1 Tuesday, 28 May 2013
2 (10.30 am)
3 (Delay in proceedings)
4 (10.39 am)
5 THE CHAIRMAN: Good morning, everyone. Welcome back for the
6 start of the next segment of the inquiry, which for the
7 next number of weeks will be looking at the aftermath of
8 the death of Lucy Crawford who was initially treated
9 in the Erne Hospital in the then Sperrin Lakeland Trust
10 and was transferred to the Royal.
11 What will happen today is Ms Anyadike-Danes will
12 give a summary opening of the long written opening which
13 was circulated to everyone last week. After she has
14 finished that, we will deal with some outstanding issues
15 before the evidence starts tomorrow morning.
16 Ms Anyadike-Danes?
17 Opening by Ms ANYADIKE-DANES
18 MS ANYADIKE-DANES: Thank you very much, Mr Chairman. Good
19 morning, everyone.
20 As you will be aware, those of you who were involved
21 in the Raychel Ferguson case, which immediately preceded
22 this, we heard the clinical issues in that case, and
23 this section, as the chairman has announced, is devoted
24 to the aftermath of Lucy Crawford. That really,
25 Mr Chairman, is to assist you in determining to what

1 extent there was a failure to learn appropriate lessons
2 from Lucy's death and whether any such failure had
3 important consequences for how Raychel was subsequently
4 treated.
5 There will be further hearings concerning the
6 particular management and governance issues in
7 Raychel Ferguson's case and there will be a separate
8 opening dealing with that, but this is the Lucy
9 aftermath.
10 Lucy was born on 5 November 1998 and she died on
11 14 April 2000 at the Royal Belfast Hospital for Sick
12 Children, the Children's Hospital, having been
13 transferred there after treatment at the Erne Hospital
14 in Enniskillen. Therefore, she died some 14 months
15 before Raychel was admitted into the Altnagelvin Area
16 Hospital, and her death and the response to it formed
17 an important part of the UTV Live Insight documentary,
18 "When Hospitals Kill". At least one showing of it was
19 on 21 October 2004 and that was in turn the impetus
20 really for this inquiry.
21 But there were some changes and it's right that I go
22 through them now because it has an impact on the work
23 that we have done and the way that this section will be
24 conducted. The inquiry had revised terms of reference
25 and that's what we really need to pay attention to.

1 Lucy's name was originally included in the terms of
2 reference which were published on 1 November 2004 by the
3 then minister with responsibility for the Department of
4 Health and Social Services and Public Safety. And then,
5 on 26 May 2008, Lucy's parents asked, for family
6 reasons, that Lucy's death be removed from the work of
7 the inquiry. On 30 May 2008, there was a public hearing
8 at which, Mr Chairman, you made a public announcement
9 that the circumstances surrounding the death of
10 Lucy Crawford would no longer be considered by the
11 inquiry and thus an investigation would not be carried
12 out by the inquiry into the care and treatment she
13 received. The then health minister, Mr McGimpsey,
14 revised the original terms of reference. He did that on
15 17 November 2008 and he excluded Lucy's name entirely.
16 Since I'm talking about the revised terms of
17 reference, we can pull that up at 303-034-460. There
18 you see them. The only named children are Adam Strain
19 and Raychel Ferguson. But you can see at (ii):
20 "The actions of the statutory authorities, other
21 organisations and responsible individuals concerned
22 in the procedures, investigations and events which
23 followed the deaths of Adam Strain and
24 Raychel Ferguson."
25 The interpretation of those revised terms of

1 reference was a matter that the minister left to you,
2 Mr Chairman. He expressed himself as mindful of the
3 independence of the inquiry and the fact that this
4 investigation may extend to officials past and present
5 of the department.
6 So Mr Chairman, you had to consider in the light
7 of -- because you invited them -- submissions and
8 comments from Lucy's parents and the representatives and
9 the interested parties as to how those revised terms of
10 reference should be interpreted in relation to Lucy's
11 case.
12 Although it was clear that we weren't going to look
13 at the care and treatment which she received, that
14 didn't mean that the issues raised by her death weren't
15 of interest to the inquiry. The initial failure to
16 recognise that hyponatraemia was involved in her death
17 and to disseminate that to the wider medical community
18 in Northern Ireland was viewed by the inquiry as being
19 of potential significance for the case of
20 Raychel Ferguson, who, as I said, had died some 14
21 months later, and more to the point, in a hospital which
22 is covered by the same board as the Erne Hospital. So
23 failure to learn lessons from what happened to Lucy was
24 considered to be an essential part of the inquiry's
25 investigation into what happened to Raychel.

1 And so, Mr Chairman, you issued a paper to the
2 interested parties on 10 June 2009 and in that paper you
3 set out two alternatives. One was that the deletion of
4 any reference to Lucy in the inquiry meant that we
5 simply wouldn't look at anything that happened in the
6 Erne Hospital or in the then Sperrin Lakeland Trust and
7 that would all just be absolutely excluded and
8 effectively her name would just never be mentioned.
9 Alternatively, we could look at what happened after her
10 death for the purposes of seeing whether that has any
11 impact or could have had any impact at all on the
12 treatment that Raychel subsequently received. And
13 ultimately, Mr Chairman, it was that latter version that
14 you took. One sees it in a decision that you issued,
15 you sent a letter to all the interested parties --
16 I pull one up as a specimen, 303-037-466.
17 So if we see it in the third paragraph:
18 "Having considered everybody's views, my decision
19 is that I shall take the options set out at paragraph
20 7(b) of the June 2009 paper. This means that there will
21 be an investigation into the events which followed the
22 death of Lucy Crawford, such as the failure to identify
23 the correct cause of death and the alleged
24 Sperrin Lakeland cover-up because they contributed,
25 arguably, to the death of Raychel Ferguson in

1 Altnagelvin."
2 So that was the interpretation. And so one reads
3 into the revised terms of reference that part of the
4 investigation which would address the aftermath, as
5 I call it, of Lucy's death.
6 Mr Chairman, that's been our task. That is how the
7 investigation has proceeded to date. It is worth
8 saying, because Lucy's parents didn't want her death to
9 be investigated, that we have tried to be sensitive to
10 that as we have proceeded with the investigation. They
11 are aware of what we are doing, but nonetheless we
12 recognise that for their own very personal reasons they
13 would have preferred there to be no investigation into
14 the issues relating to her death.
15 Then, Mr Chairman, if I outline a little bit how
16 we have conducted our work. It follows a very familiar
17 pattern to those who have been involved in cases prior
18 to this. One of our first tasks was to produce a list
19 of persons so that you can all see who is involved. And
20 really, the purpose of these schedules that we produce
21 is to try and synthesise quite a lot of information and
22 as an aid, not just to ourselves working through the
23 investigation, but to all of you as well, and this case
24 is one that is particularly voluminous in the papers in
25 order to address it. As I go through the opening you'll

1 begin to see why.
2 If I show you that list of persons for those who
3 haven't seen one before just to help you. 325-002-001.
4 There it is. If we can just get that all onto the one
5 page. I can tell you the format of it. You can see it.
6 It goes through the different institutions and, in this
7 case, we've started with the Erne. We then do move on,
8 for example at 325-002-004, that's the Children's
9 Hospital there. We also deal with the coroner's office,
10 the review by Sperrin Lakeland Trust, the Western Board,
11 the review carried out by the Royal College, and then
12 some others who don't fall readily into any particular
13 category.
14 The format through all those categories is the same;
15 we have the name, their position as it was at Lucy's
16 admission. We have the role and then all the statements
17 that have been provided by them. So far as we can at
18 this stage, we have indicated those where we are likely
19 only to be relying on their statements and not proposing
20 to call them as a witness. So that, I hope, will
21 orientate you. You will, of course, see that they are
22 given their grades and, as a sort of companion piece to
23 this, is two documents that we produced right at the
24 outset. One is a nomenclature and grading of doctors
25 and the other is a nomenclature and grading of nurses.

1 The nursing one is perhaps less significant for Lucy's
2 case, but the doctors might be. If we pull it up very
3 quickly, I can show you what I mean. 303-003-048.
4 There you are.
5 So, for example, Dr Malik in the Erne was an SHO.
6 So that will tell you what that means. Then we have
7 Dr Stewart at the Children's Hospital, she was
8 a registrar. If we go over the page to 049, you'll see
9 staff grades and consultants. And those are the grades
10 that are primarily involved with the clinicians in
11 Lucy's case.
12 There are some witnesses that are just not available
13 to us. Principal among those perhaps is
14 Dr Denis O'Hara. He performed the hospital autopsy on
15 Lucy and he is deceased. So we have paid particular
16 attention to the reports and correspondence that he
17 issued because that is essentially all that we have.
18 Then there's Dr Malik. He was the SHO, who together
19 with Dr O'Donohoe, treated Lucy at the Erne. He's now
20 in Pakistan, an assistant professor there, and a
21 consultant in neonatology. He has provided a witness
22 statement for us, but we haven't been able to get any
23 further details from him. If we do, of course, we will
24 be circulating them.
25 Those are the personalities, if I can put it that

1 way. We've also produced chronologies of events. We do
2 that for all cases, but in this particular case it is
3 perhaps more significant because there's so much going
4 on, both in terms of what happened clinically and also
5 from a governance point of view, and there are at least
6 three different sites that are relevant.
7 So the chronology for her clinical matters is at
8 325-003-001. If we go to the next page, I can take you
9 through some of the important elements of this, so 002.
10 There you see at 19.20, that is Lucy admitted to the
11 Erne Hospital. And then, 19.30, that's the first record
12 of observations being made, and in particular something
13 that you will see reference to or hear reference to,
14 in the middle band there you see:
15 "Capillary refill greater than 2 seconds."
16 There will be evidence about the significance of
17 that in terms of her likely level of dehydration.
18 There you see that there is an intent to commence
19 IV fluids, unsuccessful there. And then if we go down
20 to 20.50, you can see that from the bloods that have
21 been taken, her sodium reading, which was back then at
22 137, you see that just there in the middle, and so that
23 was considered to be her serum sodium level as she was
24 admitted, and that is a significant measurement as well.
25 If we go over the page to 003, there are a number of

1 other observations. One just sees briefly that she
2 appeared to have protein in her urine. You see that at
3 2100 hours. That's something that has been identified
4 for other children. It may be that she didn't when she
5 was subsequently tested. The precise implications of
6 that we don't know because it was never followed up, so
7 far as we're aware. But you see though at 22.30, so
8 either 10.30 or 11 o'clock, Dr O'Donohoe is on the scene
9 and has achieved a cannulation and her IV fluids
10 commenced. This is a very important observation that is
11 recorded here. There's an issue about its accuracy
12 insofar as Dr O'Donohoe is concerned, but what is
13 recorded is 100 ml per hour of 4 per cent dextrose in
14 0.18 per cent saline, commonly known as Solution No. 18.
15 That's when it gets started some three hours or so after
16 she's admitted.
17 If we go over the page to 004, one sees at 2.55
18 in the morning, that is when Lucy has what was
19 subsequently considered to be a seizure, and she doesn't
20 ever really recover from that collapse. You can see
21 just down there at the bottom, 3 o'clock in the morning,
22 IV fluids changed to normal saline, allow to run freely.
23 That's another significant part of her treatment. And
24 then as you see it, going over the page to 005, 500 ml
25 of normal saline was recorded as having been

1 administered. This is an area where there's a complete
2 lack of clarity as to exactly when that got started, but
3 I'll say a little more about that later on. What I'm
4 really addressing here is what was recorded. Any number
5 of the witnesses involved have given evidence as to what
6 was the case, what that means, but this is what's on the
7 face of the notes.
8 And then we see, at 3.30 in the morning, that's when
9 Lucy's pupils are first noted by Dr O'Donohoe as being
10 dilated and unresponsive and she never comes back from
11 that really. Over the page, 006, this is the
12 significant measure, 4.26, the results come back from
13 bloods that were taken when Dr O'Donohoe attended, which
14 was roughly 3.30 in the morning, and you can see there
15 in the middle, sodium 127. So when her blood serum
16 levels were back, the first time they were 137, here
17 they are 127 a few hours later on. And the purpose of
18 this chronology is really just to see, on the face of
19 the medical records, what actually has been administered
20 or provided to Lucy over that period between when her
21 serum sodium level was 137 and when it was recorded as
22 being 127. And that is an issue which we will be taking
23 forward.
24 Then you see at 5 o'clock, 30 ml of normal saline
25 and 25 ml of mannitol are infused. So the normal saline

1 had been running freely and now we're at 30 ml an hour.
2 Over the page to 007 you have, 8 o'clock, Lucy arriving
3 at PICU in the Children's Hospital, without any of her
4 Erne medical notes or her lab test results or X-rays.
5 But she does come with Dr O'Donohoe and an ICU nurse,
6 Staff Nurse MacNeill, and a transfer letter and
7 a patient transfer form and I will say a little more
8 about that later on.
9 So then we have, just down at the bottom, 8.30
10 in the morning, Dr McKaigue, who is a person who was
11 made contact with earlier, he hands over to
12 Dr Chisakuta. If you want to know their positions,
13 that is all in the list of persons, but they're
14 paediatric anaesthetists.
15 Then just coming to the close of this, 009,
16 if we move forward to that. You can see at
17 approximately midday, it is said that Dr Crean contacts
18 Dr O'Donohoe to discuss the issue of Lucy's fluids.
19 I should just say there was an earlier contact at 8.30
20 when Dr Auterson provided the Children's Hospital with
21 the 127 serum sodium result. There will be some
22 evidence around exactly what was being discussed, why
23 he was providing it in that way, but in any event it's
24 a fact that he did contact the Children's Hospital.
25 Then you see Dr O'Donohoe says that, following his

1 discussion with Dr Crean, he faxed the fluid
2 administration sheet to Dr Crean. Those sorts of
3 comments are put in as Dr O'Donohoe claims, and the
4 reason I say that is because there's no actual record of
5 it happening, but that is what he says happened, so
6 obviously there will be evidence about that and not all
7 these things that are inserted as claims are things that
8 all witnesses agree on.
9 If we go to 010, then you see at 10.30, that's the
10 brainstem tests being done, there were two sets of them,
11 doctors Hanrahan and Chisakuta performed them, Dr
12 Chisakuta as a second doctor. On both occasions they
13 were negative. And then, at 011, 13.15, Lucy's death is
14 confirmed.
15 Thereafter there are events that relate to the issue
16 of really whether there should be an inquest or whether
17 there should be a hospital post-mortem and the issue of
18 a medical certificate of cause of death. And maybe
19 if we pull up that page, 012. I won't go through it
20 all, but you can see, on 4 May, there's a post-mortem
21 report there. You can see the analysis. Interestingly
22 enough, you see also the weight. Lucy's weight is a bit
23 of an issue because that can be significant in terms of
24 trying to assess how oedematous a child is.
25 And then you see the medical certificate of cause of

1 death and they come in that order. The fact that they
2 come in that order is something that has attracted some
3 comment by the inquiry's expert, Professor Lucas, and
4 I will say a little bit about that later on.
5 So that is the clinical chronology. We have also
6 provided a governance "lessons learned" chronology
7 because that clinical chronology is really so that one
8 understands the clinical issues that formed the basis of
9 the governance issues, and it's really the governance
10 issues in the aftermath that is the focus of our
11 attention. And that governance chronology is a much
12 longer document and I won't go through it in detail, but
13 I just want to highlight certain elements to you. It
14 starts at 325-004-001.
15 This is a consolidated chronology, so it is actually
16 building on the governance chronologies for the
17 preceding children's admissions and deaths. One of the
18 reasons about that is one is assuming that there might
19 be some acquired knowledge, particularly as all these
20 children end up, if I can use that expression, at the
21 Children's Hospital. And that is something that is
22 an issue that we have been investigating as to what
23 should be the implications of that, that the single
24 body, the regional centre for Northern Ireland for
25 paediatric care, sees all these children over the period

1 of, if one starts with Adam, 1995, and goes on through
2 to Conor, 2003.
3 I don't want to go through this in detail, you can
4 look at it yourself, but the purpose of this part of the
5 section -- and they all have different colours to help
6 you find your way through -- this green section, is
7 really to show what was out there in terms of other
8 developments before even Adam was admitted into the
9 hospital. So the way it goes is that the dates
10 obviously is where they are, the events -- and that
11 "event" column is really the events to do with the
12 children, then there's a "reference" column, and the
13 final column is "other developments". By "other
14 developments", we mean things not directly to do with
15 the care and attention of the children, but perhaps of
16 a more general governance nature.
17 So just for example, I can give you one. You can
18 see, in January 1989, the publication of the Department
19 of Health's White Paper "Working for patients" and the
20 "Working for patients: Medical audit" working paper,
21 which is setting out a comprehensive system of medical
22 audit. So that is an early start to some of these
23 governance issues that we have been dealing with. Then
24 it goes -- if I pull up, for example, 004, there you can
25 see -- that hasn't quite worked out right.

1 In this blue now, we're into the Adam period. It
2 looks like mine isn't going to be correlated with yours.
3 I'm not sure why that should be the case. In case it's
4 not going to work, I'll just explain some of the issues
5 that we have recorded here, which you can then look at
6 and see. In terms of colouring, all Adam-related events
7 are blue. Then we go into Claire, which is a purple
8 colour. Claire's goes from 1996 when she was admitted
9 up until, really, 2004, but we have stopped this
10 chronology at the admission of Raychel, and we will add
11 further parts to it as we go along so hopefully, by the
12 end of all the children's cases, going into the
13 department, we will have it all so that you can see the
14 full territory of governance as we go into the
15 department section.
16 Then Lucy's is yellow, her section is yellow, so
17 when you're looking at that, that's really what you want
18 to focus on for the purposes of the governance events in
19 relation to Lucy. They are taken not just at the
20 Children's Hospital in Belfast and all that related
21 there, but also all that was happening in Sperrin
22 Lakeland with the same indications down of other
23 developments. I haven't put in all the publications
24 because there is a bibliography that deals with all the
25 publications, but I have put in the key ones: Arieff,

1 1992; Arieff, 1998; Halberthal, 2001; the paper by
2 Alison Armour in 1997; there's a paper by Dr Chisakuta,
3 which will soon be released I hope, in September 1998.
4 Those are in there because they're matters that we
5 return to fairly frequently. So that is how that works.
6 Then we do have some other documents, which I'm not
7 going to take you to, but so you know they're there.
8 There is a compendium glossary of medical terms, that
9 can be found at 325-005-001, and as the successive cases
10 come, we add the new medical terms like "sentinel
11 event", for example, which is a term that got added for
12 the purposes of Lucy. We've also produced a number of
13 other schedules, mainly schedules really, which I will
14 talk about as I go through the opening and you will see
15 how it works.
16 So that is what we've done to try and help distil
17 some of the relevant information. Many of these are
18 working documents. If there are errors in them that you
19 note because of your particular interest, you are always
20 welcome and hope that people will point them out to us.
21 If we then start with the work in relation to Lucy,
22 the starting point to that was really the revised list
23 of issues and one sees that at 303-038-478. The list of
24 issues, as you know, deals with all the children. Those
25 that relate to the Lucy aftermath start at 303-038-492.

1 There you have them, the steps taken by the Children's
2 Hospital, so A is as it says, dealing with the issues
3 that arise out of the Children's Hospital:
4 "The steps taken by the Children's Hospital to
5 investigate the circumstances leading to Lucy's death
6 and to ascertain its causes and the outcome; how the
7 cause of Lucy's death was established and agreed,
8 including how and when the clinicians responsible for
9 Lucy's treatment discussed and agreed on a cause of her
10 death; the extent and quality of the information
11 conveyed to the coroner's office about the circumstances
12 of Lucy's death; and whether it complied with any
13 governing guidelines, procedures or practices; the
14 reasons it was decided that a coroner's post-mortem was
15 not required for Lucy and why a hospital post-mortem was
16 carried out; the significance of the reference to
17 hyponatraemia within the clinical diagnosis section of
18 the autopsy request form for Lucy; and the
19 consideration, if any, that was given to hyponatraemia
20 when examining the cause of death and the conclusions
21 reached following any such consideration; the actions
22 that the Children's Hospital took and should have taken
23 to disseminate the findings of the hospital post-mortem
24 that was carried out, including whether the findings of
25 the hospital post-mortem should have been brought to the

1 attention of the coroner; and why Lucy's cause of death
2 was certified as being cerebral oedema due to or as
3 a consequence of dehydration and gastroenteritis; what
4 steps the coroner would have taken if the findings of
5 the hospital post-mortem had been brought to his
6 attention; and whether the steps taken by the Children's
7 Hospital to investigate the circumstances of Lucy's
8 death to ascertain its causes and to disseminate
9 information about the death were adequate in all the
10 circumstances."
11 So that's the Children's Hospital. That is why
12 I say this has proved to be so lengthy because that is
13 all to do with the Children's Hospital.
14 We now move on to the Erne Hospital and
15 Sperrin Lakeland Trust as it was:
16 "The steps taken by the Erne Hospital/Sperrin
17 Lakeland Trust to establish an investigation into the
18 circumstances leading to Lucy's death and to ascertain
19 its causes, and whether its establishment and conduct
20 complied with any applicable guidelines, protocols or
21 practices; the adequacy of the investigation and its
22 findings; the steps taken to disseminate the outcome of
23 the investigation to any other hospital and, in
24 particular, Altnagelvin Hospital, Craigavon Hospital and
25 other trusts, boards and the DHSSPS; whether and when

1 the Erne Hospital/Sperrin Lakeland Trust suspected fluid
2 mismanagement or hyponatraemia as being relevant to the
3 cause of Lucy's death, including consideration of how
4 the investigations conducted by the Royal College of
5 Paediatrics and Child Health were dealt with by the
6 hospital/Trust; whether the Erne Hospital/Sperrin
7 Lakeland Trust should have referred the death of Lucy to
8 the coroner's office or to any other body; whether
9 Lucy's parents were involved in the investigation and,
10 if not, whether Lucy's parents were provided with
11 information about the outcome of the investigation."
12 Then there's others:
13 "What the following bodies knew about Lucy's death,
14 when they knew it and what steps they took when they
15 received information about her death."
16 The first of those is the Western Health and Social
17 Services Board and the second is the department. And
18 we are likely to be investigating much of that part of
19 the investigation under the department section, not just
20 this, but just so that you have it.
21 Then the investigation into the extent to which,
22 at the time of Lucy's inquest in 2004, the Children's
23 Hospital revised its statistical database in the light
24 of new information about the cause of death and
25 investigation into the procedures and practices that

1 existed in Northern Ireland at the time of Lucy's death
2 in April 2000 for the reporting and dissemination of
3 information to the department and the medical community
4 in general, in relation to unexpected paediatric deaths
5 in hospital.
6 Then over the page:
7 "The respective roles in reporting, analysing and
8 disseminating information in relation to unexpected
9 deaths in hospitals of the hospital in which the
10 unexpected death occurs, the treating clinicians, the
11 trusts, the area boards and the department, and what
12 procedures or practices were in place in April 2000 to
13 ensure that any requirement to report, analyse or to
14 disseminate information relating to an unexpected
15 hospital death were complied with, and what procedures
16 or practices were in place to ensure that any lessons
17 learned were fed into teaching/training and patient
18 care."
19 As I say, some of that is going to be dealt with
20 more under the department section, but those are the
21 published issues in relation to this section of the
22 investigation.
23 The primary focus, really, has been the
24 opportunities to learn and to disseminate lessons about
25 the potential dangers of administering a low-sodium

1 fluid, such as Solution No. 18, to replace gastric and
2 diarrhoeal losses. That's really what has lain at the
3 heart of this part of the investigations into Lucy's
4 death. In particular, because that issue as to how
5 appropriate it is or isn't to replace gastric losses,
6 sodium-rich fluids, with a low-sodium fluid is something
7 that was the focus of quite a bit of evidence in
8 Raychel's case because of the extent of Raychel's
9 vomiting and the fact that Raychel was, throughout her
10 time, until at the end, on Solution No. 18, a low-sodium
11 fluid. So we have been looking here at that in relation
12 to Lucy.
13 There is, obviously, a learning and disseminating
14 opportunity created by, as I said, the fact that all the
15 children who are the subject of the inquiry's work were
16 admitted to the Royal, the Children's Hospital, either
17 because that's where they were going for their
18 treatment, which was the case with Adam, for example, or
19 because they were transferred there from another
20 hospital, and that's the case with Raychel and the case
21 with Lucy. They were treated there, they died there,
22 they had their post-mortems there to the extent they had
23 hospital post-mortems carried out there, and that's
24 something for example Lucy shares with Claire, who had
25 a hospital post-mortem at the Children's Hospital.

1 But more than that, the Children's Hospital is a
2 regional centre for paediatric care, which services the
3 whole of Northern Ireland, it provides the only
4 paediatric intensive care services in the region and it
5 shares a site with the regional neurology and the
6 regional paediatric neuropathology services. The
7 specialists in paediatrics are trained and they work
8 there on that site. So that, one might think, puts the
9 Children's Hospital uniquely placed to acquire knowledge
10 about and disseminate learning on hyponatraemia and the
11 risks posed to children by the use of low-sodium fluids.
12 And that is apparently what the coroner believed was
13 going to happen with Adam. Some hearings back now, he
14 being the first of the children to die, when he said in
15 his witness statement for the inquiry:
16 "I had assumed that the Children's Hospital would
17 have circulated other hospitals in Northern Ireland with
18 details of the evidence given at the inquest and
19 possibly some best-practice guidelines. Children are
20 not always treated in a paediatric unit and, in the
21 event of surgery, the anaesthetist may not always be
22 a paediatric anaesthetist."
23 We don't need to pull that up, but the reference for
24 it is 091/1, page 3.
25 Mr Chairman, you'll have heard the evidence about

1 what was done in the aftermath to Adam during Adam's
2 governance hearings.
3 The significance of that was looked at for Claire's
4 case and that's also a matter being considered in
5 Raychel's case because Raychel, like Adam, was
6 a surgical case. And one sees a letter that Dr Nesbitt,
7 who was then the medical director at Altnagelvin
8 Hospital, wrote to the CMO at that time,
9 Dr Henrietta Campbell, and he said -- I can give you the
10 reference to it, it's 006-045-427:
11 "I am interested to know if such guidance [by that
12 he means on hyponatraemia] was issued by the Department
13 of Health following the death of a child in the
14 Children's Hospital, which occurred some five years ago
15 and whose death the Belfast coroner investigated."
16 He's referring to Adam. Let's pull that up.
17 006-045-427:
18 "I was unaware of this case and am somewhat at
19 a loss to explain why. I would be grateful if you would
20 furnish me with any details of that particular case for
21 I believe that questions will be asked as to why we did
22 not learn from what appears to have been a similar
23 event."
24 Well, matters aren't always so clear-cut and there
25 seems to have been little dissemination about Adam's

1 case, but there were papers published on the topic. So
2 although Dr Nesbitt is talking about why the Children's
3 Hospital didn't disseminate, there was literature out
4 there, if I can put it that way, in May 1997.
5 Dr Alison Armour, who had been the pathologist in Adam's
6 case, had an article published in the BMJ, "Dilutional
7 hyponatraemia: a cause of massive fatal intraoperative
8 cerebral oedema in a child undergoing renal
9 transplantation", which in a way was addressed to the
10 pathologist community, of which Dr O'Hara was one. He
11 carried out the hospital post-mortem on Lucy. It's
12 quite clear, if you read her paper, that it's a Belfast
13 case: she refers to the Belfast coroner, she refers to
14 Dr Taylor, the anaesthetist in Adam's case, and at the
15 Children's Hospital, but she also refers to the earlier
16 case by Professor Arieff et al, "Hyponatraemia and death
17 or permanent brain damage in healthy children", and that
18 had been published in 1992. So some of that was there
19 even for the local community to see.
20 Then we have recently been advised that Dr Anthony
21 Chisakuta, a consultant paediatric anaesthetist at the
22 Children's Hospital, who was involved in Lucy's
23 treatment and who carried out, with Dr Hanrahan, the
24 brainstem death tests -- I think he was also involved in
25 Raychel's -- he gave a paper on 30 September 1998,

1 before, obviously, Lucy and before Raychel, at a talk on
2 recent advances in paediatric anaesthesia, which was the
3 inaugural meeting of the Western Anaesthetic Society,
4 which would have covered anaesthetists in the Erne and
5 the Altnagelvin Hospital. That paper included
6 a discussion on hyponatraemia as a post-operative
7 problem. And he cited the 1998 paper by
8 Professor Arieff, "Post-operative hyponatraemia
9 encephalopathy following elective surgery in children".
10 We're going to explore a little bit as to who attended
11 that meeting and what, if anything, they learned from
12 it.
13 Then there's the 31 March 2001 -- too late for Lucy,
14 but not for Raychel -- the clinical review lesson of the
15 week was published in the BMJ, "Acute hyponatraemia in
16 children admitted to hospital: a retrospective analysis
17 of factors contributing to its development and
18 resolution". In there is a telling quote:
19 "Do not infuse a hypotonic solution [low-sodium
20 solution] if the plasma sodium concentration is less
21 than 138 millimoles per litre."
22 So if Dr Nesbitt thought that Adam's case was of
23 potential significance to Raychel, then what we're
24 looking at here is the potential significance of Lucy's
25 case to Raychel.

1 It will be appreciated from the clinical hearings so
2 far that there is a very important issue surrounding the
3 use of Solution No. 18 as a replacement IV fluid. I say
4 replacement IV fluid; I meant that to distinguish it
5 from its use as a maintenance fluid. So there is
6 an important issue about that, and that has led to
7 questions as to when that practice of using it stopped.
8 The first person to make reference to that practice
9 stopping was Dr Nesbitt and at the time he did that
10 he was clinical director. In the immediate aftermath of
11 Raychel's death he contacted several hospitals in the
12 region, including the Children's Hospital, to enquire
13 about their perioperative fluid management and he set
14 out his findings in a letter dated 14 June 2001 to
15 Dr Raymond Fulton, who was the medical director at
16 Altnagelvin. We can pull that up, the reference for
17 that is 026-005-006.
18 You can see he says he has contacted several
19 hospitals:
20 "The Children's Hospital anaesthetists have recently
21 changed their practice and have moved away from
22 Solution No. 18 to Hartmann's solution. This change
23 occurred six months ago and followed several deaths
24 involving No. 18 Solution."
25 Then he goes on:

1 "Craigavon Hospital and Ulster Hospital both use
2 Hartmann's, but the anaesthetists in Craigavon have been
3 trying to change the fluid regime in Hartmann's
4 post-operatively but have met resistance in the
5 paediatric wards, whereas in Altnagelvin they have
6 followed a medical paediatric protocol."
7 So with that in mind, we tried to investigate
8 exactly when the Children's Hospital had stopped using
9 it, what had prompted them to stop using it, and what
10 had prompted Craigavon to seek to change their practice
11 as well, albeit that they hadn't at that stage been
12 successful.
13 There's a little bit more information given by
14 Dr Nesbitt to assist about that, and one finds it in
15 a statement he made to the PSNI. If one goes to
16 095-010-033. You see it towards the bottom:
17 "I was informed that the Children's Hospital had
18 ceased prescribing this fluid in post-operative children
19 some six months previously, but that, as in other
20 hospitals, it had been the default solution up to that
21 time. I requested that any data on hyponatraemia or the
22 incidence of this in Northern Ireland would be helpful
23 and Dr Taylor, a consultant paediatric anaesthetist,
24 agreed to send me these details."
25 And then later on he says who gave him the

1 information and one sees that at 095-010-040. You see
2 it towards the bottom:
3 "I spoke to Dr Chisakuta, a consultant in paediatric
4 anaesthesia and intensive care in the Children's
5 Hospital about their use of No. 18 Solution in
6 post-operative surgical children and he informed me that
7 they had been using precisely the same regime as
8 Altnagelvin Hospital, but had changed from No. 18
9 Solution six months previously because of concerns about
10 the possibility of low sodium levels. This was also the
11 position in Tyrone County Hospital."
12 And we have also sought the position in that
13 hospital without any great success at the moment. We
14 asked Dr Chisakuta about that, and he gave a statement
15 to the inquiry. If we can pull up these two pages side
16 by side, it's 283/1, pages 7 and 8. You can see the
17 question at the bottom, number 8:
18 "Did the Children's Hospital cease the practice of
19 prescribing No. 18 Solution to post-operative children?
20 I do not recall a formal protocol or directive requiring
21 clinicians to cease prescribing No. 18 Solution to
22 post-operative children. My recollection is that
23 different specialties had different practices. As
24 a paediatric anaesthetist I had limited involvement
25 in the prescription of post-operative fluids, which were

1 generally managed by ward medical staff. I do not
2 recall the discussion that Dr Nesbitt refers to ...
3 Solution No. 18 was available, i.e. physically present on
4 the wards in the Children's Hospital until around 2008
5 and it is still available for specialised use in PICU
6 and the renal unit."
7 And then it goes on:
8 "On what date was the practice of prescribing
9 Solution No. 18 to post-operative children ended? For
10 non-specialised use, the practice of prescribing
11 Solution No. 18 to post-operative children ended
12 around March 2008."
13 So we then pursued, through the DLS, to have more
14 information on exactly when that had stopped and, more
15 to the point, why it had stopped, given the way in which
16 Dr Nesbitt framed his evidence in his PSNI statement.
17 We were informed that there wasn't any protocol, there
18 wasn't any decision, and basically we weren't able to
19 ascertain exactly why it had happened. So we adopted
20 a slightly different approach and we asked for their
21 records of ordering Solution No. 18 to see if we could
22 detect from that when, effectively, they stopped using
23 it.
24 The first letter we got about it, we can pull that
25 up, 319-087A-001. It couldn't be clearer:

1 "I am instructed that the Belfast Trust has
2 confirmed that there were no orders placed with the
3 pharmacy by the Children's Hospital in respect of No. 18
4 Solution [in the period that we gave them, which was
5 January 2000 to July 2001]. Therefore it appears that
6 Solution No. 18 was not used in the Children's Hospital
7 during the period January 2000 and July 2001."
8 That proved to be, we thought, a significant period
9 because, of course, it pre-dates Lucy. That, we
10 thought, was suggesting that, before Lucy's admission
11 and treatment, the Children's Hospital had been aware of
12 something that caused them as early as January 2000 to
13 cease using Solution No. 18, albeit that there doesn't
14 appear to have been anything disseminated to any of the
15 other hospitals about whatever caused that change.
16 No sooner had we got that letter, which was dated
17 17 May, that we got another letter that retracted it.
18 You can see that at 319-087c-001. I can read out to you
19 what it says. Firstly, they approach the data in
20 a different way, as a result of which we were told this:
21 "The Trust now instructs that the information
22 contained in my letter of 17 May 2013 is incorrect. The
23 correct information, which should have been supplied in
24 response to the request, is that the pharmacy department
25 supplied a total of 6,493 bags of Solution No. 18 to the

1 Children's Hospital between 1 January 2000 and
2 31 July 2001."
3 And then they enclose a chart and table showing
4 a month-by-month breakdown of the number of bags
5 supplied by the pharmacy department to the Children's
6 Hospital. So I'm sorry it's not pulled up because the
7 chart is actually very interesting to look at, but I can
8 perhaps give you the edited highlights of it. It starts
9 in January 2000, this is month-by-month orders, with
10 359 bags. Then it keeps up into the 300s and 400s until
11 really you get to January 2001. January 2001, there's
12 493 bags. Then, February, there's a dip, almost halved,
13 to 242. It bubbles up a little bit in March to 365
14 then, in April 2001, it's right down again to 113.
15 In May, it's 137. By June it's 42 and by July it's 6.
16 We don't at this stage know why that should be the case,
17 why it should be in double figures by the time you get
18 to June and in single figures in July; and we are trying
19 to investigate what gave rise to that change in ordering
20 pattern.
21 THE CHAIRMAN: We'll know better tomorrow when we hear from
22 Dr Chisakuta. He's part of the story and then we'll
23 develop it from there.
24 MS ANYADIKE-DANES: Thank you.
25 If then we move from the focus on Solution No. 18 to

1 see what one might learn about the practice in the
2 Children's Hospital and what effect that might have had,
3 if one knows what it is, had that been disseminated, on
4 Lucy's treatment and then, of course, Raychel's, and we
5 move to the areas of opportunity, if I can put it that
6 way. We have looked at the question of the
7 opportunities that were there to understand what had
8 happened to Lucy and to learn from that and to
9 disseminate that learning, really around three principal
10 areas. The first is the Belfast area. That would be
11 the paediatric intensive care, the Children's Hospital,
12 the pathology department and the Royal Group of
13 Hospitals trust. I call that the Belfast area.
14 Then there's the coroner's office, that was another
15 area of opportunity. And then there's Enniskillen, and
16 by that I mean the Erne Hospital, Sperrin Lakeland Trust
17 as it was, and the Western Health and Social Services
18 Board. These are all places where investigations could
19 have been carried out and we will explore the extent to
20 which they should have been and whether, if they had
21 been, what would have been or might have been the result
22 and to what effect.
23 But a recurring theme, as we have been
24 investigating, seems to have emerged around the lack of
25 effective communication at almost all levels, whether

1 it's amongst the clinicians at the Erne Hospital and
2 at the Children's Hospital, between the two hospitals,
3 and also with Lucy's parents and, of course, affecting
4 the coroner's office. We don't know the extent to which
5 there was actual communication, but we are dealing with
6 what is recorded.
7 There would also seem to have been, until it's
8 explained, but just looking at the documentation, an
9 absence of at least perhaps what one might call
10 professional inquisitiveness to identify why an
11 otherwise apparently healthy child, albeit with
12 a gastric upset and consequent dehydration, could be
13 admitted at 7.30 in the evening and have irretrievably
14 collapsed by 3 o'clock the next morning, with nothing
15 really having been administered to her, apparently,
16 apart from her IV fluids.
17 And also, if as the specialists at the Children's
18 Hospital seemed to think was the case, that the
19 underlying cause of her death was gastroenteritis, then
20 there appears to have been no real consideration of how
21 comparatively rare such an event would be.
22 The inquiry's expert, Dr MacFaul, has addressed that
23 in an annex to his report and one sees that at
24 250-004-032. This is for England and Wales. He's using
25 the ICD codes, so the code 0090-9903, they all relate to

1 gastroenteritis. The other code of 558, that relates to
2 "Other and unspecified non-infectious gastroenteritis
3 and colitis". Lucy, of course, is in the age above 12
4 months and less than 14 for the first four codes. And
5 you can see in terms of deaths for -- well, it's really
6 very low. For 1997 and 1998, it's one. And then the
7 year before her death and the year of her death, it is
8 zero for the whole of England and Wales. No child died
9 of gastroenteritis or any of those
10 gastroenteritis-related conditions. If one even takes
11 the "Other and unspecified non-infectious
12 gastroenteritis and colitis" and then in her age group,
13 1 to 4, in 2000 there were only four who died of that.
14 So perhaps what I mean by professional
15 inquisitiveness is if you're told that you've got
16 a 17-month old baby who has died of that, how likely
17 is that and whether that should have sparked any query
18 at all as to how that could have happened, particularly
19 within the space of time it happened? When she came in,
20 her sodium levels were normal and, within a few hours,
21 she's collapsed irretrievably. So that is one of the
22 issues that we want to explore, why nobody actually
23 wanted to know what had happened.
24 Then if I move to those three areas and start with
25 Belfast. And by that, as you know, I mean PICU, the

1 Children's Hospital pathology department, and the Royal
2 Group of Hospitals. I have started with Belfast because
3 that is where Lucy arrived in an essentially moribund
4 state: her pupils had been fixed and dilated for
5 a number of hours, and that is where she was
6 subsequently to die. That is where the investigations
7 could have been immediately triggered. That was the
8 specialist centre and you'd like to think that is where
9 the experienced and specialist people might be who could
10 shed light on what had happened to her.
11 If we start then with the information that they had.
12 So they had clinical information from the Erne Hospital,
13 not a lot, when she was transferred, and that's going to
14 be one of the issues. They had the transfer letter from
15 Dr O'Donohoe, and the details on the transfer sheet that
16 had been recorded by Staff Nurse MacNeill during the
17 journey by ambulance to Belfast. And then there were
18 the notes, the Erne notes that were subsequently faxed
19 over, and there's going to be an issue about why she
20 didn't come with her notes and, in fact, why they didn't
21 fax all her notes. But we do have some comparisons to
22 make, which we will make, between the transfer letters
23 for Lucy and the transfer letters for Raychel, and the
24 transfer form for Lucy and the transfer form for Raychel
25 because both these hospitals are under the same board.

1 If I just pick up, for example, the transfer form for
2 Lucy, that's 061-015-040.
3 If you can pull up alongside it 041. Sorry,
4 061-016-041. That's the transfer form. You can see
5 at the top there, "Western Health and Social Services
6 Board". There is a bit of an issue that we're going to
7 explore with Dr Taylor, who was on a working party for
8 transferring children, as to what information he would
9 have expected, by 2000, to have been provided. He gave
10 evidence on what he thought that he believed the
11 position was in 1995. We're some way ahead of that now.
12 So this is what's given. You can see "Pupils fixed
13 and dilated", you can see what she's catheterised, you
14 can see the last medication, "diazepam", you can see the
15 Claforan given, mannitol. That's it really on there.
16 And then what is along the other side is the
17 observations made during the course of her trip. Right
18 at the top you see, "500 ml normal saline, 300 [sic] ml
19 an hour". So that's the only information given about
20 fluids at all.
21 But we can see, just over a year later, Raychel's
22 transfer form. Can we please replace those with
23 020-024-052 and 053 alongside it? You can now see in
24 Raychel's form there's actually a special section all
25 about the case notes. It prompts you, "Originals,

1 copies, also your X-rays", and so forth. And those are
2 all indicated for Raychel. Quite a bit of information
3 given there. If one looks to the actual record sheet,
4 this is the record of observations made about her in
5 transit from Altnagelvin to the Children's Hospital,
6 it's much more structured, much more detailed.
7 So we're going to ask why the information provided
8 about Lucy was so sparse as she was transferred. I'm
9 not going to pull up the transfer letter, that's not
10 terribly detailed either, from Dr O'Donohoe. It can be
11 compared with the transfer letter that was written
12 in relation to Raychel, which is far more detailed as to
13 exactly what was happened and when it happened. But
14 there was an opportunity to investigate right at the
15 outset.
16 They had that information and then, fairly shortly
17 afterwards -- it's not entirely clear when afterwards
18 because the fax sheet shows one time at the top and
19 another time at the bottom -- but some time in the
20 morning were faxed over Lucy's Erne medical notes. And
21 one sees that, and we've got a schedule of what was
22 actually sent, 325-006-001.
23 The purpose of having produced this schedule is to
24 help us to see what could have been gleaned from her
25 medical notes and records, even though some have

1 criticised their adequacy. So the first thing one sees
2 recorded there is she's got a slow capillary refill,
3 which I'm told indicates a level of dehydration. Then
4 you can see that they would have been able to see that
5 on admission she had normal serum sodium levels, she got
6 her line inserted at 2300 hours. Then looking through
7 the clinical notes, they would have seen that she had
8 the seizure at 3 o'clock, she had some diarrhoea before
9 and some afterwards. At that time, her capillary refill
10 was normal then, so whatever had been the cause of her
11 dehydration appears not to be affecting her capillary
12 refill at this stage, and her pupils are dilated and
13 unresponsive, and then she's got a sodium level of 127,
14 and they query a number of things. She has a clear
15 chest X-ray, which may have been relevant for Dr O'Hara
16 to see when he was carrying out the autopsy.
17 If we go over the page to 002, this is the important
18 thing that they could have seen. If they had looked
19 at the nursing notes, or if they did look at the nursing
20 notes, if they had noted this. You have:
21 "IV Solution No. 18 commenced at 100 ml an hour to
22 encourage urine output."
23 But it's there. No. 18 being started at 10.30,
24 100 ml an hour. And then you have the large vomit at
25 midnight and then you have some diarrhoea at 2.30 and,

1 by 3 o'clock, you have the seizure. And then, working
2 down, you see that Dr Malik arrives, and then the
3 IV fluids are changed to normal saline to run freely,
4 Dr O'Donohoe arrives, repeats the U&Es. So the bloods
5 taken for the serum sodium of 127 were taken in that
6 order, as is recorded. That's what was available for
7 them to see and note.
8 We go over the page to 003. In terms of her urine
9 we see there's a small amount of clear residual urine
10 and the fluid balance chart gives further information on
11 exactly what was being given or at least what's being
12 recorded as having been given, and it's quite clear
13 that, interestingly, she's taking fluid orally, so that
14 might have raised an issue as to the appropriateness of
15 her regime. Then they record her damp nappy, they
16 record her vomit, and it is clear that she is being
17 given Solution No. 18, 100 ml an hour, and when the
18 normal saline starts, and then, if we just go over the
19 page to 004, we see that she's had 500 ml of normal
20 saline administered in the children's ward. We see
21 thereafter the amounts that are being administered to
22 her. She seems to have another 250 ml.
23 These are the notes that they might have received.
24 If you see, that is "Notes not received", so they might
25 have got this further information. But even without

1 that, they had the information that she was on
2 Solution No. 18 at 100 ml an hour and they had the
3 sequence for when the bloods were taken for the 127
4 serum sodium level.
5 So that is the starting point in terms of the
6 opportunity. There was an opportunity to try and
7 analyse those notes and to see what they might tell them
8 about the cause of Lucy's condition, if I can put it
9 that way.
10 MR LAVERY: Just before my learned friend moves on, there's
11 an error in the transcript, I think. If one goes back
12 to page 37 [draft]. The top of page 37.
13 Ms Anyadike-Danes was saying what is along the other
14 side is the observations made during the course of her
15 trip, right at the top you see "500 ml of normal saline
16 at 300 ml an hour". I'm not -- that should be 30.
17 MS ANYADIKE-DANES: Thank you very much indeed, Mr Lavery.
18 So that was the information, in addition to which
19 they had the presence of the transfer team. The
20 clinicians at the Children's Hospital do refer to having
21 spoken to Dr O'Donohoe. Staff Nurse MacNeill says she
22 gave a report of what happened during the journey, so
23 they were there. So they didn't have their notes at
24 that stage, but they had the clinician, they had Lucy's
25 consultant, so there will be an issue of the opportunity

1 that they had at that first stage to understand why Lucy
2 had arrived in that condition from her own treating
3 consultant. And another opportunity they then had is
4 Dr Auterson, who stabilised and treated Lucy in
5 intensive care at the Erne, a paediatric anaesthetist.
6 He telephones through.
7 There is an issue as to what he was telephoning to
8 do. From the Children's Hospital side, their view
9 is that he was telephoning to tell them of the 127 serum
10 sodium result. From Dr Auterson's side, he says he's
11 telephoning them to see what condition Lucy's in,
12 although having sent her off in a moribund state, that's
13 not entirely clear. He doesn't deny that he may well
14 have, although he can't remember it, have told them
15 about the 127 serum sodium result. We're going to ask
16 about what prompted him to contact the Children's
17 Hospital, but more to the point, that was another
18 opportunity to talk to somebody senior who had treated
19 Lucy to find out what had happened.
20 With that kind of information, at an early stage,
21 there might have been -- in fact, Dr Crean, who is
22 a paediatric anaesthetist, does seem to have been
23 a little concerned about Lucy's fluid regime at the
24 Erne. If I pull up a schedule of fluid management in
25 a dehydrated child, one can see why he might have been.

1 325-010-001. This is to try and help with what some of
2 these levels and rates might mean. It requires a little
3 bit of explanation. There's the maintenance rate,
4 applying something that Mr Chairman, you'll have heard
5 of earlier, the Holliday-Segar formula, which is to try
6 and calculate the maintenance rate for a person
7 essentially based on their weight. For Lucy, that would
8 have equated to 914 ml a day or 38 ml an hour. That is
9 assuming her weight at 9.14 kg. That is her
10 maintenance, that is what she needs because it is what
11 she is losing just by breathing and just by doing
12 nothing very much. She needs that.
13 Then there's dehydration. It's not entirely clear
14 how dehydrated Lucy was, there have been a number of
15 figures canvassed for her by the experts, between
16 5 per cent and 10 per cent, and so most of them have
17 worked out matters on the basis of 7.5 per cent. Nobody
18 thinks she was very deeply dehydrated.
19 Then if you're going to address dehydration, that
20 means you're into replacement and you need to work out
21 what that rate would be, and we have been guided by the
22 experts to do that very thing. She would have needed
23 686 ml, the replacement rate is therefore 29 ml an hour,
24 and if you then work out her total, assuming you're
25 maintaining her and replacing, until she's not

1 dehydrated any longer, that would mean she would require
2 67 ml an hour. The experts will give their evidence on
3 this; I'm just distilling for you what they have said.
4 If she had a bolus, which is what Dr O'Donohoe says
5 she got for the first hour, you have to take that into
6 consideration, and that would produce 63 ml an hour.
7 Of course, they wouldn't know just from looking at
8 Lucy's notes what Dr O'Donohoe had intended, but they do
9 know what the notes show them, and what the notes are
10 showing is 100 ml an hour, which is not what the
11 calculation produces. If they had discussed with
12 Dr O'Donohoe and he told them what he actually intended
13 her to receive, they would have seen how far adrift she
14 was. Dr O'Donohoe certainly would see how far adrift
15 she was. In any event, there was information there to
16 indicate that her regime at the Erne might have been
17 problematic for her. And that's something that might
18 have prompted amongst the clinicians in the
19 Children's Hospital some further enquiry.
20 Dr O'Donohoe says that Dr Crean did contact him and
21 ask about the regime and when Dr O'Donohoe, according to
22 him, tells Dr Crean what he had intended Lucy to get,
23 which was 100 ml for the first hour, thereafter 30 ml
24 an hour, Dr Crean is able to say, according to
25 Dr O'Donohoe, "Well, that's not what I thought;

1 I thought she was getting 100 ml an hour". If that
2 conversation actually took place then one might say that
3 creates another opportunity to investigate. Obviously,
4 there was a disconnect. What the child had actually
5 received is not what the treating clinician intended her
6 to receive. So that, I suggest, Mr Chairman, was
7 another opportunity.
8 Then, Mr Chairman, there's a whole question about
9 the availability of the PICU clinicians for discussion,
10 even if one or other of them was not able to either have
11 the time or the experience or expertise to make all
12 those connections -- and I'm very conscious that it's
13 much easier in hindsight when you know what the end of
14 the story is -- but she didn't have one consultant
15 there.
16 I have prepared two schedules. If we pull up this
17 one first, this is just to show you who was there,
18 involved in Lucy's care at the Children's Hospital.
19 325-008-001. Can you pull up alongside it 002?
20 It's very colourful and the reason for that is that
21 each doctor has a different colour. You can just see,
22 along the left-hand side, there are the times of certain
23 sorts of events. I haven't put absolutely everything
24 in, but the sort of thing which might spark a bit of
25 discussion is in there. So you see that Dr McKaigue is

1 the first and he's responding to the emergency. He
2 hands over to Dr Chisakuta, so there's an opportunity
3 for some discussion, perhaps only briefly there. Then
4 there's Dr Louise McLoughlin, she is an SHO, she takes
5 the note, but she's got Dr Caroline Stewart, who's
6 a registrar, and she's working with her, discussing with
7 her. Then you see Dr Crean comes on and there's a ward
8 round, it's not entirely clear who was there.
9 Dr O'Donoghue says he was there, he's an acting
10 registrar, and there's a note made by Dr McLoughlin.
11 Then there's Dr Crean, at 10 o'clock, speaking to Lucy's
12 parents. That's an opportunity. You'd think, maybe
13 there would be some discussion with colleagues before
14 you went to speak to the parents, maybe another look
15 at the notes.
16 Then there's Dr Hanrahan, he examines Lucy, he makes
17 a note. Dr Hanrahan is talking to Lucy's parents, he's
18 going to tell them that she's critically ill and will
19 possibly die. That's an opportunity that maybe he would
20 have discussed with the other clinicians around him and
21 had another look at her notes. It's a time when they
22 might ask questions about why is she in this condition.
23 Then there's Dr Crean's apparent contact with
24 Dr O'Donohoe. If that happened, that's an opportunity
25 for discussion. Then Dr Chisakuta is inserting the

1 central line, he's asked to do that. Then there is
2 Dr Hanrahan informing Lucy's parents that the prognosis
3 is hopeless and he mentions a possibility of a
4 post-mortem and informing the coroner. But if he has
5 got as far as that, maybe he has talked to his fellow
6 clinicians. Maybe he should have in formulating that
7 view.
8 Then you have the next day, there's the brainstem
9 test being performed. Dr Hanrahan and Dr Chisakuta,
10 they're both doing that. That's an opportunity for them
11 to discuss. They have to sign off a form to certify
12 that there is nothing underlying that could be affecting
13 the results they achieve while carrying out the
14 brainstem death tests. Then there's Dr Hanrahan
15 reporting the death to the coroner's office and speaking
16 to Dr Curtis, the assistant State Pathologist. That's
17 a discussion that takes place as well.
18 Then Dr Stewart, she is making her entry into the
19 notes and she is making that entry in conversation or
20 discussion with Dr Stewart. She says that he provides
21 her with the information to include. And then there's
22 Dr Hanrahan contacting Dr O'Hara. They have
23 a discussion about whether Dr O'Hara will carry out the
24 hospital post-mortem. Then Dr Stewart is completing the
25 autopsy form. She says that the clinical diagnosis that

1 she included in that autopsy form, "Dehydration,
2 hyponatraemia, cerebral oedema leading to acute coning
3 and brainstem death", that that was a product of
4 discussion and agreement between the four consultants,
5 doctors Hanrahan, McKaigue, Crean, and Chisakuta, then
6 she discusses with Dr O'Hara, the pathologist.
7 And then after that, you've got the post-mortem
8 report coming in. Dr O'Donoghue is going to issue the
9 medical certificate of cause of death. He says he
10 discussed this with Dr Stewart and that the cause of
11 death was agreed with Dr Hanrahan.
12 So there were a lot of people available for
13 discussion. It's not a case, for example, like
14 Raychel's, Mr Chairman, where there was a dearth of
15 doctors, and her care was essentially being managed by
16 the nurses. This is completely different. Nor Claire's
17 where there was essentially one consultant involved.
18 If we pull up another schedule to illustrate that
19 point. 325-009-001 and 002 alongside it. This is the
20 same schedule, but what this schedule shows is the
21 grades of clinicians. Purple is consultant, pink is
22 registrar, and the green is SHO. Unfortunately, there's
23 a bit that has fallen off the side, but if one looks
24 through it, at almost every stage a consultant is
25 involved.

1 So in terms of the opportunity for discussing,
2 pooling expertise, pooling experience and knowledge,
3 there was an opportunity for that. And the issue is: if
4 there was that opportunity, how was it nonetheless that
5 nobody seems to have got to the bottom of the cause of
6 Lucy's condition, even when Dr Stewart is able to insert
7 "hyponatraemia" on the autopsy request form. So it's
8 there, but there still doesn't seem to have been
9 a discussion that could have allowed them to see the
10 potential significance of that. And that's one of the
11 things that we will be exploring.
12 But then if we get to the medical cause of death
13 certificate and just pull that up so that you see it,
14 013-008-022:
15 "Cause of death: cerebral oedema."
16 That's on the top line:
17 "Due to or as a consequence of [so working down to
18 find the underlying cause] dehydration and [below that]
19 gastroenteritis."
20 That medical cause of death has been considered by
21 the inquiry's experts to be quite simply illogical. The
22 relationship between gastroenteritis and dehydration is
23 readily explicable, but to move from dehydration to
24 cerebral oedema, that's the bit that they have
25 considered to be quite simply illogical, and they have

1 said that in their expert reports. If I just give you
2 the reference, we don't need to pull it up, but the
3 reference from Dr MacFaul, 250-003-115:
4 "The entries on the death certificate were
5 illogical, unless the dehydration listed at 1B was made
6 because Dr Hanrahan considered the treatment of the
7 dehydration was the likely cause of the cerebral oedema.
8 Dehydration itself does not cause cerebral oedema."
9 Well, if the treatment of the dehydration was the
10 cause of cerebral oedema, then the issue is: was there
11 an iatrogenic cause of Lucy's death, and if there was,
12 obviously that is a coroner's matter. And then
13 Professor Lucas puts it even more pithily. Mr Chairman,
14 we don't have to pull this up either: 252-003-011. He
15 goes through the death certificate and he says:
16 "The bottom line, 1C, is correct, gastroenteritis.
17 However, it is still illogical. Dehydration is not
18 going to directly cause brain swelling. Something
19 intervenes."
20 As Dr MacFaul was suggesting -- or at least I don't
21 say that it does -- a thing that might intervene is the
22 way you treat that dehydration, and the way you might
23 treat it to have produced cerebral oedema is an
24 excessive rehydration, and if that's what happened, as
25 I say, one begins to question about iatrogenic causes.

1 The issue is, with all the opportunity to discuss
2 amongst such a number of consultants, how could they not
3 see that that was illogical? That very question was put
4 to Dr Hanrahan in the course of his police interview
5 quite starkly:
6 "How can a child be dehydrated and have cerebral
7 oedema?"
8 The reference for it is 116-026-022. His answer to
9 that is:
10 "Yes, it's very difficult in retrospect."
11 There is a separate issue, which is not quite in
12 this line of opportunities to discuss that I've been
13 taking you through, but it is an issue that the
14 inquiry's expert has considered to be a very important
15 one, and that's one to do with timing.
16 The death certificate was issued after the
17 post-mortem, after the autopsy. Professor Lucas has
18 described that as very irregular. He says that that
19 fact, that a death certificate should follow much later,
20 after autopsy, he considers that to be very irregular.
21 He says the normal course of events is with a doctor
22 writing up a natural cause of death, that is then
23 registered officially, at which time the autopsy can go
24 ahead, and he states that to apparently wait for the
25 autopsy and/or the autopsy report before writing the

1 death certificate is at least inappropriate and
2 possibly, he suggests, "an infringement of the law".
3 And he outlines his reasons and he feels sufficiently
4 strongly about it that he has expressed himself in these
5 terms at 252-003-011, and if one pulls up alongside it
6 012.
7 He's talking about that order of doing things. He
8 says:
9 "In addition, it perverts the whole coronial
10 referral system for queried unnatural death. For
11 following a consented autopsy, more people -- i.e.
12 including the pathologist -- could more readily conspire
13 to hide a genuine unnatural death from public notice.
14 The usual process, natural death certificate or referral
15 to the coroner, makes the doctors think promptly about
16 why someone died and what to do next. This is a very
17 serious issue and could be examined in more detail
18 at the hearings."
19 We have taken that up and asked about it and it
20 seems that just was the system that they operated in the
21 Children's Hospital. So we will be asking the reasons
22 why they operated that system, having regard to the
23 comments that Professor Lucas has made.
24 If one moves on to the opportunities, the hospital
25 post-mortem investigation, that was carried out by

1 Dr O'Hara. That provided an opportunity to learn. It
2 seems he wasn't, for reasons which aren't clear and
3 which we are going to explore, provided with all of
4 Lucy's notes, but he could have asked for them if
5 he wasn't provided with them. He could have discussed
6 with the clinicians, he certainly had one discussion
7 with Dr Stewart. So there was an opportunity for an
8 exchange for him if he was not familiar with electrolyte
9 imbalances, which he might not have been, being
10 a pathologist, for him to understand what the clinicians
11 thought had happened and to factor that into his report.
12 And in fact, that whole issue of pathologists having
13 available to them the clinicians was a matter that was
14 dealt with in some detail in Claire's case in relation
15 to clinicopathological correlation and we heard from the
16 inquiry's experts, at that time Dr Squier, paediatric
17 neuropathologist, and Professor Lucas about the
18 importance of having clinicopathological correlation so
19 that what the pathologist has found during autopsy can
20 be relayed back and discussed with the clinicians who
21 treated the child during the child's life and they can
22 together reach a view as to what happened to the child
23 and why the child died in the way the child did.
24 You may recall, Mr Chairman, that you heard evidence
25 from Dr Mirakhur and Dr Herron, who were the

1 neuropathologists in Claire's case, and they talked
2 about neurological grand rounds and so forth and the
3 importance of those and we will see what, if any, of
4 that happened in relation to Lucy.
5 Then there are the meetings with Lucy's parents.
6 Dr Hanrahan met with them on 9 June and Dr O'Hara met
7 with them on 16 June. One assumes there was some
8 preparation for those meetings and that would have
9 provided another opportunity to learn what had happened
10 so that they could explain to the parents what had
11 happened. One presumes that's part of the reason for
12 having a meeting with the parents in the first place.
13 But in fact, what happens is that Dr Hanrahan suggests
14 that the parents might like to go back to the Erne and
15 find out what happened there. There seems to be no
16 indication that he explained to the parents what they
17 should be asking those clinicians at the Erne, why he
18 thinks they should be going back down to the Erne to be
19 asking their questions there. It just seems to be
20 a bald suggestion: go and ask further from Dr O'Donohoe
21 or from the other clinicians at the Erne.
22 When we asked Dr Hanrahan about that -- and we will
23 be asking further about it during the hearing -- "Why
24 did you take that approach?", he said because the
25 sentinel event had happened at the Erne, the sentinel

1 event being something that is considered to be
2 iatrogenic. In fact, as we understand it, but it may be
3 that he didn't mean it in that way.
4 The sentinel event is defined as:
5 "An unanticipated event in a healthcare setting
6 resulting in death or serious physical or psychological
7 injury to a patient or patients not related to the
8 natural cause of the patients' illness."
9 If that's what Dr Hanrahan thought had happened to
10 Lucy, then there might be an issue as to, "Why did he
11 think that had happened to Lucy?", and if he thought
12 that had happened to Lucy, why wasn't that fortifying
13 his discussions with the coroner? And in any event, why
14 wasn't he helping Lucy's parents see that that's what
15 the clinicians at the Royal thought had occurred and
16 that's why they should be taking the matter up with the
17 clinicians at the Erne.
18 Then -- and I had touched on it just briefly
19 in relation to the grand rounds that can be part of
20 a clinicopathological correlation -- there is a whole
21 issue as to, once Lucy has died, the matter has not gone
22 by way of a coroner's inquest, they've got the
23 pathologist's report back, but some or other of them
24 have their concerns maybe about Lucy's treatment, why
25 there's no actual review that goes on in relation to

1 Lucy's death at the Children's Hospital since that's
2 where she died.
3 There were a number of places where that might
4 happen. One of them is the critical incident review
5 group. As we understand it, that was established
6 in March 2000, and it had weekly meetings. Dr Chisakuta
7 was a member and he sat on those meetings and the
8 purpose of the critical incident review group was to
9 review most of the critical incidents reported weekly
10 in the Children's Hospital with a view to identifying
11 lessons learned and disseminating those lessons in the
12 Children's Hospital and the rest of the Trust via the
13 Risk Management Directorate. The reference for that is
14 a witness statement that we have from Dr Chisakuta. We
15 don't need to pull it up, but it is 283/2, page 2.
16 So that put in that way would appear to have been
17 a vehicle for a discussion about Lucy's case, if it
18 hadn't already been discussed beforehand, but when asked
19 whether Lucy's case was referred to the group,
20 Dr Chisakuta says he doesn't believe it was. His role
21 on that group was to bring a medical perspective to the
22 deliberation on critical incidents with a view to
23 learning lessons. That was his role and fortuitously
24 he had been involved in Lucy's care, but he says no
25 critical incident form was completed for Lucy, therefore

1 he doesn't think it was a matter that was discussed
2 in the group. We've asked him why he didn't think that
3 would happen and the answer is in his witness statement,
4 283/2, page 3:
5 "It was not our role in the critical incident review
6 group to decide what constituted a critical incident.
7 I would observe, however, that it appears that if there
8 was a critical incident in this case, it might be deemed
9 to have happened in the Erne Hospital rather than at the
10 Children's Hospital, so that might have affected whether
11 or not it was treated as a critical incident but in the
12 Children's Hospital."
13 So Mr Chairman, one of the matters that we want to
14 explore is, if that's going to be the approach, given
15 that the Children's Hospital is very often the hospital
16 to which children are transferred who are very, very
17 seriously ill -- as Raychel was, as Lucy was, and maybe
18 others -- where the cause of their illness or their
19 conditions may well have been treatment in another
20 hospital, unless you know that that other hospital is
21 going to carry out its own review, essentially there's
22 a lacuna in review because if you're not doing it
23 because your actions didn't give rise to the child's
24 condition and you're not sure that the referring
25 hospital is going to do it, then there is the

1 possibility for a child's death simply to fall between
2 those two particular stools.
3 Those were the opportunities that existed at the
4 Children's Hospital. The coroner's office had also an
5 opportunity. There was an opportunity there for Lucy's
6 case to have been the subject of an inquest. This
7 requires just a little bit of explanation because it's
8 statutory. Section 7 of the Coroner's
9 (Northern Ireland) Act of 1959 provides this -- and I'm
10 going to summarise a little bit:
11 "Every medical practitioner who has reason to
12 believe that the person died either directly or
13 indirectly as a result of violence or misadventure or by
14 unfair means or as a result of negligence or misconduct
15 or malpractice on the part of others or from any other
16 cause other than natural causes or disease for which he
17 has been seen and treated by a registered medical
18 practitioner within 28 days prior to death, or in such
19 circumstances as may require investigation, including
20 death as a result of the administration of an
21 anaesthetic, shall immediately notify the coroner within
22 whose district the body of the deceased is of the facts
23 and circumstances of the death."
24 So that is a very broad statutory obligation placed
25 upon clinicians and it was placed upon clinicians at the

1 Children's Hospital, at the Erne Hospital, and on the
2 pathologists and any other medical practitioner who
3 formed that belief.
4 We are fortunate that the coroner who has dealt with
5 all these children is one coroner, Mr Leckey, and he is
6 the author of the text on coronial law in
7 Northern Ireland along with Mr Greer. He says that when
8 you're reporting a death, it's important to have a close
9 scrutiny of the causal chain. That causal chain is
10 a thing we saw on the death certificate and the thing
11 that had been written down in the autopsy referral form.
12 So what that was requiring is Dr Hanrahan, for example,
13 who was reporting Lucy's death to have had a close
14 scrutiny of that, so that goes back to his opportunities
15 to look at the medical notes and records, to discuss
16 with his colleagues.
17 Then they go on in that text to assert that:
18 "Where a medical practitioner believes a death is
19 reportable to the coroner, a death certificate should
20 not be issued unless, having reported the death and
21 discussed the circumstances, the coroner directs that
22 a death certificate may be issued."
23 And that's the difficulty that is to be explored
24 in the course of the hearings because Dr Hanrahan did
25 think Lucy's death was reportable. In fact, it's in

1 Lucy's medical notes and records that:
2 "If she succumbs [so even before she's died] a PM
3 would be desirable. Coroner would have to be informed."
4 And that's what he does and he reports it and
5 Mrs Dennison in the coroner's office records the fact
6 that he has done it in the main register of deaths.
7 Then he has a discussion with Dr Curtis, who's an
8 assistant State Pathologist, the contents of which
9 neither of them can remember, and the upshot of that is
10 that a death certificate is issued. But one of the
11 things to be explored is how, in the light of what has
12 been written in the text, that was possible without
13 the coroner apparently knowing about it, or having made
14 any decision in relation to it, and that's the issue to
15 be examined, and that was the opportunity for an
16 inquest. What happened instead, of course, was
17 a hospital post-mortem, which didn't appear to
18 illuminate Dr Hanrahan at least any further and then,
19 ultimately, the death certificate is issued.
20 Then that brings me to the third area and final
21 area, which is Enniskillen. By that, of course, I mean
22 the hospital, Sperrin Lakeland Trust, as it was, and the
23 Western Health and Social Services Board, and this has
24 proved to be the most difficult area for us to
25 investigate, bearing in mind the sensitivities of Lucy's

1 parents.
2 We start with Dr O'Donohoe and the possible
3 investigations and dissemination of the learning that he
4 might have had. He, as you can see from the chronology
5 that we pulled up, was called back to the hospital about
6 3.30, and he was aware at that stage that Lucy was
7 receiving normal saline. According to him, his view was
8 a 500 ml bag of normal saline was virtually complete by
9 the time he got there. So he would have known that Lucy
10 was receiving fluids that did not accord with what he
11 had directed. At that stage he wouldn't have known why,
12 but he would have known that simple fact. And if he had
13 looked at the medical notes and records, he would have
14 realised that not only was that normal saline obviously
15 not what he had directed, but her original fluid regime
16 was not recorded in accordance to what he claims was
17 directed because what's recorded is 100 ml an hour of
18 Solution No. 18 and that is not, according to him, what
19 he directed.
20 So the issue is, if he saw that and realised that,
21 what should he have done about that, what conclusions
22 should he have formed? And whatever conclusions he
23 formed about the fact that her regime was not as he had
24 intended, what should he have done with that information
25 and how might that have affected people's understanding

1 as to the cause of her death?
2 According to him, Dr Malik told him that the normal
3 saline had been started in response to Lucy's diarrhoea.
4 That happens at about 2.30, so that means she's been on
5 a rate of 500 ml an hour because in fact the record also
6 goes to show that she had 500 ml of normal saline over
7 60 minutes, and that had happened without him being
8 contacted about it. So at the very least one would have
9 thought it would have triggered some sort of enquiry as
10 to how his SHO could have so markedly departed from the
11 regime that he had directed.
12 He also knows that the repeat U&Es are done after
13 the saline, he knows that, and he is able to form
14 whatever conclusion he can about the likely level of her
15 serum sodium at 3 o'clock before the administration of
16 that quantity of normal saline. And he could have
17 brought all that information with him to the Royal, to
18 the Children's Hospital. In fact, he could have
19 communicated it to Dr McKaigue when he is telephoning
20 Dr McKaigue in the morning about having Lucy transferred
21 over.
22 What he says is that he says that he did tell them
23 about the repeat U&Es and he relied upon them seeing the
24 fluid balance chart to discover, effectively for
25 themselves, the fluids that Lucy had received.

1 Of course, at that stage he hadn't brought the notes
2 with him; the Children's Hospital had to ask for them.
3 Then he says that Dr Crean called him in the morning
4 to query Lucy's fluids and that suggested to him that
5 the fluids and quantities given were different from
6 those that he had instructed and so what he seems to be
7 saying -- and this comes from his own witness
8 statement -- is that he hadn't really identified
9 a problem with Lucy's fluids until he got that phone
10 call from Dr Crean, even though he had been there to see
11 what fluids were actually being administered to her on
12 his arrival at 3.30, and he says that when he got that
13 telephone call from Dr Crean that prompted him to
14 examine the notes. It sounds, from the way that he puts
15 it in his evidence, as if that were the first time
16 he had looked at those notes, examined the notes, and
17 then he became confirmed that Lucy had been given more
18 fluids than he had intended and that triggered a
19 telephone conversation with Dr Kelly, the medical
20 director, but he says he didn't speak to anyone else,
21 didn't speak to Dr Hanrahan, Dr Crean, in relation to
22 Lucy.
23 So the issues to be explored around that given the
24 information that he had are why wouldn't he have
25 investigated Lucy's fluid management with his colleagues

1 even before Dr Crean called him? All the information
2 that I have just been relaying he had before Lucy was
3 actually transferred. He was aware that the 500 ml of
4 normal saline had been given, he knew her neurological
5 status, her pupils were fixed and dilated, he was aware
6 her serum sodium was low. How was it that he wasn't
7 able to either put all that together himself or be
8 providing that information to the Children's Hospital,
9 or just discussing it within the Erne as to what the
10 implications of all of that might be for a child who
11 appears to have collapsed fatally so quickly?
12 So those are some of the issues that arise out of
13 that opportunity that Dr O'Donohoe seems to have had.
14 And then -- and this goes back to the point that I was
15 making earlier about communication -- why is he saying
16 that he only discussed Lucy with Dr Kelly? Why is it
17 not the most natural thing in the world to be discussing
18 what happened with Dr Malik, or to be discussing what
19 happened with Dr Auterson, or any of his other senior
20 colleagues at the Erne? And why doesn't he tell
21 Dr Crean, in a way that's recorded, what fluids Lucy
22 actually received? Why doesn't he provide that kind of
23 information, his concern that there had been some sort
24 of confusion over fluids, which is how he actually
25 reports it to Dr Kelly? Why doesn't he provide that in

1 his report for the Trust's review, when the
2 Sperrin Lakeland get round to instituting a review? Why
3 doesn't he provide that information so that that can be
4 considered along with other matters that they are
5 considering?
6 Well, it may be, though, that Dr O'Donohoe did
7 discuss, and the reason why I pose it in that way
8 is that Dr Kelly claims to have learned from Dr Malik,
9 during a conversation shortly after Lucy's death, that
10 Dr O'Donohoe had told him that the death was likely to
11 be the subject of various investigations and that he,
12 Dr Malik, should seek support from colleagues or the
13 BMA. Well, that seems to be a strange thing to be
14 discussing if that discussion took place with Dr Malik,
15 unless you thought something might have gone wrong with
16 Lucy's fluid regime. And if thought something had gone
17 wrong with Lucy's fluid regime, then you had an
18 opportunity with the review to feed that information in
19 and you also had an opportunity to see whether indeed
20 this matter should be referred back to the coroner.
21 Dr O'Donohoe also sees Lucy's parents, but according
22 to them he sees them without the benefit of Lucy's notes
23 because, according to him, he can't find them. He
24 claims to have told them that he didn't have a clear
25 understanding of what had happened, and he passed the

1 notes to Dr Kelly. But he doesn't seem to have told
2 them what he knew, which is that Lucy did not get the
3 fluids that he directed. And an issue there is why on
4 earth wasn't he trying to explore the matter further so
5 that he could provide the parents with some better
6 explanation of what had happened to their child? There
7 simply seems to be no explanation for that on the papers
8 at all.
9 Dr Hanrahan asks Dr O'Donohoe to see Lucy's parents
10 again. There's absolutely no indication that he
11 contacted Dr Hanrahan to find out why, at the most basic
12 level, so that he would know what Lucy's parents would
13 be coming to want to talk to him about. There just
14 seems to have been, on the papers, a failure to
15 communicate amongst the clinicians. In fact, there is
16 a general point to be made about the communications
17 between the clinicians and the parents. I'm not going
18 to go into that overly because I'm conscious of the
19 sensitivity of the parents. It might be very difficult
20 to hear what people say they were telling you when
21 you're not wishing to participate in the investigation,
22 but there is still an important point to be made, which
23 is that all those opportunities to discuss -- not actual
24 opportunities, all those actual meetings with the
25 parents should have created the opportunity to learn

1 more about what had happened to Lucy if for no other
2 reason than to explain it better to her parents, but it
3 doesn't seem to have had that effect, and that is an
4 issue that we can take up without trespassing too much
5 into the area of Lucy's parents.
6 Then we come to Dr Auterson. Dr Auterson does seem
7 to have actually figured out what happened. In his
8 evidence to the inquiry, he has worked out in the course
9 of resuscitating Lucy that her serum electrolytes were
10 low on repeat testing. He has formed the conclusion
11 that she had an incorrect fluid management in the sense
12 of too much of the wrong type of fluid, so he sees that.
13 He also recognises that she had become hyponatraemic.
14 So that would suggest that Dr Auterson had formed the
15 view that there might well have been an iatrogenic cause
16 contributing to Lucy's death. If he did, then what is
17 the opportunity that that created for a better
18 investigation into Lucy's cause of death, greater
19 learning as to how it had happened and therefore the
20 possibility of dissemination?
21 There doesn't seem to be any communication from
22 Dr Auterson to the Royal as to his view. He also
23 provided a report to the Sperrin Lakeland Trust review.
24 He didn't say anything about the problems with fluid
25 management or his view that that might have been

1 a contributory factor to Lucy's death, and when he's
2 asked about that, he says he thought it was an obvious
3 conclusion. It was so obvious he didn't need to say it.
4 Well, if it was that obvious then it begs the
5 question as to why others didn't and, even if it was
6 obvious, it's still an issue as to why you can't
7 communicate the obvious since the issue is about the
8 investigation into the cause of a child's death. He
9 claims he wasn't asked by the Trust to discuss what had
10 caused Lucy's condition to deteriorate and one infers
11 that by not having been asked by the Trust to discuss
12 it, he didn't think it necessary to inform them about
13 it. That's a matter that we will be taking up with him.
14 He could have raised an adverse incident report himself.
15 He could have had a discussion with Dr O'Donohoe to see
16 if Dr O'Donohoe agreed with him. He could have had
17 a discussion with any of the consultants at the
18 Children's Hospital to see if they agreed with him since
19 they're the specialists, but none of that seems to have
20 had happened.
21 So the issue then, Mr Chairman, is how can a child
22 die in such apparently unusual and unexpected
23 circumstances and yet no one seems to be tasked with
24 providing an explanation for what has happened? The
25 Sperrin Lakeland Trust established a review, which one

1 might think would have been the very opportunity, if
2 none of these other opportunities had been availed of,
3 to find the answer to that question. But our
4 investigation has suggested, at least thus far, that it
5 was conducted in such a way that the key clinicians --
6 doctors O'Donoghue, Malik, Kelly -- were not actually
7 interviewed about the events they had participated in or
8 witnessed, let alone challenged about them to be asked
9 their views. Each of the clinicians who were directly
10 involved have said that they were merely asked to
11 provide a factual account of their role. And so
12 incredible as it may seem, in their statements for the
13 review, the clinicians did not provide any opinion about
14 why Lucy had deteriorated, even those who had actually
15 formed one. None of them even provide a basic account
16 setting out the detail about the fluids she had received
17 and an explanation for why she might have received those
18 fluids and certainly not about the fluids she was
19 intended to have.
20 So the key questions simply weren't addressed to
21 those treating clinicians. What fluids were prescribed
22 and why? What fluids did she receive and why did she
23 not get what was originally time prescribed? What time
24 were the bloods taken for her repeat electrolytes? How
25 much normal saline had she received by that time? At

1 what time were her pupils fixed and dilated as opposed
2 to when Dr O'Donohoe says he first noted them? What
3 time were repeat electrolyte results available?
4 The limited accounts which are available were not
5 passed to Dr Quinn, who had ruled out interviewing
6 staff. He was largely dependent on a set of notes which
7 were already, one might think, regarded as not easy to
8 interpret, incomplete and, from Dr O'Donohoe's
9 perspective, absolutely incorrect because they were not
10 what he had directed. There was nowhere in the notes
11 where it reflected what he had directed -- there was
12 somewhere in the notes that reflected what she had
13 received -- but that disparity was not clear on the
14 notes.
15 Dr Ashgar wrote to Mr Mills on 5 June to express
16 concern about the management of Lucy's fluids and that
17 concern was brought to the attention of Dr O'Donohoe,
18 but for reasons which are unclear, it wasn't made known
19 to Dr Quinn who was carrying out the review. So given
20 that Dr Quinn was retained to look at the fluids issue,
21 that raises the question of wasn't it important to bring
22 to his attention the expressions of concern articulated
23 by other members of staff, even those who hadn't
24 directly treated Lucy?
25 So the result, Mr Chairman, was a report that might

1 have, albeit not perhaps intentionally, deflected
2 everybody from further investigation on the issue of
3 fluid management. That was the very issue that had
4 caused, really, the Trust to wish to have an
5 investigation in the first place.
6 So despite not obtaining a clear explanation for
7 Lucy's cerebral oedema, which it hadn't, the Trust did
8 not launch a further investigation. Well, that might
9 have been another opportunity. If they had seen
10 Dr Quinn's report and said, "We don't see that it's very
11 clear to us exactly what has happened, maybe we need
12 another investigation", the board and Dr Quinn each
13 claim that they advised that further steps should be
14 taken. The board claims that had raised concerns about
15 the perceived independence of Dr Quinn.
16 The Trust did receive opinions from Dr Stewart and
17 Dr Jenkins and Dr Stewart and Dr Boon, which all said or
18 at least strongly suggested that poor fluid management
19 was the cause of Lucy's deterioration. Unfortunately,
20 with the exception of the first report from Dr Stewart,
21 all that information would have emerged too late to
22 impact on how Raychel was managed.
23 But two points can be made. The findings of the
24 reports weren't shared with the coroner, the parents,
25 the Children's Hospital, and it's not clear why that

1 wouldn't have happened. And if those findings were open
2 to these experts, the findings in terms of what had
3 happened, then why weren't they reached by all the
4 others who had an opportunity to consider her case,
5 including Dr Quinn? And for that matter, why was
6 Dr Stewart's report, which was the first opportunity
7 really after Dr Quinn, not written in the more robust
8 terms that Dr Boon's report was? Those are matters that
9 we're going to explore.
10 And even though we are going to explore those during
11 the oral hearings, Mr Chairman, one thing does seem to
12 be clear, and that is until the coroner's verdict was
13 announced in 2004, it remained the publicly-stated
14 position that the cause of Lucy's death was, as has been
15 described in her death certificate, cerebral oedema due
16 to or as a consequence of dehydration and
17 gastroenteritis.
18 So Mr Chairman, the issue then is, 14 months after
19 Lucy's death, when Raychel was admitted for treatment in
20 Altnagelvin, there was a failure to identify and
21 disseminate the true cause of Lucy's death, at least as
22 it would appear on the paper. That is what gives rise
23 to the proposition that, as a consequence, the medical
24 profession and the healthcare providers in
25 Northern Ireland might have been deprived of an

1 opportunity to extract and learn appropriate lessons
2 from Lucy's death before Raychel died.
3 Then if I just may conclude with one point, although
4 made in perhaps a few different ways, which is this.
5 Having gone through all those potential opportunities,
6 we don't know whether they were real opportunities,
7 Mr Chairman, and that's one of the things we hope to
8 discover during the oral hearing so that you can rule on
9 the matter.
10 But having set them out in that way, the big
11 question becomes: if any of those opportunities had been
12 availed of, would they have led to any lessons reaching
13 the Altnagelvin Hospital in time to influence the
14 treatment given to Raychel? Because that's the point of
15 what we're looking at: it's not just to look at missed
16 opportunities for Lucy; it's missed opportunities
17 directed towards something that might have affected Lucy
18 or influenced Raychel's treatment. That is why I said
19 there's a number of points to it.
20 If there had been an inquest, whether it's because
21 Dr Hanrahan was fortified in his view from his
22 discussions with his colleagues or from a better reading
23 of Lucy's notes and therefore had simply not been
24 prepared to have a medical cause of death certificate
25 signed because he couldn't sign it in the appropriate

1 way or at least he certainly couldn't delegate it to his
2 registrar to do that, so it could have been an inquest
3 in that way. It could have been that Dr O'Hara, having
4 carried out the post-mortem felt, "I can't properly
5 explain what has happened, that chain of causation
6 that's been put to me doesn't seem terribly logical or
7 it is logical when you put in the hyponatraemia, the
8 Dr Stewart in, and one way of getting hyponatraemia is
9 excessive rehydration, that would be an iatrogenic
10 cause, I ought to put this back to the coroner". It
11 could have happened in that way and, in fact, Dr Herron
12 in Claire's case said he had done that on a number of
13 occasions, had been carrying out a post-mortem, a
14 hospital one, and realised it's something to refer to
15 the coroner. It could have happened like that or could
16 have happened because any of those clinicians in the
17 Erne, they could have thought, "This is something that
18 should go to the coroner".
19 I should say one of the reasons some of them say
20 they didn't think about reporting it is because they
21 felt that it had already been reported to the coroner
22 and was already being dealt with, with the exception of
23 Dr O'Donohoe, who apparently knows that it's not because
24 Dr Hanrahan tells him that. Why he doesn't share that
25 with his colleagues is totally unclear, but in any event

1 it could have got to the coroner in a number of
2 different ways and there could have been an inquest.
3 Then the question is: if there had been an inquest,
4 could that inquest have led to something which would
5 have had an impact on Lucy's treatment, or would it have
6 been more of the sort of outcome that one had with Adam
7 where people thought there had been learning, thought
8 it would be taken forward, but it wasn't? And if it
9 could have led to that kind of effect, what would have
10 to be the mechanism by which Altnagelvin would hear of
11 that result, appreciate its significance, and modify its
12 protocols? So that's one area.
13 Then there's another area, the clinicians, of all of
14 the ones that I have been discussing, whether they be
15 at the Children's Hospital or they be at the Erne, if
16 they could have spoken out more critically about the
17 fluid regime and its possible role in Lucy's death.
18 Well, if they had done that, what would be their vehicle
19 for doing that? Well, they could have published papers,
20 but there had been papers published before.
21 Alison Armour had published a paper. She thought
22 that Adam's death in terms of what she saw from the
23 autopsy was so striking and what she had learned in the
24 inquest was so striking that she wrote a paper about it.
25 It's not clear what audience it achieved. Dr Chisakuta,

1 he apparently gave a paper in 1998 where some of
2 those -- and we don't know, we will wait to find out --
3 at the Altnagelvin may have attended. It's not clear
4 what that would have achieved if there had been another
5 paper after Lucy.
6 It could have attracted press coverage. That might
7 have done something. Them speaking out together with
8 possibly an inquest, with the coroner now having had
9 a second case, maybe that would have been enough to give
10 it some greater attention. So that's an issue.
11 If Dr Quinn had been in a position to provide
12 a report in the more robust terms that Dr Boon did for
13 example and that had been provided to Mr McConnell on
14 the Western Board, would that have had an effect? Would
15 the Western Board have wanted to disseminate information
16 like that to the other hospitals within its area?
17 Maybe.
18 But all of these things, Mr Chairman, drive towards
19 one thing -- and it is something that we will need to
20 explore more in the Raychel governance aspect -- which
21 is: if, in all those different ways, the information had
22 got out, what really would it have taken, and what would
23 be the mechanism for it to happen, for the clinicians in
24 Altnagelvin to have changed their practice in time to
25 have affected Raychel?

1 Mr Chairman, you have heard of the fact that there
2 was some resistance to the change that even Dr Nesbitt
3 was proposing when they had their own death from
4 hyponatraemia. So those are the issues as we see them
5 just on the investigation that we have been able to
6 carry out to date, but there is much, as I hope can be
7 appreciated, that we really still need to have the help
8 of the witnesses on so that you can understand what
9 those opportunities would have achieved.
10 THE CHAIRMAN: Thank you very much indeed. For those of you
11 who don't already have it, the full copy of the opening,
12 which Ms Anyadike-Danes has just summarised, will be
13 available on the inquiry website later today. There are
14 some housekeeping issues which we have to go through,
15 but we need to take a break for a little while. We'll
16 do those at 1.30. Thank you.
17 (12.50 pm)
18 (The Short Adjournment)
19 (1.30 pm)
20 Housekeeping discussion
21 THE CHAIRMAN: For this next hour or so we need to do some
22 housekeeping. Let me explain the premise on which we're
23 doing it. There have been concerns at our end and the
24 end of various witnesses over the previous segments of
25 the inquiry that we haven't adhered very well, from time

1 to time, to the timetable that we've set out and that
2 has sometimes meant having to ask doctors, nurses and
3 Health Service managers to come back or to re-arrange
4 their schedules on a number of occasions.
5 I'm very anxious to avoid that in this segment of
6 the hearing and until the end of the inquiry at
7 Halloween. Therefore, we have prepared a schedule for
8 witnesses to give evidence. The first three weeks of
9 that schedule is with you up to Friday, 14 June. We
10 then had planned to finish the oral evidence about the
11 aftermath of Lucy's death by Thursday 20th, the
12 following week, and to do two weeks of Raychel
13 governance before the summer.
14 It now seems most likely that, in fact, the
15 aftermath of Lucy's death will run up to 27 June, which
16 will give us the following week starting Monday, 1 July,
17 to do one week of Raychel governance and then to do the
18 second week of Raychel governance in September, before
19 we go into Conor and before we go into the department.
20 Let me add, there's one more twist in that, that
21 Professor Lucas is not available to us at all until
22 Monday, 1 July, so the schedule will involve him giving
23 his evidence on Monday 1 July, and on that week we will
24 sit from Tuesday to Friday to get well into Raychel
25 governance. Insofar as Raychel's governance is

1 concerned, we have covered some of the issues to some
2 degree. There are other outstanding issues and there
3 are other issues which we need to look into in some more
4 detail, but between that week and the week in September,
5 I think it's realistic to anticipate that we can
6 complete Raychel governance.
7 But that makes it all the more important that when
8 witnesses come to give evidence, we are prepared and the
9 witnesses are prepared. And I want to highlight
10 a number of issues, which already makes that difficult
11 and which have to be corrected immediately.
12 The first is that, on Friday afternoon, after
13 4 o'clock, we received for the first time the
14 Brangam Bagnall Royal Trust file on Lucy's inquest. We
15 received it in a form which had privileged documents
16 removed from it and replaced with just a page saying
17 "privileged". Mr Lavery, why did that happen on Friday
18 afternoon?
19 MR LAVERY: It's regrettable, Mr Chairman, that it did
20 happen.
21 THE CHAIRMAN: It's more than regrettable. This is
22 a recurring theme. I'm not claiming perfection on the
23 part of the inquiry, but I have to say when I was told
24 over the weekend that this had come in on Friday
25 afternoon, I was astonished. And I am going to ask

1 Ms Simpson in a few moments -- that we haven't even yet
2 received the Sperrin Lakeland file.
3 Let's deal with the Royal file. What's going on?
4 MR LAVERY: Part of the problem, Mr Chairman, is that two
5 members of the team who were working around the clock on
6 all of these cases, two members of that team
7 unfortunately were -- one of them is still on leave.
8 One of them was on bereavement leave and another is
9 still on leave at the moment and it is hoped that she
10 might be back by the end of this week.
11 That, from a practical point of view, presented
12 a problem in terms of getting some of the information,
13 but there are other problems, Mr Chairman, which as
14 a result of these requests for information, which are
15 coming from the inquiry -- and it's not a very
16 straightforward process for the Trust once it receives
17 a request for information.
18 When that request comes from the inquiry, deadlines
19 are sometimes set, which are quite difficult for the
20 Trust to adhere to on occasion. Part of the problem in
21 relation to that, Mr Chairman, is that the Trust have to
22 identify the individuals involved, some of whom may or
23 may not be working for the Trust any more, some of them
24 may be abroad. There are archaic computer systems
25 sometimes -- Mr Chairman, it is not just a matter of

1 going to a search engine on a computer --
2 THE CHAIRMAN: Is it not obvious that if there was
3 a Brangam Bagnall inquest file in Adam's case, if there
4 was a Brangam Bagnall inquest file in Claire's case,
5 that there was going to be a Brangam Bagnall inquest
6 file in Lucy's case?
7 MR LAVERY: I accept that, Mr Chairman.
8 THE CHAIRMAN: I think the points that you have made about
9 tracking witnesses who are long gone from the Trust and
10 tracking down more random or documents which are harder
11 to trace, I accept that from time to time the requests
12 which come from us are not easy to respond to
13 immediately. I think there's a world of difference,
14 Mr Lavery, between that on the one hand and the inquest
15 file on the other. I'm also concerned, I should say,
16 about the privilege claim. Without me suggesting
17 there's anything sinister about the claim for privilege,
18 we know from previous hearings that documents for which
19 privilege is claimed turn out not to be privileged at
20 all.
21 In Raychel's case, it took a number of days for
22 Mr Johnson and Ms Dillon to go backwards and forwards --
23 and I think involving Mr Stitt as well and perhaps even
24 yourself -- before we finally got the agreed file.
25 We've received this on Friday afternoon. It's going to

1 take potentially some time -- and I'm told that the
2 request for the inquest file was sent on 23 January. So
3 while I accept you can legitimately make a general point
4 about documentation, I don't accept that it applies to
5 this file or its production on Friday afternoon.
6 My primary concern about this is to make sure that
7 we have all the documents. I want to make sure that
8 there's nothing like what there was, for instance, in
9 Raychel's case, Dr Warde's report, and I want to make
10 sure that when the witnesses come, they come, we get
11 through their evidence, and they're finished on
12 schedule.
13 I have told my team that I want these witnesses
14 dealt with on schedule. I want, for instance, when
15 Dr Chisakuta and Dr Stewart come tomorrow, I want their
16 evidence finished tomorrow so that neither of them is
17 recalled and I want that done without me sitting until
18 6 o'clock or 5 o'clock at night. That comes as good
19 news to everybody.
20 For that to be done, I need to be sure that the
21 inquiry has the relevant documents. It might be that
22 some of these files turn up not very much or things that
23 we have already in duplicate from another source, and if
24 that's the case, fine. But I'd be embarrassed to ask
25 Dr Chisakuta, for instance, to be recalled beyond

1 tomorrow because we've got late production of a file
2 which was asked for some months ago. Okay?
3 Ms Simpson, turning to you on what was the
4 Sperrin Lakeland file. The position's even worse there,
5 isn't it? We don't have it.
6 MS SIMPSON: Sir, I can only reiterate what my learned
7 friend has said. We're probably in a worse situation.
8 I can only apologise --
9 THE CHAIRMAN: What makes this worse is that we're told that
10 it is in the hands of Miss Brown to look through.
11 Miss Brown is sitting at the back of the inquiry today.
12 That means it's not being looked through today and we're
13 told we're not going to get it until Miss Brown's looked
14 through it, presumably in conjunction with the legal
15 team, and then a decision is made about what documents
16 we get. How is that going to happen this week?
17 MS SIMPSON: I honestly don't know. I will certainly stay
18 until that process is completed.
19 THE CHAIRMAN: Well, physically, is the file here today for
20 you to take? We're going to finish early this afternoon
21 obviously. Is the file physically here?
22 MS SIMPSON: Yes. Apparently the file is here.
23 THE CHAIRMAN: This needs to be sorted out or else we're
24 going to be in this position with the witnesses from the
25 West that I'm trying to avoid with the witnesses from

1 the Royal that people are going to be recalled or we're
2 going to do it in some sort of a half-baked way. And
3 I'm not for one moment claiming perfection on the part
4 of the inquiry, but with every child we've looked at to
5 date, there has been an issue about the inquest files,
6 and for us not even to have the Sperrin Lakeland Trust
7 file on Lucy's inquest on the day that we start looking
8 at the aftermath of Lucy's death is simply not
9 acceptable.
10 Mr Lavery, your turn again, I'm afraid.
11 Dr Chisakuta. I understand that Dr Chisakuta's giving
12 evidence tomorrow; right? I understand that we've
13 received a letter to indicate that as a result of
14 a consultation -- I think it says it was
15 a consultation -- that he's now going to produce
16 a further statement; is that right?
17 MR LAVERY: He has been asked to produce a statement, but
18 the terms of that statement -- I think
19 Ms Anyadike-Danes, in her opening, outlined to the
20 inquiry what the nature of that statement will be in
21 terms of the conference, the lecture that he attended
22 back in 1998, the Western Society of Anaesthetists.
23 THE CHAIRMAN: Is it going to be available this afternoon?
24 MR LAVERY: We can't say, Mr Chairman, unfortunately.
25 THE CHAIRMAN: I was told that contact was made by the

1 inquiry team with DLS over lunch and they have been in
2 touch with the Trust who were trying to contact
3 Dr Chisakuta and Dr Gannon, who for a slightly better
4 reason, wants to provide an additional statement for
5 Thursday, but nobody's contactable. If Dr Chisakuta is
6 coming tomorrow morning, is it not fair for my team to
7 say we would like to see his statement this afternoon?
8 MR LAVERY: Mr Chairman, I don't think there's going to be
9 any great surprise in the statement.
10 THE CHAIRMAN: That might be, but the Trust has a constantly
11 moving position about Solution No. 18, so that as was
12 opened by Ms Anyadike-Danes this morning, a letter
13 was sent to us saying they had stopped ordering
14 Solution No. 18 has now been reversed, but the volume of
15 Solution No. 18 that they were ordering was diminishing
16 substantially during the first half of 2001.
17 MR LAVERY: If anything, Mr Chairman, that just highlights
18 the difficulties that the Trust are under in terms of
19 gathering this information and it's important, from
20 their point of view, that they do provide the inquiry
21 with the right information. And sometimes,
22 unfortunately, when they're rushed, that can't happen
23 because a lot of the information has to be quality
24 assured. Once it is quality assured, the information
25 goes back to the DLS, the DLS then have to draft

1 a letter to the inquiry. That letter has to be
2 approved. So there is regrettably, Mr Chairman, a long
3 process and it's not just a straightforward process
4 gathering this information. Many of the doctors from
5 whom this information is sought may be in theatre -- the
6 Trust are trying to contact them in the evenings, over
7 weekends.
8 THE CHAIRMAN: There is a pretty significant issue in the
9 inquiry generally about the use of Solution No. 18.
10 Dr Nesbitt has given a statement, which has been
11 referred to, in which he says he was told -- this
12 document was referred to some months ago now. He was
13 told, he says, by Dr Chisakuta that the Royal had
14 stopped using Solution No. 18 some six months before
15 Raychel died and we were given a letter to confirm that
16 and now the Royal is saying that's not right. Is the
17 Royal now saying that's not right because Dr Chisakuta
18 wasn't spoken to when the original information was
19 provided, but he now has been spoken to? How has this
20 come about?
21 MR LAVERY: I don't have an answer to that, Mr Chairman.
22 THE CHAIRMAN: Okay. You can sit down. It's somebody
23 else's turn now.
24 Mr Green, I understand that a report was sent to the
25 inquiry last week on behalf of Dr Kelly. It was sent

1 last Thursday afternoon marked "Private and
2 confidential" for me, and it's an expert report which
3 was used by Dr Kelly, produced to the GMC last year.
4 MR GREEN: Yes, it was, sir. The position is it was
5 unclear, until we received the report of Dr MacFaul and
6 the consolidated advisers' report for this segment of
7 the inquiry, whether and if so to what extent Dr Kelly
8 was going to face prospective criticism. That report
9 was received earlier this month and then the
10 consolidated advisers' report later still was dated, as
11 you will be well aware, 15 May.
12 THE CHAIRMAN: But he had been made an interested party some
13 considerable time ago on the basis that he may face
14 criticism.
15 MR GREEN: Mr Chairman, those who instruct me were not aware
16 that he was an interested party until Miss Dillon
17 contacted Mr McMillan last week and confirmed the same
18 because one of the points he made in an exchange of
19 correspondence with her was that we still were in the
20 dark as to whether he had been made an interested party.
21 That's the position. We note that he is now because
22 we've been told so last week.
23 The position is now that last year, you will recall,
24 sir, receiving possession and therefore having sight of
25 a determination made on behalf of the General Medical

1 Council, cancelling the referral of Dr Kelly to
2 a fitness to practise hearing, in terms because it
3 wasn't felt that there was any longer a case for him to
4 answer, suggesting that his fitness to practise was
5 impaired by reason of misconduct. That report, as
6 you will recall, sir, extensively referenced Dr Durkin's
7 report and indeed that cancellation decision was based
8 very extensively on that report.
9 So it's something which we've all been aware of and
10 the inquiry indeed has been aware of for a number of
11 months now, but it was not clear, as I emphasise, until
12 Dr MacFaul's report was received and the consolidated
13 advisers' report followed hot on its feet whether and if
14 so to what extent Dr Kelly's actions in the aftermath of
15 Lucy Crawford's death were going to personally be
16 criticised. It is plain that there's at least one
17 expert who proposes now to do so and that is Dr MacFaul.
18 Therefore, to assist the inquiry, it was thought by
19 those who instruct me right that Dr Durkin's report be
20 provided to the inquiry so you could see that there is
21 another expert who has given an opinion which is
22 somewhat different. So it was in direct response, as it
23 were, to Dr MacFaul's report. This isn't the case where
24 evidence has been suppressed on a wait-and-see basis.
25 On the contrary, this is, as I emphasise, something

1 which the inquiry and you, Mr Chairman, have known of
2 for some months now. That's not a criticism of the
3 inquiry, but nor is its relatively late service, in my
4 submission, a proper basis to criticise Dr Kelly.
5 THE CHAIRMAN: In light of what you have told me, my concern
6 is Dr Kelly wasn't aware until, what, last week that
7 he was an interested party?
8 MR GREEN: Absolutely. The position is, sir --
9 THE CHAIRMAN: I will check, Mr Green, how that came about
10 because I'm staggered. I'm not sure whether it might be
11 a staggering fault at our end or whether it might be
12 a staggering fault at somebody else's end, but I'm very,
13 very surprised.
14 MR GREEN: Wherever the fault lies, Mr Chairman, we are
15 where we are with it, and the position is we are all now
16 doing our best to get this thing up and running within
17 the timetable which you properly want to keep tight.
18 THE CHAIRMAN: Thank you very much, Mr Green.
19 Mr Lavery, we got an order from the Lord
20 Chief Justice, I think, two weeks ago -- I'm moving on
21 to Claire Roberts' case now. In file 150, the records
22 of other patients, there was a reference to a patient
23 who we know as W2 and that there might be something --
24 I think there is something relevant, we're told, in that
25 patient's file, tying in with Dr Webb.

1 MR LAVERY: It may be in relation to the prescription of
2 midazolam.
3 THE CHAIRMAN: Yes. We had hoped after we got the court
4 order that that document could be provided effectively
5 by return, but I'm told there's something more happening
6 to it. Is that ... Sorry, maybe Ms Anyadike-Danes can
7 help on this.
8 MS ANYADIKE-DANES: Mr Chairman, I can help with that. What
9 we received after the service of the court order was
10 a very heavily redacted extract from W2's notes. In
11 fact, heavily redacted to the exclusion of the lines
12 that actually refer to midazolam. So all those things
13 that had previously been in the W2 notes that we have
14 were all redacted out and the references to midazolam
15 are such that they're quite difficult to make out. So
16 for reasons which aren't clear, we've now got two
17 versions of W2's notes: one which is open to relevant
18 issues, but with the particular references to midazolam
19 redacted; and another which has some of the references
20 to midazolam unredacted and everything else redacted.
21 So I think what we asked is: could you please put
22 those two together so we could have one set of available
23 notes that actually has all the information which the
24 court order has entitled us to? So that was the first
25 thing -- and while you're about it, could you please

1 check so that we can properly understand what the
2 writing is that is a bit difficult to work out?
3 The other thing we wanted to see, and partly because
4 the writing is a bit difficult to work out, and also
5 because we weren't entirely sure about some of the
6 redactions is, could you please bring to the inquiry the
7 original of the notes, as has happened in every other
8 occasion, so that I and Mr McAlinden can look at those
9 notes in the way I looked at the others? There was
10 a bit of a kerfuffle about that and ultimately that has
11 been resolved, I'm happy to say, so that Mr McAlinden
12 and I are going to look at the originals this evening.
13 So I think we have a way of resolving that because we
14 probably can mark out on a fresh set just the bits that
15 properly should be redacted and then we will be ready to
16 issue a fresh set of notes to everybody else, but that
17 has been the delay.
18 THE CHAIRMAN: Okay. Then I can leave that with
19 Mr McAlinden, Mr Lavery and Ms Anyadike-Danes. It's
20 urgent to sort that out because Mr and Mrs Roberts want
21 some finality to the odds and ends which are running
22 over from Claire's case and the sooner we get that done,
23 the better.
24 MS ANYADIKE-DANES: We'll do that this evening and make sure
25 we get to some sort of an agreed position on that for

1 you for tomorrow.
2 THE CHAIRMAN: Staying with Claire, Mr Quinn, I got a letter
3 last week, I think from your solicitors, suggesting we
4 carry out some more analysis of records. I don't think
5 that letter's been circulated. I think it is
6 particularly relevant to the Trust and may be to some of
7 the other parties. I will circulate that letter and
8 we can discuss it at some short point later on this week
9 whether to take any further action on it.
10 MR QUINN: Just for clarity's sake, that's the letter of
11 24th May?
12 THE CHAIRMAN: It's about analysis of documents.
13 MR QUINN: It's a five-paragraph letter dated 24 May 2013,
14 with reference RO298.002.
15 THE CHAIRMAN: 24 May, yes. I will circulate that and
16 we can come back to it later on this week.
17 MR QUINN: Yes, because quite clearly my submissions would
18 carry more weight if there is any point in relation to
19 the midazolam issue.
20 THE CHAIRMAN: We'll get the midazolam note circulated,
21 which will be circulated, circulate this letter, and
22 come back to this this week.
23 MR QUINN: I'm obliged.
24 THE CHAIRMAN: There's one more issue about the statements
25 coming from the Trust direction on Raychel governance.

1 Ms Simpson, although you're representing the
2 Western Trust, are you representing the old
3 Sperrin Lakeland arm of the Trust rather than the
4 Altnagelvin arm?
5 MS SIMPSON: Yes, that's absolutely right. That's my
6 understanding.
7 THE CHAIRMAN: Is it you Mr Lavery, then? Are you still
8 with Mr Stitt on the Altnagelvin end?
9 MR LAVERY: That's certainly my understanding, yes.
10 THE CHAIRMAN: There's an issue, which we need to sort out
11 sooner rather than later, and it's about the role of
12 Miss Brown in the provision of information and the
13 returning of witness statements. There has been some
14 correspondence.
15 MR LAVERY: Yes.
16 THE CHAIRMAN: Because at the moment, the witness statement
17 requests are sitting with us, waiting to go out to the
18 Trust -- and I'll open it up, particularly for Mr Quinn,
19 for your clients. The concern is that Miss Brown is an
20 interested party, but she's also the person who the
21 Trust has identified as the central person who will
22 coordinate the provision of information in order that
23 people make statements. We've been unhappy about that
24 and, again, we're not entirely sure how that can
25 possibly be coordinated if Miss Brown is going to be

1 present for significant parts of this hearing. It's
2 obviously an issue we need to sort out sooner rather
3 than later because those witness requests, the statement
4 requests, are sitting with us, waiting to go out once we
5 get some reassurance about the position. What I might
6 do -- let me leave that point for this evening and we'll
7 pick it up tomorrow morning.
8 MR LAVERY: I should say, Mr Chairman, that it will cause
9 considerable difficulties for the Trust if Miss Brown
10 has to step aside. She is the linchpin. She is
11 effectively the corporate mind of the Trust and she
12 has --
13 THE CHAIRMAN: I understand that that point has been made,
14 but she seems to be the corporate mind of what was
15 Altnagelvin Trust, of what was Sperrin Lakeland Trust,
16 and she's an interested party. The idea that there's
17 a single person in the West who can fulfil this role
18 seems, to us, to be disappointing. Let me pick it up
19 and see if there's any other way we can deal with it.
20 MR LAVERY: Yes, Mr Chairman.
21 THE CHAIRMAN: Thank you very much.
22 Mr Uberoi for Dr Taylor. There has been some
23 correspondence between your solicitors and the inquiry
24 about the extent of any further reporting from
25 Professor Kirkham. And I think the best way to approach

1 that is for us to circulate that correspondence and then
2 come back to it when people are better informed later on
3 this week. The fact that we're not going to quite
4 finish Raychel's governance areas until September makes
5 it a bit easier to deal with that because if something
6 more needs to be done with Professor Kirkham then
7 we have the summer break to ask her to engage and move
8 on. We'll debate how necessary or advisable that course
9 of action is, but I think it's better to do it when we
10 inform the various other parties about the way forward;
11 is that okay?
12 MR UBEROI: Yes. Thank you, sir.
13 THE CHAIRMAN: The only outstanding issue that I have, at
14 the end, to raise, subject to anything that anyone else
15 wants to raise, is that everyone who is giving evidence
16 this week and was due to receive a Salmon letter has
17 done so. Some of the people who are due to give
18 evidence next week have received their Salmon letters.
19 All other Salmon letters for the remainder of the
20 witnesses next week and for the week beginning 10 June
21 will be issued either by close of business tomorrow or
22 on Thursday morning. That's the morning of Thursday the
23 30th. Is there any other business this needs to be
24 sorted out this afternoon? Ms Anyadike-Danes?
25 MS ANYADIKE-DANES: I should have mentioned this before, but

1 I was waiting to get Mr Durkin's report. It relates to
2 a matter that you had raised with Mr Green. I'm anxious
3 to make sure that any of the information that comes
4 later for whatever reason, the consequences of that do
5 not end up delaying matters. You may not have had an
6 opportunity to look at that report, but a significant --
7 THE CHAIRMAN: It has been withheld from me for the moment,
8 but in light of what Mr Green has said, I can now look
9 at it.
10 MS ANYADIKE-DANES: Thank you. A significant part of it,
11 for the purposes of trying to get information in for the
12 subsequent hearing, particularly bearing in mind
13 Raychel's governance hearing, is that it refers to there
14 being communications between Dr Kelly and senior members
15 of the clinical team at Altnagelvin Hospital. Just when
16 you're looking at the report, Mr Chairman, it comes
17 under item 7. Also, there is reference to it being
18 apparent that he shared the findings of published
19 material with staff at Altnagelvin Hospital.
20 Of course, if there is any communication between
21 those at the Erne and those at Altnagelvin, then that is
22 something that we would like to see the evidence of.
23 I don't know whether any of that is recorded in writing,
24 but I'm wondering if, Mr Chairman, you can signal now
25 that, when people do provide information, they look at

1 what they're providing and, knowing what the list of
2 issues are for us all, that if they know of
3 documentation -- better yet even if it refers to it --
4 that they be a little more proactive to try and get that
5 material for us before we start having to request it
6 with all the attendant delays that sometimes brings.
7 THE CHAIRMAN: If that information -- it's a Dr Durkin who
8 provided that report, is it? If that information was
9 given to Dr Durkin, Mr Green, I'm sure there's no
10 reason -- if that information has got to Dr Durkin in
11 order for him to prepare his report, giving an expert
12 report on Dr Kelly's wrongdoing or good doing, there's
13 no reason why all of that information can't be made
14 available to the inquiry, sure there isn't.
15 MR GREEN: I agree. If it is in the possession of my
16 instructing solicitor -- and it may be for the reason
17 you rightly identify -- that will be done.
18 Could I mention a slight difficulty which has
19 arisen, which is that the Trust was written to, or DLS
20 was written to, in the last few weeks by Mr McMillan on
21 behalf of Dr Kelly asking for the provision of copies of
22 all records relating to this segment of the case which
23 referred to or related to Dr Kelly? And the response
24 which Mr McMillan received, if I can give you the
25 shortened version of what it amounts to, is, "No, sorry,

1 privileged".
2 THE CHAIRMAN: Sorry, what could the privilege attach to?
3 MR GREEN: It goes back to a point that you made a moment
4 ago: that privilege seemed to be being asserted here at
5 various turns where there, in fact, is no conceivable
6 basis for asserting that privilege.
7 THE CHAIRMAN: Well, if Mr McMillan could provide that
8 correspondence to the inquiry later this afternoon,
9 that's an issue we'll pick up tomorrow. Because I see
10 Dr Kelly is due to give evidence on Wednesday the 12th.
11 We'll sort out any privilege issues about that request
12 tomorrow.
13 MR GREEN: I'm very grateful because that will assist us as
14 well as the inquiry. Thank you.
15 THE CHAIRMAN: Ladies and gentlemen, unless there are any
16 other issues, I will rise now and we'll start tomorrow
17 morning at 10 o'clock sharp.
18 Ms Anyadike-Danes, is it Dr Chisakuta first or
19 Dr Stewart?
20 MS ANYADIKE-DANES: Dr Chisakuta first, Mr Chairman.
21 THE CHAIRMAN: Thank you very much indeed.
22 (2.05 pm)
23 (The hearing adjourned until 10.00 am the following day)
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25