 issue. When you were asked, just after the break this  
24 morning, by Mr Stewart about the Royal  
25 Children's Hospital moving away from Solution No. 18,

134

1 there is a comparatively small medical and local  
2 population, it might be easier to get the word out if  
3 there are changes afoot, but we're also part of the UK  
4 Health Service. It seems it could become impossibly  
5 large to try to spread lessons around, but up to the  
6 point of your retirement was there a better system of  
7 learning significant lessons from developments  
8 elsewhere?  
9 A. Well, I think some systems had improved. I mean, part  
10 of my contribution was to publish articles in literature  
11 that I hope will be read by people in the relevant  
12 specialties. For example, at the end of 2002 when we  
13 sought to publish something in the Archives of Disease  
14 in Childhood, which would be read by all paediatricians,  
15 but in fact the journal didn't see this as a high enough  
16 interest topic, and they did not accept the article we  
17 submitted, but did subsequently publish a letter, albeit  
18 in 2004, so in the interim we published in the Ulster  
19 Medical Journal, which would have had a limited  
20 distribution. So the literature, I think, is one of the  
21 areas which can be taken to do this.  
22 The second thing, which I think and hope has been  
23 more effective, was the NPSA safety alert, and there's  
24 certainly in my experience, prior to my retirement,  
25 a much greater attention being paid to those types of

136

1 communications, which are generated centrally, but are  
2 then distributed through a formal network to all trusts.  
3 In the case of NPSA, of course, not necessarily  
4 involving Northern Ireland, but within the context of  
5 GB, which was, I think, where you asked me the question.  
6 THE CHAIRMAN: Yes. Okay, thank you very much for that.  
7 Thank you for coming today. Unless there's anything  
8 that you want to add to anything you have said, you're  
9 now free to leave.  
10 A. Could I just say something very briefly?  
11 THE CHAIRMAN: Yes.  
12 A. From the outset of my contribution to this area  
13 in September 2001, I sought to assist with the positive  
14 aspects to develop guidance, to try to prevent this  
15 happening again. However, I have become aware, not at  
16 least through the work of the inquiry, that in doing so  
17 I may have inadvertently and unintentionally caused hurt  
18 or distress to some. If that has been the case, then  
19 I am deeply sorry and I hope that they can accept my  
20 apology.  
21 THE CHAIRMAN: Thank you very much indeed, doctor.  
22 Thank you.  
23 (The witness withdrew)  
24 THE CHAIRMAN: Mr Stitt, was there a point that you wanted  
25 to make to me?

137

1 MR STITT: Order 25 was amended in 2009 to include -- I will  
2 call them, broadly speaking, medical negligence actions,  
3 and that was coming into effect on 7 September 2009.  
4 Before that, we had the, what I will call the old Order,  
5 the former Order 25, paragraph 1 of which -- it's short  
6 and I'll just read it if I may:  
7 "This Order applies to all actions for damages in  
8 respect of personal injury or death, except while  
9 liability remains an issue for actions grounded on an  
10 allegation of medical or surgical negligence."  
11 The logicity of that is that if in a medical --  
12 I'll call it for short a medical negligence case. If in  
13 a medical negligence case, liability is still an issue,  
14 clearly the liability evidence is going to come from  
15 a medical expert. If it was a factory accident and  
16 liability was in dispute, it is most unlikely that the  
17 medical evidence would come from a medical expert,  
18 probably an engineer or somebody else and there was no  
19 rule to the contrary that I am aware of.  
20 The actual practice was, in 2003, that in a medical  
21 negligence action, the first time that either side would  
22 probably be aware of the contents of a medical report  
23 dealing with liability as opposed to a quantum report  
24 would be when the plaintiff's expert went into the  
25 witness box. And the format would often be -- and I can

139

1 MR STITT: If I may, Mr Chairman. It's touching on the last  
2 witness and the three Jenkins reports. I did mention  
3 this to Mr Stewart. It's very brief, but it's simply  
4 this. You observed or you put to -- I think it was  
5 Dr Nesbitt -- last week, or it might have been this  
6 week -- I can't recall exactly where and I couldn't find  
7 the reference, but it was simply this.  
8 In relation to providing the third report and not  
9 providing the first two reports, the trust/DLS/trust  
10 legal team were not even acting in the manner which  
11 would be appropriate for a clinical negligence action  
12 in the High Court. You remember that, do you?  
13 THE CHAIRMAN: Yes.  
14 MR STITT: And I made no response as I had no response to  
15 make, and my colleague made a short response. I thought  
16 it important to just have a look and to refresh my  
17 memory because time can sometimes be abridged in one's  
18 memory, and this isn't the sort of thing which is often  
19 found in the textbook or in case law. So what I'm  
20 saying is my research, my best endeavours to try and  
21 assist you, sir, in putting this into perspective.  
22 The time that we're talking about is early 2003.  
23 Going back in time, you will be intimately familiar with  
24 Order 25.  
25 THE CHAIRMAN: Yes.

138

1 speak with some experience -- that the plaintiff's  
2 counsel would, after the swearing of the witness, have  
3 the witness introduce himself or herself, and then the  
4 question often was: my Lord, the witness has compiled  
5 a report; would it be helpful if that report was shared  
6 and could be read into the evidence?  
7 And the judge almost invariably agreed to that and  
8 time was not taken for all parties to read that report,  
9 and that was the first time that the defence would have  
10 seen the plaintiff's report and either at that stage or  
11 later in the hearing, the defence would make a similar  
12 application and often hand over its reports.  
13 There are cases when, in fact, reports were not  
14 handed over, but as the years progressed it became more  
15 common for that to be the case, but not before the  
16 morning of the hearing. That was the accepted practice  
17 in 2003.  
18 One has to fine-tune that to some degree to look  
19 at the question of whether or not, when that report was  
20 handed in, there was an obligation, a duty or  
21 a requirement on that counsel to hand in any previous  
22 report. And in this case, for instance, we have the  
23 report of November 2002, the second report, that's  
24 12 November 2002, the second report is 27 January 2003,  
25 and the final report is 30 January 2003.

140

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

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

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

141

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

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

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

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

25 THE CHAIRMAN: Well, we'll see.

143

1 MR STITT: I won't call it up then, but for the record it's  
2 022-010a-041. That's the second page of his first  
3 report. It says:

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

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

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

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

142

1 Mr Reid?

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

4 DR BRIAN McCORD (called)

5 Questions from MR REID

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

16 A. Thank you.

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

18 As the chairman's just said, you gave evidence on  
19 13 March 2013 in the clinical hearings before the  
20 inquiry. Since then, you have made two witness  
21 statements, and if I could just get you to adopt those  
22 witness statements. The first was WS032/3, and that was  
23 a collection of governance-based questions. Do you  
24 recall that statement that you made?

25 A. I cannot see it.

144

1 Q. It's not going to be called up, doctor. Your witness  
2 statement dated 15 July 2013, do you remember making  
3 that?  
4 A. Yes, I do.  
5 Q. And the fourth was WS032/4, which was your water-bottle  
6 example statement. Do you wish to adopt those two  
7 statements?  
8 A. That was in June.  
9 Q. Yes.  
10 A. Yes.  
11 Q. Thank you, doctor.  
12 I don't intend to go through your CV because  
13 Ms Anyadike-Danes did it on a past occasion, but is it  
14 correct to say that at the time of Raychel's admission  
15 you had been a doctor for 22 years and a consultant for  
16 12 years?  
17 A. That's correct.  
18 Q. Thank you. The inquiry's heard from Mr Gilliland, as  
19 regards surgery at Altnagelvin, and Dr Nesbitt as  
20 regards anaesthetics. To some extent, you are here as  
21 the paediatric representative of Altnagelvin in  
22 Raychel's case.  
23 A. Okay.  
24 Q. Can I ask you just about teaching and education,  
25 firstly? How, in general, would new teaching, new

145

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

147

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

146

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

148

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

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

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

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

21 A. It depends what the statement was.

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

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

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

149

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

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

15 Q. Let's bring up that statement I was referring to.

16 I have got a reference now. It's 011-014-107a, please.

17 I'll just give you a moment to read that, Dr McCord.

18 (Pause).

19 A. I don't recognise the signature.

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

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

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

150

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

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

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

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

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

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

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

24 A. Mm-hm.

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

151

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

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

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

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

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

152

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

153

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

155

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

154

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

156

1 point.  
2 MR REID: Let's just look at the involvement of surgeons  
3 in the paediatric ward, Ward 6. This was touched on  
4 somewhat during your previous evidence. If we call up  
5 pages 22 and 23 of your evidence on 13 March 2013,  
6 please.  
7 Ms Anyadike-Danes asked you:  
8 "Were you aware there was a bit of concern from the  
9 nurses [this is at line 10, page 22] that the surgeons  
10 perhaps just weren't as accessible as they might want  
11 them to be for their patients?"  
12 You answered:  
13 "I did get, you know, that impression, yes and you  
14 know, it was mentioned from time to time and it seemed  
15 to flare and then quieten, improve for a while and then  
16 it would come to the surface again. But it did seem to  
17 be an issue for the nursing staff."  
18 Would it be fair to say this was a source of tension  
19 between the nursing staff and the surgeons that kept  
20 bubbling up?  
21 A. Tension, again, I'm not sure ... I think an annoyance,  
22 an irritation might be a more appropriate term. Because  
23 things didn't generally get done, just maybe not as  
24 quickly as everybody would have liked them. I wasn't  
25 aware of any issue of patient safety and these were just

157

1 in those days, really, we were leading the care, I feel,  
2 in looking after children."  
3 Does that feeling of Sister Millar's reflect what  
4 the situation sometimes was in 2001 on Ward 6?  
5 A. I think I would have some sympathy towards that view.  
6 My own context earlier on was thinking of the paging  
7 system that doctors weren't -- surgical doctors weren't  
8 immediately available. In terms of check electrolytes,  
9 certainly all I can comment is on the fact that on the  
10 medical side we did them a lot more regularly. I don't  
11 know what structures in detail were available or advice  
12 was available from the surgical doctors to the nurses or  
13 whether ... Are they in part a prompt? I suppose one  
14 of the reasons why a child is in a paediatric ward is  
15 for nursing, is for paediatric nursing expertise. Does  
16 the day-to-day management, the electrolyte checks --  
17 is that part and parcel of that? It could be argued  
18 either way. Technically, it is a medical decision to  
19 do, but where nurses are there continuously, prompting  
20 for doctors who are a little forgetful, or surgical  
21 doctors who are forgetful and are not available ...  
22 Q. This is an issue between the surgeons and the nurses?  
23 A. It is, yes.  
24 Q. But it's happening on paediatric Ward 6?  
25 A. Yes.

159

1 giggles that people weren't available when you would  
2 like them to be or as soon as you would like them to be.  
3 Q. How often did that issue keep raising its head?  
4 A. It'd only be a guess, I'm sorry, I couldn't put any  
5 figure to that at all.  
6 Q. Was it a regular issue that --  
7 A. Not regularly, it was an intermittent phenomenon.  
8 Q. But it did come round more than twice?  
9 A. It did come round from time to time.  
10 Q. Because I think you might be aware of what Sister Millar  
11 has said on behalf of the nurses.  
12 A. Mm-hm.  
13 Q. If I can actually just drop page 23 for the moment and  
14 bring up the 1 March 2013, page 58, please. If we can  
15 start at line 7:  
16 "I said that I thought it was totally unfair that  
17 the nurses had such responsibility for the surgical  
18 children. I felt it was unfair. I felt that we had to  
19 be the lead all the time in looking after the surgical  
20 children. We are nurses, we're not doctors, and whilst  
21 we do our very best, I don't think we should be  
22 prompting doctors. We would now maybe, but 12 years  
23 ago ... Or I don't think we should be telling a doctor  
24 to do electrolytes. It's different now: we're more  
25 knowledgeable, we've had quite a bit of education. But

158

1 Q. What did you or the other consultant paediatricians do  
2 about that issue that was there?  
3 A. Again, it was a surgical in-house problem, but I think  
4 Sister Millar did mention it at one sisters' or  
5 consultant meeting, and we advised -- certainly I think  
6 I advised to speak to Mr Bateson, who would have been  
7 the surgical lead at that time, to take that issue  
8 through that way.  
9 Q. You said it was a surgeon's in-house issue and you said  
10 to Sister Millar, "Speak to Mr Bateson about it"?  
11 A. Yes.  
12 Q. Did you speak to Mr Bateson about it?  
13 A. I did not.  
14 Q. Did you give Mrs Millar or the nurses any support or  
15 encouragement to back them up?  
16 A. I'm just wondering what form -- I tried to be there, you  
17 know, sort of thing, with a friendly aspect. I didn't  
18 do any formal thing in terms of that particular request  
19 about Mr Bateson. I suppose, had Sister Millar come  
20 back to me and said, "I have approached Mr Bateson,  
21 I didn't get any satisfaction", I hope I would have had  
22 the sense to say, "Look, gather information", the way  
23 Sister McKenna had done about the staffing issue, gather  
24 actual examples and go back to Mr Bateson at that stage.  
25 It would be unusual, because of the different

160



1        directorate, for one directorate to point out issues in  
2        another, unless there were specific details about a  
3        patient-harm issue or something.  
4        Q. Doctor, you say it would be unusual for one directorate  
5        to involve themselves in another directorate --  
6        A. Yes.  
7        Q. -- and you have said it's an in-house issue --  
8        A. Yes.  
9        Q. -- but these are patients that are on your ward; isn't  
10       that right?  
11       A. It doesn't belong to me, it's the hospital ward --  
12       Q. Yes, but --  
13       A. -- where I happen to practise as well.  
14       Q. It's a paediatric ward.  
15       A. It's a ward where children under 14 tend to be nursed,  
16       both surgical and medical.  
17       Q. But ostensibly it's the paediatric ward and ostensibly  
18       the paediatricians are in charge of the paediatric ward?  
19       A. Not at all. Not at all.  
20       THE CHAIRMAN: That's the debate, Mr Reid.  
21       A. For paediatric medical children we look after  
22       a different set of conditions. I have no experience in  
23       post-operative child management. I have never had  
24       experience -- I have had no training in it, and that's  
25       been part of the issue, you know.

161

1        page 44:  
2        "The majority of patients on any children's ward in  
3        a hospital like this, where there's only one children's  
4        ward, will be medical. The paediatric staff will be  
5        there virtually the whole day. The nurses will know  
6        them as well. The surgical teams will be much less  
7        involved."  
8        And later on at line 12:  
9        "Surgical doctors can sometimes be difficult to get  
10       hold off for very good reasons because they may be in  
11       theatre, but even if they're not in theatre they'll be  
12       tied up with adults in a different part of the hospital,  
13       which may be a long way away and they may be extremely  
14       busy dealing with very sick adults and the children's  
15       ward is often quite a long way down their list of  
16       priorities."  
17       Is that a reality that you also experienced as  
18       a consultant paediatrician?  
19       A. Well, paediatricians are often off the ward too because  
20       they have clinics, they have neonatal intensive care,  
21       they have day care units, they have A&E resuscitation  
22       calls. So it's not 100 per cent strictly true that  
23       there's a paediatric presence there 24/7. We are there  
24       more of the time because our throughput is much higher.  
25       We would see many, many more patients, short stay in,

163

1        MR REID: All I'm saying is you see there's this issue  
2        there. Do you not think that it's incumbent on you or  
3        the other consultant paediatricians to do something?  
4        A. It's incumbent upon the practitioner themselves if they  
5        see paediatric -- to see paediatric patients that they  
6        have to be responsible. And children are not  
7        mini-adults; it does require a certain degree of  
8        training and expertise. We provide advice if requested,  
9        but we do not take responsibility. We can't. We do not  
10       have the resources and we do not have the training.  
11       Q. Can I ask you about another aspect of that, which is  
12       of course how the paediatricians step in if the surgeons  
13       are unavailable. To what extent was that an issue or  
14       a problem for the paediatricians as opposed to the  
15       nurses?  
16       A. I think it was based on goodwill, you know, it was done  
17       with a "Oh, let's do it and get on with it", that kind  
18       of thing. So it was really the practical things,  
19       re-erecting cannulas, writing up IV fluids, what  
20       Dr Butler did, that sort of level.  
21       Q. Dr Scott-Jupp has commented on this. If I can bring it  
22       up, it's 20 March 2013. Pages 44 and 45, please.  
23       Dr Scott-Jupp is the inquiry's expert consultant  
24       paediatrician, and like you, he works in a district  
25       general hospital. If we look at the very last line on

162

1        out, you know, that kind of way, than what the surgeons  
2        would. By virtue of that then we are around and do get  
3        to know the nurses better. But again, the same applies,  
4        on goodwill we will help if asked, but not as a matter  
5        of routine. But we have stretches on our resources too.  
6        Q. As you know, obviously one of the issues in Raychel's  
7        case was the availability of the surgical staff as  
8        opposed -- and because of the fact that Raychel wasn't  
9        seen by any senior doctor throughout the main day --  
10       A. Yes.  
11       Q. -- after she'd been seen in the morning and it was only  
12       junior doctors who were in to see her. What has been  
13       done since 2001, doctor, in order to solve or at least  
14       try and address the issue of the responsibility for  
15       surgical patients on Ward 6?  
16       A. I don't know in detail because, again, we run side by  
17       side rather than concurrent. But a formal ward round  
18       done, post-take ward round, AM ward round is done.  
19       There have been guidelines issued about the electrolyte  
20       checks, and I think to date I have not heard any  
21       significant issues from the nursing staff in recent  
22       times, but things have changed for the better in terms  
23       of the regularity of assessment and regularity of review  
24       of intravenous fluids, et cetera, especially the  
25       intravenous fluids.

164

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

165

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

167

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

166

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

168

1 is mainly directed towards surgeons. Would you have  
2 expected these sort of issues in regards to  
3 responsibility to have been addressed prior to 2001?  
4 A. We weren't aware there was a problem until 2001, and  
5 again, if it ain't broke, don't fix it. Everybody --  
6 nobody had any indication that there was any issue with  
7 No. 18 or the surgeons -- as I say, there was irritation  
8 but not aware of anybody coming to harm.

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

15 A. It opened up a whole can of worms and I think up until  
16 2001 we were probably just fortunate. You know, luck  
17 was on our side that nobody had come to harm by it.

18 THE CHAIRMAN: Thank you.

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

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

24 (3.27 pm)

25 (A short break)

169

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

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

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

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

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

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

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

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

171

1 (3.37 pm)

2 MR REID: Dr McCord, if I can refer now to the critical  
3 incident meeting of 12 June 2001. You touched on this  
4 briefly in your evidence with Ms Anyadike-Danes  
5 in March. Can I just ask you, as a preliminary  
6 question, how much can you recall of the meeting itself?  
7 A. It is fading with time. When I looked at my rota,  
8 relatively recently, I had been working nine consecutive  
9 days with four overnight on call periods during those  
10 days, so I must have been pretty tired by the end of  
11 that Tuesday afternoon. That may be in part responsible  
12 for the memory.

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

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

170

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

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

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

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

18 Q. You said --

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

22 A. Yes.

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

172

1 say, "This is what you need to do differently or better  
2 in the future", it's easier to do that if you have  
3 the --  
4 A. I rescind that comment. Chairman, that does make sense.  
5 THE CHAIRMAN: The fact that they are there doesn't mean  
6 they have to be criticised, but they can piece together  
7 the story.  
8 A. Thank you, yes. I concur with that, apologies.  
9 THE CHAIRMAN: Not at all.  
10 MR REID: In answer to Ms Anyadike-Danes in March, you  
11 stated -- and this is at page 144 of 13 March, line 4 --  
12 that you thought there was a general acceptance that  
13 things could have been done better.  
14 A. Yes.  
15 Q. What did you mean by that?  
16 A. That we'd failed Raychel and if we had dotted all the  
17 Is, crossed all the Ts, that there might have been  
18 a better outcome.  
19 Q. And at that meeting on 12 June, what did you identify as  
20 the major failings?  
21 A. "Failings" is probably not the right word, but there  
22 were problems. The electrolytes not being checked.  
23 Timing wise, most commonly they're done first thing in  
24 the morning, on the ward round. Would that have  
25 predicted it? A possibility it might not. It probably

173

1 A. I cannot remember in detail. I'm unsure whether there  
2 was discussion because, as it turns out, as you know,  
3 there is a disparity between the nurses' view and mum  
4 and dad's view. I'm not sure whether that was highly  
5 discussed at that meeting. I cannot remember. And  
6 being a nursing issue, it may have gone over my head.  
7 I didn't make a big conscious note of it. What I did  
8 take away from it, from the nursing point of view, that  
9 you've heard many, many times, is that they didn't  
10 appreciate a significant concern -- it didn't generate  
11 a significant concern with them, the degree of vomiting  
12 that there was.  
13 THE CHAIRMAN: I think more fundamentally, they thought that  
14 if Raychel was on Solution No. 18 she was going to be  
15 okay. So they didn't correlate the vomiting to the  
16 continued infusion of Solution No. 18, nor did they  
17 connect either of those to the fact that she should have  
18 been up and about, as the day went on, and when she  
19 wasn't up and about, instead of thinking it was  
20 a vomiting problem, they didn't also then think "Well,  
21 could it be more than a vomiting problem? What's the  
22 root of the vomiting problem?"  
23 A. Yes.  
24 THE CHAIRMAN: It's easy for me to --  
25 A. Maybe I went blindly into it in the sense that

175

1 would be more meaningful in early evening, mid-evening  
2 type electrolyte, where there might have been  
3 opportunities because there had been medical contact on  
4 the basis of the nurses having concerns. That would  
5 have been probably an ideal time to have had an  
6 electrolyte check, but it wasn't.  
7 Q. You said that things could have been done better. Was  
8 it accepted that in the same way that errors had been  
9 made, if I can draw a distinction between those two  
10 things --  
11 A. I don't understand the ...  
12 Q. Things were okay but they could have been done better,  
13 is one scenario. The other is that errors were made as  
14 in something wasn't done properly or there was a mistake  
15 made.  
16 A. Right. I don't think there was that air to it. I don't  
17 think it was critical, you know, of what an individual  
18 did or did not do. It was sort of a group admission, if  
19 you like, you know: these weren't done as such, but no  
20 particular individual faulted.  
21 Q. There was no attribution of blame?  
22 A. Not that I picked up on, no.  
23 Q. Can you recall what the discussion was as regards  
24 Raychel's vomiting at the critical incident meeting on  
25 12 June?

174

1 I respected the experience of the nurses involved. The  
2 cumulative experience of the nursing staff that were  
3 seeing Raychel from time to time was phenomenal. I'd  
4 never had any concerns or issues about the nursing  
5 practice in my contact with them. And there's one sure  
6 thing that's probably saved many a paediatrician along  
7 the way is that a good nurse will alert you, no matter  
8 what the blood tests or the observations are, a good  
9 nurse knows a sick child. I have often gone on that  
10 premise, that nurses would alert me.  
11 THE CHAIRMAN: I think, unfortunately, doctor, it's almost  
12 exactly the problem here that the nurses didn't spot the  
13 sick child.  
14 A. Exactly, that's where the system failed.  
15 MR REID: Let's look at your reaction to what happened at  
16 the meeting. If we bring up the action points following  
17 the meeting. 022-108-337, please. There's the action  
18 points there, and you will see at point 5 your action  
19 point is:  
20 "A chart for IV fluid infusion rates to be displayed  
21 on Ward 6 to guide junior medical staff."  
22 A. Mm-hm.  
23 Q. And I believe that you made a chart and supplied that  
24 somewhere between July and September of that year.  
25 A. Yes. There should be a copy.

176

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

177

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

179

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

178

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

180

1 But no, there was no resistance. I don't think it  
2 was ever countenanced by us to use Hartmann's; it  
3 wouldn't be a commonly used paediatric solution in the  
4 medical sense.  
5 Q. If we move to the meeting with the parents on  
6 3 September 2001 now. Mrs Ferguson gave her evidence on  
7 26 March of this year. If I can bring it up on screen,  
8 it's 26 March, page 177, lines 11 to 19.  
9 Would it be correct to say, Dr McCord, that  
10 following your giving of evidence that you went and  
11 spoke to Mrs Ferguson; is that correct?  
12 A. I can't remember the incidence of that now.  
13 THE CHAIRMAN: It was after you gave evidence here in March.  
14 A. Oh yes.  
15 THE CHAIRMAN: I think we understood that you had then  
16 spoken to Mr and Mrs Ferguson.  
17 A. Yes. I thought you were referring to September 2001.  
18 I do beg your pardon.  
19 MR REID: In March of this year after you gave your  
20 evidence, you went and spoke to Mr and Mrs Ferguson; is  
21 that right?  
22 A. Yes, we spoke outside.  
23 Q. Mrs Ferguson in her evidence said at line 11:  
24 "By September, they all knew full well [she's  
25 speaking here about the September meeting] what had

181

1 sure what it set out to do in terms of -- there was no  
2 agenda, no plan, no prior thought as to who was going to  
3 speak. The setting wasn't good, we arranged ourselves,  
4 you know, in a cold, blue-coloured room, it was an  
5 echoey Portakabin.  
6 Only a few of the relevant clinicians were there,  
7 myself, Dr Nesbitt, you know, who had been there towards  
8 the end of Raychel's hospital episode. There was no  
9 surgeon. It would have been nice to have had  
10 a radiologist there. There were nursing staff there and  
11 from the trust point of view, Mrs Burnside, senior  
12 member, was there. But even with that, I think it was  
13 still incomplete. I'm not sure what it started out as,  
14 but at the end of it, as it progressed, it really  
15 slipped away into a question-and-answer session. And at  
16 the end of it, there was no structure to it, no order,  
17 no sense that we'd achieved anything at the end of it  
18 that was going to help.  
19 My abiding memory is speaking to mum briefly  
20 afterwards, because she wore a little lapel badge with  
21 Raychel's face, and the most striking thing was I spoke  
22 to mum -- and she reminded me of it recently -- despite  
23 the events of June, I couldn't remember Raychel's face.  
24 I could see the body, I could see Raychel lying there,  
25 but I couldn't see her face and that has still haunted

183

1 happened and I make no apology for it that I still feel  
2 so angry reading the notes of the September meeting.  
3 Dr McCord has told us personally that that meeting was  
4 a disaster."  
5 Doctor, can I ask: is that what you said to  
6 Mrs Ferguson following your giving of evidence in March?  
7 A. It is a flippant comment that I have been known to use,  
8 you know. It was perhaps inappropriate in the setting.  
9 THE CHAIRMAN: Doctor, don't misunderstand. In fact,  
10 I think Mr and Mrs Ferguson welcomed that. They don't  
11 regard your comment as flippant. In fact, if  
12 I understand correctly, they're welcoming the fact that  
13 you have acknowledged that however you thought the  
14 meeting went at the time, that on reading more about it  
15 and reading their understanding and their recollection  
16 of events, that whatever the meeting was supposed to  
17 achieve to help the Fergusons, it didn't go anywhere  
18 near it.  
19 A. Just in terms of the word "disaster", it was not a good  
20 meeting.  
21 THE CHAIRMAN: I don't want to trawl through all this, but  
22 do I understand it that that's not the impression that  
23 you had when you left the meeting in September 2001,  
24 or --  
25 A. I was unhappy. Unhappy. It was a meeting -- I'm not

182

1 me to this day, that thing, you know. So it did have an  
2 impact, it wasn't a good meeting, I didn't enjoy it. It  
3 could have been done better, I think.  
4 THE CHAIRMAN: And had you come subsequently to realise from  
5 the perspective of the Fergusons just how hugely  
6 unsatisfactory it was for them?  
7 A. Oh, absolutely.  
8 THE CHAIRMAN: Do I take it from what you're saying that you  
9 are not surprised by their reading of the meeting  
10 because you yourself weren't happy with it?  
11 A. Yes. I have no direct experience of one case where it's  
12 been spread across many specialties. That hampered us.  
13 I'm much more used to dealing in an ordered, structured  
14 way, after a neonatal death, you know, where you would  
15 have a post-mortem there. So I'm not sure if mum and  
16 dad were totally aware of what this meeting was going to  
17 avail them of, that kind of thing, and it kind of got  
18 away from us, if you like, and didn't do anybody any  
19 good, I thought. But again, that's a personal opinion.  
20 THE CHAIRMAN: Okay.  
21 MR REID: If I could ask you as a final issue, doctor, just  
22 about the inquest. The coroner's inquest comes round  
23 in February 2003. You give a statement to the trust,  
24 dated 12 June 2001, just a week or two after Raychel's  
25 death, a week after Raychel's death. And that is the

184

1 statement that you effectively adopt at the inquest;  
2 is that right?  
3 A. Yes, it's less than a week. It was actually the weekend  
4 of the happening. It was typed up on the 12th by my  
5 secretary, but I'd worked with a previous colleague some  
6 years ago with North American experience and he always  
7 reminded me, after any unexpected death, get something  
8 down on paper, it'll stand you in good stead and make it  
9 as contemporaneous as you can. There didn't seem any  
10 point -- I didn't think I had any more to add for the  
11 coroner's statement when it did come round.  
12 Q. Looking back at that coroner's inquest, are you  
13 satisfied that you said everything that you think you  
14 should have said to the coroner?  
15 A. My understanding of the coroner's inquest, it would  
16 be -- it was to be an outline plan of my clinical  
17 involvement with Raychel, which I think I did in fairly  
18 chronological order.  
19 Q. Because if we bring up your deposition -- it's  
20 012-036-170 and 171, firstly, please. Do you recognise  
21 that as the main deposition that you gave?  
22 A. Yes.  
23 Q. We'll look in a moment just at the other evidence that  
24 you gave in answer to questions.  
25 Would you accept, Dr McCord, that that's generally

185

1 reflection of his perception at the time. He agreed it  
2 was concerning, now that he had the full picture in  
3 retrospect, but said he relied on those below him,  
4 including the nurses, to bring it to his attention.  
5 He had no access to medical notes. He concurred that  
6 'some vomiting' was not appropriate, but only in  
7 hindsight."  
8 Can I ask you about just what you meant that you  
9 found it concerning just in retrospect as opposed to  
10 previously at the time?  
11 A. At the time of my writing of my report --  
12 Q. Yes.  
13 A. -- which was 12 June, I did not inspect the fluid  
14 balance sheets. This was written, not freehand, but  
15 freely without access to clinical notes. Verbally, it  
16 had had some mention from the nursing staff about  
17 vomiting. I think "some vomiting" in retrospect was an  
18 inappropriate term. I should either have said -- it  
19 probably would have been better to say vomiting without  
20 qualifying it. "Some" implies small, I would have  
21 thought, and just left it as "vomiting".  
22 Q. Was it the case that once you saw the medical notes, you  
23 realised "some vomiting" was an inappropriate term?  
24 A. It was an inappropriate term, you know, or the  
25 discussions thereafter.

187

1 a quick history, as you saw it, of Raychel's medical  
2 history during her care at Altnagelvin?  
3 A. It was a brief précis, but the detail would have been  
4 mainly on that two-hour, two to three-hour period where  
5 I would have had clinical contact with Raychel, which  
6 I thought was what the coroner required of me.  
7 Q. Do you consider that any of the elements that you  
8 discussed at the clinical incident meeting of 12 June  
9 should have been brought out at the coroner's inquest as  
10 well?  
11 A. At the time, no. I have learned substantially with the  
12 reading and questioning that that is an issue that would  
13 make me probably change my practice if I was involved in  
14 a coroner's case tomorrow of a similar type and nature.  
15 But at the time, I had no inkling to go beyond what  
16 I did there, and then answer the questions that were  
17 offered to me appropriately, or as best as I could.  
18 Q. If I can bring up 098-034-108, please, and 109. This is  
19 counsel's note of your evidence, Dr McCord. It started  
20 on the previous page, 107, but if we look at the last  
21 paragraph on the left-hand side:  
22 "Mr Foster began by inviting the doctor [Mr Foster  
23 was the counsel for the Ferguson family] to reconsider  
24 his description of some vomiting in paragraph 2 of his  
25 deposition. He declined, saying it was a fair

186

1 Q. Were you aware -- and we had Dr Jenkins giving evidence  
2 earlier -- of Dr Jenkins' report?  
3 A. Not in detail, only recently in terms of the content.  
4 I was aware that there were reports around, you know,  
5 and Dr Jenkins had been asked.  
6 Q. Let me be more clear. Were you aware at the time of the  
7 inquest that Dr Jenkins had produced a report for the  
8 trust?  
9 A. Yes, indeed.  
10 Q. Had you seen a copy of that report?  
11 A. No.  
12 Q. You simply knew that he'd produced a report. And then  
13 did you see that report then at the inquest?  
14 A. I'm not sure whether it was at the inquest or  
15 afterwards.  
16 Q. Did you see, other than the report from the inquest, any  
17 other versions of Dr Jenkins' report?  
18 A. No.  
19 Q. Were you aware of a report from Dr Warde?  
20 A. I heard the name mentioned with some rumouring that  
21 there was a report by an anaesthetist, which I presume  
22 is Dr Warde, and that it had offered some slight  
23 criticism of my junior colleague, Dr Trainor. That was  
24 the context of the rumour. There seems to have been  
25 some veracity in it, you know, when I subsequently did

188

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

189

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

191

1 the moment and continuing, and have been for some time  
2 now. We can never be 100 per cent safe. Always be  
3 prepared to expect the unexpected because that's the way  
4 it'll creep up and bite you. Auditing. But again, you  
5 know, we have to keep doing it, keep doing it and keep  
6 doing it. But I can't think of any single thing that's  
7 going to reassure the public by my doing it or other  
8 medical staff doing it. Just be on your guard.  
9 MR REID: Nothing further, Mr Chairman.  
10 THE CHAIRMAN: Any questions from the floor?  
11 MR QUINN: I have a question, sir.  
12 Questions from MR QUINN  
13 MR QUINN: You said that you only became aware of Dr Warde's  
14 report because it contained some rumour that may affect  
15 a junior colleague, who you thought was Dr Trainor.  
16 A. Mm-hm.  
17 Q. Can you tell us when you first became aware of  
18 Dr Warde's report?  
19 A. That would have been around the inquest time, around the  
20 coroner's inquest time.  
21 Q. Can you recall how that came to your notice, how that  
22 information came to you?  
23 A. No, I have no idea. It was a rumour I heard. I'm sorry.  
24 Q. I wonder could we have up WS032/3, page 10, please. In  
25 question 28 you have been asked about Dr Warde and

190

1 are that there are two absolutes: Raychel was admitted  
2 and Raychel died. Between those two points there are  
3 many if onlys, buts and presumptions and otherwise.  
4 Nothing can bring Raychel back. However, I think  
5 a fitting tribute to her memory would be that since  
6 Raychel's death, things have changed, that has  
7 precipitated a whole lot of changes and I would be  
8 hopeful that this will be a fitting tribute to her  
9 memory, knowing that others have gone forward and are  
10 safer than they would have been before 2001. Thank you.  
11 THE CHAIRMAN: Thank you very much, doctor.  
12 Tomorrow morning at 10 o'clock with Dr Crean.  
13 Thank you.  
14 (4.10 pm)  
15 (The hearing adjourned until 10.00 am the following day)  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

192



I N D E X

1  
2  
3 Timetable discussion .....1  
4 DR JOHN JENKINS (called) .....3  
5     Questions from MR STEWART .....3  
6     Questions from MS GOLLOP .....130  
7 DR BRIAN McCORD (called) .....144  
8     Questions from MR REID .....144  
9     Questions from MR QUINN .....190  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25