1 Monday, 20 February 2012

2 (10.00 am)

3 (Delay in proceedings)

4 (10.10 am)

5 THE CHAIRMAN: First of all, ladies and gentlemen, thank you
6 for coming today. Everyone is welcome to the opening of
7 this Inquiry. As you know, from a note which was issued
8 by me on Friday, there have been developments and they
9 will be the subject of debate later on today. But
10 before we get into that area, I now want to invite
11 Ms Anyadike-Danes, senior counsel to the Inquiry, to
12 give her opening address.

13 After she has completed that, any other party who
14 has signalled an intention to make an opening submission
15 will do so and, after the opening submissions are
16 complete, we will then turn to deal with the immediate
17 issue, which was the subject of Friday's note.

18 Ms Anyadike-Danes?

19 Opening by MS ANYADIKE-DANES

20 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
21 I wonder if we could just check if the IT is working as
22 I see that screen doesn't seem to be. (Pause).

23 First, may I introduce myself. I am
24 Monye Anyadike-Danes, senior counsel to the Inquiry.
25 I should like to start by saying that the whole of the

1 whole legal team is very much aware that we are dealing
2 here with the deaths of young children, some of whom
3 were very young and some were the only child or the only
4 daughter. On behalf of us all, I should like to express
5 our condolences to the families of the children.
6 However, this Inquiry is not just about the deaths
7 in hospital of Adam Strain, Claire Roberts, Lucy
8 Crawford, Raychel Ferguson and Conor Mitchell, nor is it
9 just about the role of hyponatraemia and the intravenous
10 administration of what has become known as "Solution No.
11 18" played in their deaths or any other mechanism that
12 might have led to the gross cerebral oedema and coning
13 although it involves all of those matters -- but
14 arguably the legacy questions which arise from them
15 are: how should lessons be learned from the deaths of
16 children in hospital so as to reduce the incidence of
17 such deaths recurring? Who has the responsibility to
18 ensure that those lessons are learned and practices
19 changed accordingly?
20 Nevertheless, the deaths of Adam, Lucy and Raychel
21 were instrumental to the establishment of this Inquiry
22 and the deaths of Claire and Conor are also crucial for
23 the issues the Inquiry is to consider and may well be so
24 for the recommendations that you, Mr. Chairman, will make
25 in due course.

1 I shall therefore start by briefly saying something
2 about each of the children. What I say now is not
3 intended to be an opening into the issues concerning the
4 cases of the individual children; there will be separate
5 openings for the cases of Adam, Claire and Raychel,
6 which will include Lucy's death and its aftermath, and
7 for Conor. I also need to say that the Inquiry's
8 investigations are continuing into some of the clinical
9 issues in Adam's case and clinical issues into the cases
10 of the other children. Furthermore, the investigation
11 into the governance issues for all of the children's
12 cases and the position of the department is still
13 continuing. Accordingly, what I can say in this general
14 opening will, to some extent, be constrained by the need
15 to ensure that those investigations are not compromised.
16 So then if I start with the children and start with
17 Adam, who is first in time. Adam Strain was born on
18 4 August 1991 and he was an only child. He was born
19 with cystic, dysplastic kidneys with associated problems
20 with the drainage of his kidneys relating to obstruction
21 and vesico ureteric reflux. There is a glossary of
22 medical terms and we have prepared that and it has been
23 compiled for Adam's case and there will be one for the
24 cases of each of the other children. I'm going to call
25 that up now. The actual glossary is at

1 reference 303-002-011, but I'd like to call up the
2 particular part of that glossary that deals with Adam's
3 diagnosis. If I can call up 303-002-022.
4 And then we can see there the term "dysplastic
5 kidneys". So far as we have been able to do it, all the
6 medical terminology that has been used, whether it's in
7 expert reports or in witness statements, has been
8 reduced to this glossary. This is really in aid of you
9 and us, for that matter. And if we go to the other part
10 of his diagnosis -- and if I call up now 303-002-047,
11 you can see there the vesicoureteral reflux. There you
12 see it.
13 In general, therefore, unless it is of particular
14 significance to a matter in issue, I shall not provide
15 a definition of medical terms and conditions. However,
16 for present purposes, Adam's condition basically meant
17 that his kidneys were abnormally formed before birth,
18 causing them to be small and to function poorly and
19 improperly. But despite his medical problems, his
20 mother describes Adam as a very happy, content child who
21 was full of energy and bore bravely the very many
22 procedures that he had to undergo. He was his mother's
23 only child and she has provided a handbook, "Adam Strain
24 and the Hyponatraemia Public Inquiry", as a tribute to
25 him. I should say that all these documents that I refer

1 to I have provided a reference, and when you get the
2 written opening or you look at it online, you'll be able
3 to see all the documents that I have referred to.
4 Adam was placed on the kidney transplant register on
5 24 November 1994. On 26 November 1995, there was an
6 offer of a kidney for Adam and he was admitted to the
7 Royal Belfast Hospital For Sick Children that evening.
8 Adam's kidney transplant surgery was commenced the
9 following morning. His consultant nephrologist was Dr
10 Maurice Savage who was professor of paediatrics at
11 Queen's University Belfast. He was not available for
12 the entirety of the surgery and cover was provided by
13 another consultant nephrologist, Dr Mary O'Connor. The
14 transplant surgeon was Mr Patrick Keane and he was
15 assisted by Mr Stephen Brown, who was also at the
16 Belfast City Hospital.
17 The anaesthetist was Dr Robert Taylor and he was
18 assisted by Dr Terence Montague, who has since left the
19 Royal Belfast Hospital For Sick Children. Dr Montague
20 did not remain for the entirety of the surgery. There
21 is an issue to be addressed in the oral hearing in
22 Adam's case as to whether or not Dr Montague was
23 replaced and, if so, by whom.
24 A comprehensive list of persons has been provided in
25 Adam's case, which shows the title, grade and role of

1 all those involved in Adam's clinical case, and I'm just
2 going to pull up one part of the beginning of it to show
3 you how it works. That's at reference 303-001-001. If
4 you see that now, you will see that there is a reference
5 to the witness number down at the immediate left and
6 then there is the name of the witness, the position they
7 hold, a description of their role and then, towards the
8 right-hand side, there are columns which indicate
9 whether they've made statements previously and, if so,
10 when they made them and for whom they made them. If I
11 just show one by way of example. Can we look at
12 Dr Alison Armour there?
13 You see that she's witness 12. You see what her
14 position was. And you see where she is now. She's now
15 consultant pathologist, Royal Preston Hospital. You can
16 see her role, she carried out the post-mortem
17 examination of Adam and reported the cause of his death.
18 If you go back again to the main part of that, if you're
19 still following along that line, you'll see she provided
20 a deposition to the coroner, she also made a statement
21 to the PSNI. She has made two statements for the
22 Inquiry and she is a proposed witness.
23 That list of persons works its way through in that
24 form with different categories, whether they are main
25 medical clinicians -- that means that they were involved

1 in the 26th to 29th -- or there were other medical
2 clinicians -- and that means they were involved at some
3 time with Adam prior to that date -- whether they are
4 experts, if so who for, and so on. It is there for you
5 to see and is intended to assist you as you hear the
6 names called or work your way through them to know who
7 these people are and what role we think they may have
8 had.
9 A similar list will be provided for each of the
10 other children's cases as well as for the governance
11 issues. There's a companion document which has been
12 compiled, providing the nomenclature and grading of
13 doctors, together with a similar document for nurses.
14 We can look at that quickly. The one for doctors is
15 referenced at 303-002-048. There you see the purpose of
16 this is really to help you a little bit with the
17 nomenclature for the various doctors and their grading
18 and, as that happened over time -- and I have pulled up
19 the first page there -- but it goes on through to show
20 all the positions. If we call up the equivalent for
21 nurses, 303-003-051, there's the equivalent for nurses.
22 Unless it is of particular relevance to the issues,
23 I will not propose to deal with grading or training of
24 any particular clinician. Obviously, I will give their
25 position, but I will leave it for the nomenclature to

1 assist you in what that actually means. Obviously, if
2 something turns on it, then we will address it.
3 An important issue for the Inquiry in Adam's case,
4 as with all the cases, is the nature of the intravenous
5 fluids he received. Adam and several of the other
6 children were administered an intravenous solution of
7 0.18 per cent sodium chloride in 4 per cent dextrose,
8 which is known colloquially as Solution No. 18. Over
9 the course of his surgery, from the initial preparation
10 for anaesthesia to the end of his surgery, Adam received
11 1,500 ml of that solution, along with approximately
12 1,500 ml of blood and other solutions. The type, volume
13 and rate of administration of the intravenous fluids are
14 issues for the Inquiry in all the cases.
15 Unfortunately, Adam did not recover from his
16 transplant surgery and he died on 28 November 1995.
17 An autopsy was carried out on 29 November 1995 by Dr
18 Alison Armour, who was then a senior registrar in
19 forensic science at the State Pathologist Department.
20 The extent to which she sought and received specialist
21 assistance with it from Dr Mirakhur, who was then the
22 consultant neuropathologist at the Royal, and Dr Denis
23 O'Hara, who was a consultant paediatric pathologist, now
24 deceased, or Dr Bharucha, then a consultant
25 haematologist at the Royal, and the extent to which any

1 of that input is reflected in her report and autopsy are
2 all matters to be addressed in the oral hearing in
3 Adam's case.
4 Also on 29 November 1995, Adam's death was referred
5 to Mr John Leckey, then the Coroner for Greater Belfast.
6 He now holds the position of Senior Coroner for
7 Northern Ireland. Mr Leckey was also the coroner for
8 the inquests into the deaths of all the other children.
9 An inquest was conducted into Adam's death on 18 June
10 and 21 June 1996 by the coroner and he engaged a number
11 of experts to assist him, Dr John Alexander, firstly.
12 He was consultant anaesthetist at Belfast City Hospital;
13 he's now retired. He concluded that:
14 "The complex metabolic and fluid requirements of
15 this child having major surgery led to the
16 administration of a large volume of hypotonic saline,
17 which produced a dilutional hyponatraemia and subsequent
18 cerebral oedema."
19 He also expressed the view that hyponatraemia and
20 subsequent cerebral oedema -- and the view that the
21 problem could not be recognised until the surgery was
22 completed.
23 The coroner also had Dr Edward Sumner, who was then
24 the consultant paediatric anaesthetist at Great Ormond
25 Street. He concluded:

1 "On the balance of probabilities, Adam's gross
2 cerebral oedema was caused by the acute onset of
3 hyponatraemia from the excess administration of fluids
4 containing only very small amounts of sodium. This
5 state was exacerbated by the blood loss and possibly by
6 the overnight dialysis. A further exacerbating cause
7 may have been the obstruction to the venous drainage of
8 the head. If drugs such as antibiotics were
9 administered through a venous line in a
10 partially-obstructed neck vein then it is possible that
11 they could cause some cerebral damage as well."
12 And he went on to comment in his evidence to
13 the coroner:
14 "I believe that without the venous drainage problem,
15 Adam may have survived, provided his serum sodium level
16 did not drop below 123."
17 Professor Jeremy Berry, another expert who was
18 available to the coroner, he was from the department of
19 paediatric pathology at St Michael's Hospital, Bristol.
20 He had the benefit of histological slides and concluded
21 that:
22 "Oedema was not conspicuous in the lungs. Curious
23 foci of clear cell change in heptocytes scattered
24 throughout the liver substance [the significance of
25 which he did not know] and that the transplant kidney

1 was infarcted [dead]. The extent of the change
2 suggested that this occurred at or before the time of
3 transplantation."
4 Dr Sumner was also appointed by the coroner as an
5 expert in the inquest into the deaths of all the other
6 children, save for Claire, whose inquest was held in
7 2006. Accordingly, the coroner had the benefit of
8 Dr Sumner's view of the relationship between the
9 administration of excessive amounts of low sodium
10 fluids, hyponatraemia, and gross cerebral oedema in the
11 cases of four of the children, all with different
12 presentations, and spanning a period of eight years.
13 The significance, if any, of that consistency of view is
14 a matter being considered by the Inquiry.
15 The verdict on inquest -- and we can pull that up
16 for Adam at document 011-016-114 -- there you see it.
17 That identified cerebral oedema as the cause of
18 Adam's death with dilutional hyponatraemia and impaired
19 cerebral perfusion as contributory factors. And
20 the coroner found that the onset of cerebral oedema was
21 caused b y the acu te onset of hyponatraemia from the e xcess administration of fluids containing only very small amounts of sodium and
22 this was exacerbated by blood loss and possibly the
23 overnight dialysis and the obstruction of the venous
24 drainage from the head. The inquest verdict is recorded
25 on Adam's death certificate as the cause of his death.

1 The effect of the fluids that were administered to
2 Adam, their content, infusion rate and total amount will
3 be addressed in the oral hearing in to his case. So too
4 is the extent to which there was any obstruction of the
5 venous drainage from Adam's head, and if there was, how
6 it occurred and what effect it had.
7 In the course of giving evidence to the inquest,
8 Dr Taylor produced a draft statement on future practice,
9 the contents of which were reported in the media. It
10 seems that that statement was the product of all the
11 consultant paediatric anaesthetists at the time, namely
12 Dr Taylor, Dr Peter Crean who was a consultant in
13 paediatric anaesthesia in intensive care, Dr Seamus
14 McKaigue, he was a consultant paediatric anaesthetist,
15 as well as being approved by Dr Joseph Gaston. He was
16 consultant anaesthetist and clinical director for
17 anaesthesia, theatres and intensive care. The coroner
18 has expressed a view that he had assumed that the
19 Belfast Hospital For Sick Children would have circulated
20 other hospitals in Northern Ireland with details of the
21 evidence given at the inquest and possibly some best
22 practice guidelines.
23 The reasons why he might have formed that view
24 precisely what happened to the statement, and more
25 generally what happened as a result of Adam's death, are

1 all matters to be investigated during the oral hearing
2 in Adam's case.
3 If I move now to Claire. Claire was born on
4 10 January 1987. She was the youngest of three children
5 and the only daughter and she is described by her father
6 as a little girl who had overcome her early setbacks and
7 was happy, active and much loved. During her early
8 childhood, she had suffered from convulsions, for which
9 she was prescribed Tegretol and then Epilim. However,
10 her convulsions appeared to have ceased from
11 about September 1991, when she was four years old, and
12 she was weaned off the Epilim over a period of a few
13 months from February 1995.
14 On 21 October 1996, Claire's GP, Dr Savage,
15 referred her to the Belfast Hospital For Sick Children
16 with a recent history of malaise, vomiting and
17 drowsiness. She was admitted to Allen Ward under the
18 care of Dr Heather Steen, who was a consultant
19 paediatrician. She was seen there by a number of nurses
20 and doctors, including Dr Andrew Sands -- he was
21 a paediatric registrar -- who sought specialist
22 assistance from Dr David Webb, and he was a consultant
23 paediatric neurologist. Precisely which of those two
24 consultants, Dr Steen or Dr Webb, had the responsibility
25 for Claire's care and treatment from approximately

1 1400 hours onwards on 22 and 23 October 1996, together
2 with the implications of that, are matters being
3 investigated by the Inquiry.
4 On her admission on 21 October 1996, Claire was
5 prescribed IV fluids by the admitting doctor, Dr Bernie
6 O'Hare, paediatric registrar. Like Adam, she was
7 administered solution No. 18, which she continued to
8 receive during her time on Allen Ward. Again, the
9 appropriateness of the type, rate and volume of fluid
10 administered to Claire are issues to be considered by
11 the Inquiry.
12 There are a number of other important aspects of the
13 care and treatment that Claire received during the
14 course of her stay on Allen Ward that are under
15 investigation. Early in the morning of 23 October 1996
16 at approximately 2.30, before she was seen by Dr Steen,
17 Claire suffered a respiratory arrest and was transferred
18 to the Paediatric Intensive Care Unit. She was seen
19 there by Dr Taylor who was involved in Adam's kidney
20 transplant surgery. Dr McKaigue, who was the consultant
21 on call when Claire was admitted to PICU and Dr Crean is
22 noted as the consultant on the case note discharge
23 summary. Both of them were involved with Dr Taylor in
24 production of the draft statement on future practice,
25 which was produced after Adam's death.

1 Unfortunately, Claire did not recover and she died
2 in PICU on 23 October 1996. Her death was not reported
3 to the Coroner and a brain-only autopsy was carried out
4 on 24 October 1996 with the permission of Claire's
5 parents. The basis on which such a decision was made
6 and the reasons for it are matters being investigated by
7 the Inquiry.
8 The pathologist on the autopsy report is shown to be
9 Dr Brian Herron, who was then a senior registrar in
10 neuropathology, but the report itself is unsigned. At
11 that time, Dr Mirakhur was his consultant
12 neuropathologist. She is the same consultant whose
13 involvement in the production of Dr Armour's autopsy
14 report on Adam is in issue. The autopsy report was not
15 conclusive. It found that the features of the brain
16 were those of:
17 "... cerebral oedema with neuronal migrational
18 defect and a low grade meningo-encephalitis. The
19 reaction in the meninges and cortex is suggestive of
20 viral aetiology, although some viral studies were
21 negative during life and on post-mortem CSF. With a
22 clinical history of diarrhoea and vomiting, this is
23 a possibility, though a metabolic cause cannot be
24 excluded. As this was a brain-only autopsy, it is not
25 possible to comment on other systemic pathology in the

1 general organs."

2 Claire's death certificate showed the cause of her
3 death as cerebral oedema and status epilepticus. That
4 was called into question after a UTV television
5 documentary into the deaths of Adam and two of the other
6 children, Lucy and Raychel, was aired in 21 October
7 2004. Claire's parents watched that programme and it
8 prompted them to contact the Belfast Hospital For Sick
9 Children about the circumstances of their daughter's
10 death. During a meeting with the Belfast Hospital For
11 Sick Children's personnel and Claire's parents on
12 7 December 2004, a query was raised over the role that
13 fluid management, especially low sodium, might have
14 played in Claire's death. The reason why that was not
15 appreciated sooner by the Belfast Hospital For Sick
16 Children is a matter being investigated by the Inquiry.

17 The coroner was notified and an inquest into
18 Claire's death was carried out by John Leckey on
19 4 May 2006. He engaged experts to assist him.
20 Dr Robert Bingham, who was paediatric consultant
21 anaesthetist at Great Ormond Street. He pointed out
22 that the current guidance to use fluid with higher
23 sodium content was not in place when Claire was being
24 treated in 1996. He referred to confusion over Claire's
25 usual neurological status and the effects of that on

1 diagnosis and treatment. He presented a mixed picture:
2 "The hyponatraemia was probably an associated
3 feature of Claire's condition, rather than the primary
4 illness. It was most likely to have been a result of
5 the combination of raised levels of antidiuretic
6 hormone, together with the intravenous infusion of low
7 sodium content, although the volumes infused do not
8 account for the sodium becoming so low.
9 "I think it most likely that hyponatraemia was
10 a cause of the neurological deterioration. It is not,
11 however, possible to completely exclude the possibility
12 that the serum sodium result was an isolated artefact
13 and the deterioration was due to acute encephalopathy."
14 Dr Ian Maconochie, he was the consultant in
15 paediatric A&E medicine at St Mary's London, he
16 considered that the management plan to treat the
17 possibility of non-convulsive status epilepticus was
18 correct at the time of practice, as was her subsequent
19 management in terms of her neurological presentation.
20 The verdict on inquest -- and that is a document
21 that we can pull up and see. Its reference is
22 091-002-002.
23 That found the cause of Claire's death, as you can
24 see there, to be:
25 "1(a), cerebral oedema due to (b)

1 meningo-encephalitis."

2 Then it goes:

3 "Hyponatraemia due to excess ADH production and
4 status epilepticus."

5 The coroner also made findings, principally, that
6 the degree of hyponatraemia that she suffered -- and
7 that's a fall in her serum sodium level to 121 --
8 contributed to the development of the cerebral oedema
9 that caused Claire's death, but that the
10 meningo-encephalitis and status epilepticus were also
11 causes, albeit he could not determine the proportionate
12 contribution of the three conditions to her death.

13 The coroner accepted Dr Steen's evidence at inquest
14 that the blood test showing 121 should have been
15 repeated and that there should have been a reduction in
16 her fluids. He noted Dr Steen's evidence that now the
17 fluid management of Claire would have been different.
18 That latter point is a matter that is to be investigated
19 by the Inquiry.

20 The coroner's finding gave rise to a new
21 registration on 10 May 2006 with the cause of Claire's
22 death so as to reflect the coroner's verdict on inquest.
23 The reissued death certificate does not appear to have
24 been issued until 2 February 2012. The circumstances in
25 which there was a new registration and the issuance of

1 a new death certificate are all matters being
2 investigated by the Inquiry.
3 If I turn now to Lucy. Lucy was born on
4 5 November 1998. She was the youngest of her parents'
5 three children and was described by her mother as
6 "a very special little girl". Lucy was admitted to the
7 Erne Hospital in Enniskillen on 12 April 2000, at about
8 19.20, about a recent history of drowsiness and
9 vomiting. She came under the care of Jarlath O'Donohoe,
10 consultant paediatrician, and was also treated by
11 Dr Malik, a senior house officer in paediatrics, and
12 a number of nurses. It is understood that following
13 admission, Lucy was given a 100 mil bolus of fluids and
14 juice and that she started on IV fluids at approximately
15 22.30. The IV fluid was Solution No. 18 and it appears
16 to have been accepted by clinicians and nursing staff
17 that this was given at the rate of 100 ml an hour. At
18 approximately 2.55 on 13 April 2000, Lucy suffered
19 a seizure and was transferred to the intensive care unit
20 at the Erne Hospital where steps were taken to stabilise
21 her for transfer to the Belfast Hospital For Sick
22 Children. She was taken to the Belfast Hospital For
23 Sick Children in a seemingly moribund state, by
24 ambulance, accompanied by Dr Jarlath O'Donohoe and was
25 admitted to PICU there under the care of Dr Peter Crean.

1 She was "hand-bagged" throughout the 90-minute trip by
2 either Dr O'Donohoe or the nurse, Siobhan McNeill, who
3 accompanied him.
4 For those unfamiliar with the geography, the
5 difference between those two hospitals can probably best
6 be appreciated by a map. If I can call up the
7 reference. There you are. If you look at that, you can
8 see, to the bottom left, the Erne Hospital in
9 Enniskillen. And then if you look across to the right,
10 you will see where the Belfast Hospital For Sick
11 Children is. And there's a blow-up to the far right.
12 That map also shows you the trusts and the boards as
13 they were at that time. That's pretty much across
14 Northern Ireland she was being driven.
15 Lucy was seen at the Royal Belfast Hospital For Sick
16 Children by Dr Hanrahan, Dr Chisakuta, and by a
17 specialist registrar in paediatrics, Dr Caroline
18 Stewart. Lucy was declared dead at 13.15 on 14 April
19 and her death was reported to the coroner's office that
20 day. It was decided that it was unnecessary to conduct
21 a coroner's post-mortem. Quite how that decision came
22 to be made is a matter that may be investigated by the
23 Inquiry. Nevertheless, it was agreed with the consent
24 of Lucy's parents, but apparently without the knowledge
25 of the coroner's office, that there would be a hospital

1 post-mortem. The autopsy request form, dated
2 14 April 2000, was sent by Dr Caroline Stewart to
3 Dr Denis O'Hara and it recorded the following clinical
4 diagnosis:
5 "Dehydration and hyponatraemia, cerebral oedema,
6 acute coning plus brainstem death."
7 Dr O'Hara is the same pathologist who is referred to
8 by the coroner as having, along with Dr Bharucha, seen
9 certain slides in relation to Adam's autopsy and
10 expressed certain views. He conducted the hospital
11 post-mortem on Lucy later that day.
12 THE CHAIRMAN: If you just pause for one moment. I should
13 say now, for the record and to get this out of the way,
14 that the Doctor Denis O'Hara, who's been referred to
15 a number of times, is no relation of mine. He is now
16 dead, but he and I are not in any way related.
17 MS ANYADIKE-DANES: Thank you, sir. I should have made that
18 clear myself. Thank you for doing so.
19 Lucy's death was certified by Dr Dara O'Donoghue
20 as being caused by "cerebral oedema due to or as
21 a consequence of dehydration and gastroenteritis".
22 Lucy's death certificate showed the cause of her death
23 as:
24 "1(a) cerebral oedema, (b) dehydration and (c)
25 gastroenteritis."

1 On 14 April 2000, Lucy's death was notified to the
2 Sperrin Lakeland Trust by Dr O'Donohoe and on or about
3 18 April 2000, Mr Eugene Fee, who is director of acute
4 hospital services at the trust, took the decision to
5 instigate a review of the care that Lucy had received at
6 the Erne Hospital. The following day, on 19 April 2000,
7 Mr Hugh Mills -- he was chief executive of the Sperrin
8 Lakeland Trust -- informed Martin Bradley, who was chief
9 nurse at the Western Health and Social Services Board,
10 of the issues.
11 The review was coordinated by Mr Fee with
12 a Dr William Anderson, and he was clinical director of
13 the women and children's directorate at the
14 Erne Hospital.
15 In addition, on 20 April 2000, Mr Mills asked
16 a Mr Murray Quinn, he was consultant paediatrician at
17 Altnagelvin Area Hospital, to contribute to the review
18 by examining the fluid regime which was adopted with
19 Lucy and providing an external paediatric opinion on the
20 management of her care. Dr Quinn was provided with
21 Lucy's clinical notes and asked to provide his opinion
22 on three issues:
23 "1, the significance of the type and volume of fluid
24 administered. 2, the likely cause of the cerebral
25 oedema. 3, the likely cause of the change in the

1 electrolyte balance."

2 At that time, the Erne Hospital and Altnagelvin Area

3 Hospital were in different trusts, respectively the

4 Sperrin Lakeland Trust -- in fact, we can see that on

5 the map that's still there -- and Altnagelvin Group of

6 Hospitals trust. However, as is clear from that map,

7 they were both under the same Western Health and Social

8 Services Board. The extent to which that may have been

9 significant is something that is being investigated by

10 the Inquiry.

11 Dr Quinn provided a draft report which was

12 incorporated into the final review report of Mr Fee and

13 Dr Anderson, dated 31 July 2000. The review report

14 rehearsed Dr Quinn's view that the total volume of fluid

15 intake was within the accepted range. He also stated

16 that:

17 "Neither the post-mortem result or the independent

18 medical report on Lucy Crawford provided by Dr Quinn can

19 give an absolute explanation as to why Lucy's condition

20 deteriorated rapidly, why she had an event described as

21 'a seizure' at around 2.55 on 13 April 2000, or why

22 cerebral oedema was present on examination at

23 post-mortem."

24 Lucy's death was not reported to the Coroner's

25 office by the Erne Hospital or by the Sperrin Lakeland

1 Trust. The significance of that, as is the failure to
2 inform the coroner that a hospital post-mortem was being
3 carried out are matters that are being investigated by
4 the Inquiry.
5 The review, Dr Quinn's report and exactly what was
6 done at the Erne Hospital as a result of Lucy's death
7 was the subject of a critical UTV documentary broadcast
8 in October 2004. It is also an issue to be investigated
9 by the Inquiry as is what happened at the Belfast
10 Hospital For Sick Children after Lucy's death.
11 Following the inquest into Raychel's death on
12 5 February 2003, the circumstances of Lucy's death were
13 referred to the coroner, who applied to the Attorney
14 General of Northern Ireland for a direction that an
15 inquest should be held into Lucy's death.
16 On December 2003, the legal secretariat for the
17 Attorney General's chambers notified the coroner that
18 the Attorney General had made an order, directed him to
19 carry out an inquest into the circumstances surrounding
20 Lucy's death. The coroner invited Dr O'Hara to convert
21 his hospital post-mortem report of 17 April 2000 into
22 a coroner's report. Dr O'Hara furnished such a report,
23 dated 6 November 2003, in which he expressed the view
24 that there were two potential causes:
25 "Firstly, hyponatraemia causing cerebral oedema due

1 to disturbance which occurs in the quantities of water
2 moving into the brain. Secondly, bronchopneumonia, both
3 toxic and hypoxic effects, and is also well-known as
4 a cause of cerebral oedema."
5 He concluded that it would be difficult to be
6 certain what proportion of the cerebral oedema could be
7 ascribed to each of those processes.
8 Unfortunately, Dr O'Hara is deceased, as the
9 chairman has said, and we have only his two reports and
10 his letter to the coroner of 23 October 2003 to assist
11 us with his views on what happened, particularly in the
12 light of the opinion of Dr Edward Sumner, who was
13 engaged by the coroner as an expert. And this is what
14 Dr O'Hara said in that letter of 23 October:
15 "I have read Dr Sumner's report and believe that
16 this will pose difficulties in that he confuses matters
17 of fact with matters of opinion and approaches the
18 matter in a some what 'tunnel vision' way. There is
19 a history of a presentation which will be entirely
20 consistent with an infective condition and then there
21 is, as pointed out by Dr Sumner, objective evidence of
22 hyponatraemia. The problem is that both these
23 conditions can bear directly on the brain and give rise
24 to the problems of which were the ultimate cause of
25 death, namely the cerebral oedema with its effect on

1 vital respiratory and cardiac centres."
2 The inquest was conducted by John Leckey from
3 17 February to 19 February 2004, and in addition to
4 Dr Sumner's expert report, he also had the benefit of
5 two other expert reports. There was Dr Dewi Evans, he
6 was consultant paediatrician at the Singleton Hospital
7 in Swansea and was engaged for Lucy's parents.
8 He pointed out that if Lucy had been managed
9 according to the basic standards of paediatric practice
10 from a district general hospital, then it was, in his
11 opinion, extremely unlikely that she would have
12 developed cerebral oedema, ie treating Lucy with
13 a standard therapy for children with gastroenteritis
14 would have prevented the cerebral oedema and prevented
15 the neurological collapse.
16 He also had available to him the report of Dr John
17 Jenkins and he was senior lecturer in child health and
18 consultant paediatrician at Antrim Hospital, engaged by
19 the Directorate of Legal Services for Sperrin Lakeland
20 Trust. He pointed to the absence of clear
21 documentation regarding the fluid type and rate
22 prescribed, together with clear records as to the exact
23 volumes of each fluid, which were in fact received by
24 the child throughout the time period concerned and the
25 confusion between the staff involved.

1 The implications of the observations of those
2 experts for lessons learned, hospital management and,
3 indeed, for governance generally are matters being
4 investigated by the Inquiry. The verdict on inquest of
5 Lucy's death -- and we can see that document,
6 031-067-113. Pull that up.
7 You can see the cause of death. It found:
8 "1(a), cerebral oedema, (b), acute dilutional
9 hyponatraemia, (c) excess dilute fluid, and, 2,
10 gastroenteritis."
11 The coroner also made findings that the dilutional
12 hyponatraemia was caused by a combination of the
13 inappropriate fluid replacement therapy, 0.18 per cent
14 saline, and a failure to properly regulate the rate of
15 infusion. There were other findings in respect of the
16 poor quality of the medical record keeping and the
17 confusion amongst the nursing staff as to the fluid
18 regime prescribed having compounded the errors in fluid
19 management.
20 As a result of the inquest, Lucy's death certificate
21 was amended to show the cause of her death as shown
22 in the coroner's verdict on inquest.
23 I turn now to Raychel. Raychel Ferguson was born on
24 4 February 1992. She was her parents' only daughter and
25 a sister to three brothers. Her mother describes her as

1 a lively, chatty outgoing girl who loved fashion and
2 music. Raychel had never previously been admitted to
3 hospital until she was admitted to the Altnagelvin Area
4 Hospital on 7 June 2001. Following her arrived in the
5 Accident & Emergency unit with a recent history of
6 abdominal pain and complaining of dysuria and nausea.
7 That's painful -- including burning -- urination and
8 difficult urination. She was admitted to the children's
9 unit of Altnagelvin Hospital and came under the care of
10 Mr Robert Gilliland, who was a surgical consultant,
11 although he did not see her during her admission to the
12 Altnagelvin Area Hospital, and apparently did not
13 appreciate that a patient under his care had died until
14 the day after her death.
15 Raychel was examined by Mr Makar, who was a surgical
16 senior house officer, who considered that she had acute
17 appendicitis. The earlier complaint of dysuria was not
18 revisited and Mr Makar took the decision to perform an
19 appendectomy, which was performed late that night. The
20 anaesthetists were Dr Gund and Dr Jamison, both of whom
21 were senior house officers. However, Dr Jamison left
22 before the completion of surgery. The records show that
23 Raychel was commenced on Solution No. 18 at 22.15 at
24 infusion rate of 80 ml an hour. Mr Makar had initially
25 prescribed intravenous Hartmann's solution for Raychel

1 in the Accident & Emergency department, but upon being
2 informed by Staff Nurse Noble that this was inconsistent
3 with the common practice on the ward, Mr Makar changed
4 the fluid prescription to Solution No. 18.
5 The fluids were continued at this rate until on or
6 about 2300 hours when Raychel was taken to theatre. The
7 records show that Raychel was recommenced on this fluid
8 at this rate at about 2 o'clock in the morning on 8 June
9 after the completion of surgery. As with the other
10 children, the administration of this particular fluid at
11 the rate and in the volume that was administered to
12 Raychel is an issue to be considered by the Inquiry.
13 Raychel was seen by a number of nurses and doctors,
14 including Mr Zafar -- he was a surgical senior house
15 officer -- Dr Joe Devlin -- he was a surgical junior
16 house officer -- and Mr Michael Curran -- he was
17 surgical junior house officer -- who were called because
18 of Raychel's continued vomiting. Raychel was also seen
19 by Dr Jeremy Johnson, the paediatric senior house
20 officer, as a result of a seizure that she suffered in
21 the early hours of 9 June.
22 Following her subsequent collapse, Raychel was seen
23 by a number of other clinicians, including Dr Bernie
24 Trainor, paediatric senior house officer, Dr Brian
25 McCord, consultant paediatrician on call, Dr Date,

1 specialist registrar in anaesthetics, and Dr
2 Geoff Nesbitt, the clinical director and consultant
3 anaesthetist.
4 Raychel's pupils were found to be dilated and
5 unreactive and her oxygenation deteriorated to 80
6 per cent oxygen and her respiratory efforts declined.
7 CT scans were performed and she transferred to the
8 intensive care unit of Altnagelvin later that morning.
9 Later on, on 9 June 2001, Raychel was transferred to
10 PICU at the Belfast Hospital For Sick Children. Again,
11 for those unfamiliar with the geography, the distance
12 between the two hospitals can be seen at the map that
13 I brought up before.
14 There you see Altnagelvin at the top left. She's
15 coming down again to the Belfast, you see it there.
16 The transfer letter from Dr Bernie Trainor and
17 presented on her arrival at midday said:
18 "Very unwell, pupils dilated and unresponsive."
19 The note made of the examination of Raychel that was
20 carried out shortly after her admission to PICU and
21 prior to the brainstem tests being carried out records:
22 "Overall there appears to be no evidence of
23 brainstem function. Her limb movements are not, in my
24 opinion, of cerebral origin."
25 At PICU, Raychel came under the care of Peter

1 Crean -- who had not only been involved in Lucy's case,
2 but had knowledge of Adam's case and was noted in
3 Claire's case -- he considered that brainstem death had
4 already taken place and she was also seen by
5 Dr Hanrahan, a consultant paediatric neurologist who had
6 been involved in Lucy's case. Unfortunately, Raychel
7 did not recover and, following two brainstem tests, she
8 was pronounced dead at 12.09 on 10 June 2001, and
9 the coroner's office was notified.
10 At the request of the coroner, a post-mortem
11 examination was carried out by Dr Herron, and he was the
12 neuropathologist who had been involved in the brain-only
13 post-mortem on Claire, and Dr Al-Husani, pathologist, on
14 11 June 2001. Dr Herron had carried out that
15 post-mortem examination on Claire when he was senior
16 registrar in neuropathology and here he is as a
17 consultant neuropathologist. Prior to the completion of
18 the post-mortem report and on 12 June 2001, a critical
19 incident Inquiry was established at the
20 Altnagelvin Hospital by Dr Raymond Fulton, who was the
21 medical director, in accordance with the hospital's
22 critical incident protocol. One of the action points
23 involved a review of the continued use of Solution No.
24 18 post-operatively.
25 The post-mortem report was completed on 20 November

1 2001, with the clinical summary completed on
2 4 December 2001. The post-mortem report was provided on
3 21 December with input from Clodagh Loughrey, who is
4 a consultant chemical pathologist.
5 Raychel's death certificate shows the cause of her
6 death was "1(a) cerebral oedema and (b) hyponatraemia".
7 The inquest into Raychel's death was conducted on
8 5 February 2003 by John Leckey. He engaged Dr Edward
9 Sumner again as an expert. He reported in February 2002
10 that in his view Raychel died from:
11 "Acute cerebral oedema leading to coning as a result of
12 hyponatraemia. I believe that the state of
13 hyponatraemia was caused by a combination of inadequate
14 electrolyte replacement in the face of severe
15 post-operative vomiting and the water retention also
16 seen post-operatively from inappropriate secretion of
17 ADH."
18 The coroner also had the assistance of Dr Jenkins,
19 who had once again been engaged by the Director of Legal
20 Services and he concluded:
21 "My impression is that they [the doctors and nurses]
22 acted in accordance with the custom and practice in the
23 unit at that time. Raychel's untimely death highlights
24 the current situation whereby one sector of the medical
25 profession can become aware of risks associated with

1 particular disease processes or procedures through their
2 own specialist communication channels, but where this is
3 not more widely disseminated to colleagues in other
4 specialities who may provide care for patients at risk
5 from the relevant condition."
6 That situation that Dr Jenkins highlighted is
7 a matter that is being investigated by the
8 Inquiry.
9 The verdict on inquest -- and we can see that
10 document at 012-026-139 -- found the cause of Raychel's
11 death to be cerebral oedema with hyponatraemia as
12 a contributory factor. The coroner also made findings
13 that the hyponatraemia was caused by a combination of:
14 "Inadequate electrolyte replacement following severe
15 post-operative vomiting and water retention resulting
16 from the secretion of antidiuretic hormone."
17 Then we come to Conor. Conor Mitchell was born on
18 12 October 1987 and was subsequently diagnosed with
19 spastic tetraplegia, a severe form of cerebral palsy,
20 and mild epilepsy. He was an only child, who had been
21 described by his family as "upright, full of fun, very
22 motivated and highly intelligent". On 28 April 2003,
23 Conor was taken to Dr Patterson at Moores Lane surgery
24 in Lurgan with a sore throat and he had been vomiting.
25 Over the next few days, he continued to be unwell and

1 was vomiting, although the precise cause was unclear.
2 Ultimately, on 8 May 2003, Dr Doyle at the same Moores
3 Lane surgery examined Conor and advised that he should
4 be taken to hospital for blood tests and 24-hours
5 observation. Conor was taken to Craigavon Area Hospital
6 later on 8 May 2003, where he was admitted to the A&E
7 department with signs of dehydration and for
8 observation.
9 At that time, Conor was 15 years old. He weighed
10 approximately 22 kilos, he was of slim build and was
11 described as having "the body habitus of an 8 to 9
12 year-old child". He was seen by Dr Suzie Budd, who was
13 a staff grade doctor in Accident & Emergency, and Dr
14 Paul Kerr, who was a consultant in Accident & Emergency.
15 He was then admitted to the medial admissions unit --
16 which is not a paediatric unit -- by staff nurse Ruth
17 Bullas for the purposes of observation. Conor was
18 examined in the medical admissions unit by, variously,
19 Dr Catherine Quinn, who was a senior house officer,
20 Dr Andrew Murdock, who was a medical registrar, and Dr
21 Jill Totten, who was a junior house officer.
22 The reasons why Conor was not admitted into
23 a paediatric unit or on to a paediatric ward and the
24 implications of that for his care and treatment are
25 matters being investigated by the Inquiry.

1 Whilst Conor was admitted to the medical admissions
2 unit, unlike the other children, he was not prescribed
3 Solution No. 18, but instead received a combination of
4 Hartmann's solution and normal saline. And the extent
5 to which the care and treatment which Conor received
6 both in Craigavon Area Hospital and the Belfast Hospital
7 For Sick Children was consistent with the then training
8 and teaching on fluid management and record keeping, in
9 particular the guidelines on hyponatraemia that have
10 been published by the department in 2002, are all
11 matters that are being investigated by the Inquiry.
12 But over the course of the afternoon of 8 May 2003
13 and on into the evening, Conor's condition deteriorated.
14 Staff Nurse Bullas, who having transferred from the
15 Philippines and was in her final month of her six-month
16 preceptorship noted that he had spasms and had developed
17 a pink rash on his abdomen and thighs. Dr Murdock was
18 unable to find evidence of a rash, however Conor's
19 family queried whether he should be transferred to the
20 Royal Belfast Hospital For Sick Children and it was
21 agreed that a second opinion should be sought from the
22 paediatric team and Dr Marian Williams, the on call
23 paediatric registrar, was contacted. At about 20.30 and
24 whilst he was being examined by Dr Williams, Conor
25 suffered two episodes of seizure activity in rapid

1 succession and stopped breathing. Several doctors then
2 attended Conor in a short period of time, including
3 Dr Murdock, Dr Michael Smith, who was a consultant
4 paediatrician, Dr Hutchinson, who was a specialist
5 registrar in anaesthesia. And Conor required intubation
6 and ventilation, following which a CT scan was conducted
7 which showed a very abnormal scan and a sub-arachnoid
8 bleed. Conor was then admitted to the intensive care
9 unit of the Craigavon Area Hospital under the care of
10 Dr William McCaughey, who was the consultant
11 anaesthetist. He is recorded as being unresponsive on
12 arrival with pupils that were fixed and dilated.
13 The following day, Conor was making no spontaneous
14 effort breathing and the inpatient follow-up notes
15 record:
16 "All appearances are that this unfortunate young
17 fellow is brainstem dead."
18 He was transferred to PICU at the Royal Belfast
19 Hospital For Sick Children on 9 May 2003 under the care
20 of James McKaigue, who was a consultant paediatric
21 anaesthetist. The reasons why and the process by which
22 Conor was admitted to PICU at RBHSC are matters being
23 investigated by the Inquiry, as are the implications of
24 that admission for his care and treatment.
25 Subsequent brainstem tests were shown to be negative

1 and he was pronounced dead on 12 May 2003. The inquest
2 into Conor's death was conducted on 9 June 2004 by
3 John Leckey and he engaged Dr Edward Sumner as an
4 expert. Despite the inquest, the precise cause of
5 Conor's death remains unclear. The clinical diagnosis
6 of Dr Janice Bothwell, who was a paediatric consultant
7 at the Royal, was:
8 "Brainstem dysfunction with cerebral oedema related
9 to viral illness, over-rehydration, inappropriate fluid
10 management, with status epilepticus causing hypoxia."
11 Dr Herron, from the Department of Neuropathy,
12 Institute of Pathology, Belfast, performed the autopsy.
13 He was unsure what sparked off the seizure activity and
14 the extent to which it contributed to the swelling of
15 Conor's brain, but he considered that the major
16 hypernatraemia had developed after brainstem death had
17 occurred and that it therefore probably played no part
18 in the cause of the brain swelling. He concluded in his
19 autopsy report that the ultimate cause of death was
20 cerebral oedema. Dr Edward Sumner commented in his
21 report of November 2003 that Conor died of the acute
22 effects of cerebral swelling, which caused coning and
23 brainstem death, but he remained uncertain why. He
24 noted that the total volume of intravenous fluids given
25 was not excessive and that the type of fluid was

1 appropriate for Conor, but he queried:
2 "Was the initial rate of administration too great
3 for Conor? There was no pulmonary oedema, but his face
4 did become puffy."
5 That query was raised in his correspondence shortly
6 after the inquest verdict to Dr Jenkins dated
7 11 June 2004. And he copied that to the Chief Medical
8 Officer, Dr Henrietta Campbell and to the coroner. This
9 is what he put in the correspondence to Dr Jenkins:
10 "Having got home from Conor Mitchell's inquest,
11 I feel I must communicate my great unease. This is the
12 fourth inquest I have attended in Belfast where
13 sub-optimal fluid management has been involved. There
14 was no calculation of the degree of dehydration, nor the
15 fluid deficit, and no calculation of the maintenance
16 fluids for a 22-kilogram child. My overall impression
17 from these cases is that the basics of fluid management
18 are neither well understood nor properly carried out.
19 Has this been your experience? What is the remedy?"
20 In his response of 28 June 2004, Dr Jenkins referred
21 to the results of a regional audit that had assessed the
22 implementation of the hyponatraemia guidelines issued
23 in March 2002. He went on to refer to arrangements
24 being made by the chief medical officer for a workshop
25 at which issues of fluid management can be discussed

1 between colleagues and relevant specialities within
2 medicine and, indeed, nursing. He also referred to
3 highlighting with the General Medical Council the issue
4 of training in fluid administration and management and
5 of drawing the matter to the attention to the
6 Northern Ireland postgraduate dean and director of
7 undergraduate medical education.
8 That audit on the implementation of the
9 hyponatraemia guidelines was the subject of a paper by
10 Dr Jarlath McAloon and Raj Kottyal. Respectively, they
11 were consultant paediatrician and senior house officer
12 at the Antrim Hospital, and they published, in the
13 Ulster Medical Journal, "A study of current fluid
14 prescribing practices and measures to prevent
15 hyponatraemia in Northern Ireland's paediatric
16 departments".
17 In summary, the paper concluded that, "the evidence
18 suggests that implementation has so far been
19 incomplete", and it highlights problem areas. The
20 extent to which the March 2002 hyponatraemia guidelines
21 were being effectively implemented is an issue being
22 investigated by the Inquiry, as is the actions of the
23 Chief Medical Officer and others in relation to the
24 emerging issue of the appropriate intravenous fluid
25 management of children in hospital.

1 If we go back to the verdict for Conor, the verdict
2 on inquest, which we can see at document 087-057-221.
3 It stated that the cause of death was to be -- we see it
4 there:
5 "1(a) brainstem failure, (b) cerebral oedema, (c)
6 hypoxia, ischaemia, seizures and infarction and, 2,
7 cerebral palsy."
8 The coroner also made findings. He was satisfied
9 that there was seizure activity in the afternoon, but
10 found that there was no evidence that any clinicians had
11 seen the series of 10 to 12 seizures, the increasingly
12 vivid intermittent rash or heard the choking noises
13 described by the family. He concluded there was no
14 evidence viral illness contributing to the underlying
15 causes of Conor's death and the coroner also found that
16 the fluid management at Craigavon Area Hospital was
17 acceptable.
18 So those are the children. I want now to move on to
19 the issue of hyponatraemia and Solution No. 18.
20 Throughout the children's cases, there is reference to
21 hyponatraemia. What it means is relatively
22 straightforward. A working definition, simply for the
23 purposes of this general opening, Mr Chairman, is that
24 when the blood level of sodium is lower than normal,
25 either because of an excess excretion of sodium over

1 intake and subsequent water intake/retention, or by an
2 excess of water intake over output diluting the serum
3 sodium. That latter is dilutional hyponatraemia and
4 that is the reason most often referred to in the
5 children's cases. To varying degrees, the extent to
6 which these children developed dilutional hyponatraemia,
7 how and why they did so, whether it could have been
8 avoided, whether it could have been arrested and
9 reversed with appropriate treatment, and crucially, the
10 extent to which it killed them, are all matters that are
11 the subject of the investigation into these respective
12 cases.
13 If I turn now to Solution No. 18. 0.18 per cent
14 sodium chloride and 4 per cent glucose or dextrose
15 intravenous fluid solution, or Solution No. 18, is
16 so-called because it comprises that 4 per cent of
17 glucose and 0.18 per cent sodium chloride with the
18 remainder being free water. This means it contains one
19 fifth of the sodium and chloride ions that are found in
20 an isotonic solution. An isotonic solution, such as
21 Hartmann's solution, contains approximately the same
22 number of sodium and chloride ions as are in human
23 blood. Solution 18 was used intravenously with all the
24 children, except Conor, and is at the heart of the
25 criticisms made of their fluid management. Low-level of

1 sodium content connected with the development of
2 dilutional hyponatraemia. There is an issue, which the
3 Inquiry's investigating, over the extent to which, at
4 the time of Adam's admission and for some time
5 afterwards, Solution No. 18 was a fairly standard
6 intravenous solution for use with children. That
7 investigation includes:
8 "1, the purpose for which it was considered that
9 Solution No. 18 could appropriately be administered at
10 the time when it was prescribed or administered to the
11 children. For example, whether it should have been used
12 as a maintenance fluid, that is to match the fluids
13 being lost or a replacement to match fluids already
14 lost.
15 "Alternatively, whether it should not have been used
16 for either purpose and, secondly, the extent to which
17 the dangers of using too large a quantity of Solution
18 No. 18 or at too fast a rate should have been
19 recognised. In other words, whether it should have been
20 appreciated that such use will lead to a dilution of
21 sodium in the body and a chain of events which, if
22 unchecked, would culminate in dilutional hyponatraemia,
23 leading to cerebral oedema.
24 "Thirdly the extent to which it is the presence of
25 the low sodium in the Solution No. 18 in combination

1 with the 4 per cent glucose that presents a problem in
2 terms of dilutional hyponatraemia leading to fatal
3 cerebral oedema or whether the same result would be
4 produced by a similar quantity and rate of
5 administration of water or glucose without sodium.
6 "The precise mechanism by which dilutional
7 hyponatraemia develops in children receiving intravenous
8 fluids together with its consequences and significance
9 are matters that will be addressed in greater detail
10 during the oral hearings for each of the children."
11 I go now to the hyponatraemia guidance:
12 "Another important aspect of the work of the Inquiry
13 is the impact of the guidance 'On the prevention of
14 hyponatraemia in children' which the department issued
15 in 2002 before the Inquiry was established."
16 We can just call that up. 007-003-004. There you
17 see it. If you go to the top:
18 "Any child on IV fluids or oral rehydration is
19 potentially at risk of hyponatraemia."
20 And then that guidance goes on to set out in
21 bullet-point form how serious it is, what sort of
22 failures it reflects, its complications. It then
23 provides simple guidance as to the baseline assessment,
24 fluid requirements, choice of fluid, monitoring, the
25 significance of that and, most importantly, when to seek

1 advice.

2 It is possible that the need for such guidance was
3 raised at a meeting on 18 June 2001 of medical
4 directors, within just days of Raychel's death.
5 However, the guidance itself was published on 25 March
6 2002, after the deaths of all the children, except
7 Conor.

8 The hyponatraemia guidance starts with the warning
9 that I have just read out there:

10 "Any child on IV fluids or oral rehydration is
11 potentially at risk of hyponatraemia."

12 And it highlights the particular risks of the
13 condition, including those associated with
14 post-operative patients and bronchiolitis with vomiting.
15 And it addresses, as I listed out before, the baseline
16 assessment and so forth, culminating in the importance
17 of seeking advice.

18 The circumstances giving rise to the formulation of
19 the hyponatraemia guidance, its implementation,
20 monitoring, auditing and evaluation, are a fundamental
21 part of the Inquiry's role and will be addressed in the
22 oral hearings, particularly those dealing with hospital
23 management and governance.

24 I will move on now to the establishment of the
25 Inquiry. On 21 October 2004, UTV aired an hour-long

1 Insight special entitled "When Hospitals Kill". It
2 features the deaths of Adam, Lucy and Raychel, claiming
3 they had all died of the same cause: namely by hospitals
4 accidentally administering too much of the wrong type of
5 intravenous fluid. It also sought to expose what it
6 claimed was a deliberate cover-up of the cause of Lucy's
7 death. The documentary prompted the department to take
8 action, and on 1 November 2004, Angela Smith
9 announced -- we can pull up her announcement, actually.
10 008-032-093.
11 She announced that she had appointed John O'Hara,
12 you, Mr Chairman, to conduct a public Inquiry into the
13 issues that it raised. At that time, there was direct
14 rule from Westminster and Angela Smith was the minister
15 with responsibility for health, social services and
16 public safety in Northern Ireland. The department
17 recognised that public confidence had been damaged and
18 wished the terms of reference for the Inquiry to be
19 sufficiently broad to enable the concerns of not just
20 the families, but also the wider public to be fully
21 addressed. In announcing the Inquiry, the minister
22 stated:
23 "I believe it is of the highest importance that the
24 general public has the confidence in the quality and
25 standards of care provided by our health and social

1 services. The death of any child is tragic and it is
2 essential that the investigation into these deaths is
3 independent, comprehensive and rigorous."
4 That document can be called up at 021-010-022. She
5 goes on to say that:
6 "The terms of reference that I have set for the
7 Inquiry and the powers available to it are wide-ranging
8 and should ensure that the Inquiry deals with all the
9 issues of concern."
10 The terms of reference were announced on
11 18 November 2004. 021-010-024:
12 "In pursuance of the powers conferred on it by
13 article 54 and schedule 8 to the Health and Personal
14 Social Services (Northern Ireland) Order, the Department
15 of Health here appoints Mr John O'Hara to hold an
16 Inquiry into the events surrounding and following the
17 deaths of Adam Strain, Lucy Crawford and
18 Raychel Ferguson, with particular reference to: 1, the
19 care and treatment of Adam Strain, Lucy Crawford and
20 Raychel Ferguson, especially in relation to the
21 management of fluid balance and the choice and
22 administration of intravenous fluids in each case.
23 "2, the actions of the statutory authorities, other
24 organisations and responsible individuals concerned in
25 the procedures, investigations and events which followed

1 the deaths of Adam Strain, Lucy Crawford and Raychel
2 Ferguson. 3, the communications with and the
3 explanations given to the respective families and others
4 by the relevant authorities."
5 So as can be seen, the first part of the Inquiry's
6 work under the terms of reference -- and this is true
7 also of the revised terms of reference since the
8 structure remains the same -- relates to the children's
9 treatment. That part of the terms of reference requires
10 an investigation into their care and treatment, plain
11 and simple. So for Adam and Raychel, that involves an
12 investigation into the decisions over their surgery,
13 when it was to be carried out, who was to do it, as well
14 as to how it was actually performed. However, that is
15 not everything. Attention is drawn to the management of
16 the children's fluid balances. In Adam's case, that
17 would involve the calculations made to arrive at the
18 fluid management plan for his renal transparent surgery
19 and any adjustments made to that plan during the course
20 of his surgery.
21 Attention is also drawn to the choice of intravenous
22 fluids. So for example, in Raychel's case, that would
23 involve the reason for and the justification of the
24 change from Hartmann's solution that had initially
25 prescribed for her during her surgery to Solution No. 18

1 that was administered to her on the ward. The
2 difference between those two intravenous solutions lies
3 largely with the level of sodium, which for Hartmann's
4 is 131, whilst for Solution No. 18 is 30.
5 The second part of the terms of reference is very
6 broad and the range of persons involved is constrained
7 only by the requirement that they were concerned in the
8 procedures, investigations and events that followed the
9 children's deaths. At one level, that will involve an
10 investigation into the process by which the Belfast
11 Hospital For Sick Children's protocol on renal
12 transplantation in small children was revised
13 in September 1996 following Adam's death. It extends to
14 the nature and adequacy of the Inquiry carried out at
15 the Erne Hospital into the circumstances of Lucy's
16 death, as well as the conduct of the chief medical
17 officer at the time following Raychel's death. It also
18 takes in the means by which the department's guidance on
19 the prevention of hyponatraemia in children was
20 produced, the process by which it was introduced into
21 hospitals and the extent to which its enforcement was
22 audited and evaluated together with the quality of the
23 governance exercised by the department in relation to
24 the occurrence of serious adverse incidents in
25 hospitals.

1 The Inquiry has compiled a chronology to summarise
2 the events and lessons learned in relation to this
3 aspect of its work, which is being updated to reflect
4 the results of the investigation into the governance
5 issues arising out of each of the children's cases.
6 It is intended that the first part of it will be
7 provided prior to the start of the oral hearing on the
8 governance issues in Adam's case.
9 There are, of course, other bodies whose conduct
10 in relation to the particular issues of concern may fall
11 within the scope of the Inquiry's work.
12 For example, one, the School of Medicine Dentistry
13 and Biochemical Science at Queen's University, Belfast,
14 which provides undergraduate training and research
15 facilities. The school has established sub-deaneries
16 within the local health trusts to try and ensure greater
17 integration between academic and clinical colleagues and
18 it may well prove to be an issue how successful that has
19 been.
20 Two, Northern Ireland Medical and Dental Training
21 Agency and its predecessor, the Northern Ireland Council
22 for Postgraduate Medicine and Dental Education. The
23 task of both of those bodies was to ensure that doctors
24 and dentists [although they're not relevant to this
25 Inquiry] are effectively trained to provide patients

1 with the highest standards of care.
2 Three, the Medicines and Healthcare Products
3 Regulatory Agency and its predecessor, The Medicines
4 Control Agency, which ensures that medicines and medical
5 devices work and are acceptably safe. The commission on
6 human medicines is a committee of the Medical and
7 Healthcare Products Agency whose duties came into being
8 on 30 October 2005. For the purposes of this Inquiry
9 and in relation to the use of Solution No. 18, its
10 duties include advising ministers on matters relating to
11 human medicinal products and promoting the collection
12 and investigation of information relating to adverse
13 reactions for human medicines for the purposes of such
14 advice. And prior to its formation, that function was
15 carried out by the Medicines Commission and the
16 Committee on Safety of Medicines.
17 Four, there is a National Health Patient Safety
18 Agency, which coordinates the efforts of the entire
19 country to report and learn from mistakes and problems
20 that affect patient safety.
21 And then fifth, there's the HPSS Regulation and
22 Quality Improvement Authority, sometimes known as the
23 RQIA, which promotes safe practice on the use of
24 medicines and products and is Northern Ireland's
25 independent health and social care regulator.

1 The third part of the terms of reference, though,
2 Mr Chairman, takes us back to the children and their
3 families. It encompasses a range of communications, for
4 example the nature and extent of the information given
5 to Adam's mother about renal transplantation at the
6 Royal Belfast Hospital For Sick Children, the accuracy
7 and the quality of the information given to the parents
8 of the other children as to why they became so ill and
9 died, together with the degree to which the clinicians
10 concerned listened to the concerns of the parents in all
11 the cases.
12 Then if we go to the early stages of the Inquiry's
13 work, starting first with the approach. The approach to
14 the terms of reference was signalled almost immediately
15 by your statement, Mr Chairman, of 18 November 2004,
16 when you said:
17 "The terms of reference of the Inquiry, which have
18 been published today, are very broad and I believe they
19 will enable me to look at all the issues that need to be
20 examined."
21 The commitment to investigating the broader issues
22 was reiterated by you, Mr Chairman, in a public hearing
23 on 3 February 2005.
24 We can call up that little extract, it's reference
25 303-005-055. There you say:

1 "I am determined to get to the heart of the issues
2 which led to the administrative decision to establish
3 the Inquiry, specifically that the public needs to know
4 that our health service is managed and organised in such
5 a way that when unfortunate events happen, as they
6 inevitably will, lessons are learned to prevent their
7 repetition. Nobody can reasonably expect that mistakes
8 will not occur in our health service. What we all
9 should expect, however, is that steps will be taken to
10 help to minimise the risk to the health of others in the
11 future."
12 Perhaps the single most important general issue is
13 what procedures have been in place to ensure that
14 information and lessons which emerge from inquests are
15 disseminated within the hospital concerned, within the
16 Health Service of Northern Ireland and the health
17 service throughout the United Kingdom generally. Some
18 of the heightened concern over the incidence of
19 hyponatraemia-related deaths in Northern Ireland was
20 generated by that discovery in December 2004 of Claire's
21 death. That was a hitherto unknown child's death in
22 which hyponatraemia was believed to be implicated. That
23 discovery prompted an almost immediate parliamentary
24 question from Iris Robinson, who was then the MP for
25 Strangford, on 25 January 2005 to Angela Smith, and she

1 asked:

2 "How many dilutional hyponatraemia-related deaths

3 occurred in the province in each of the last 20 years?"

4 The answer was provided on 27 January 2005, and

5 we can pull that up at reference 073-019-093. There

6 it is. That's the table that was provided by way of

7 answer. You can see there, apart from the date, then

8 you have the deaths where the primary cause of death was

9 hyponatraemia or fluid overload. And then you have,

10 in the third column, deaths where an associated or

11 secondary cause of death was hyponatraemia or fluid

12 overload.

13 You can see from that first column that there were

14 six deaths where the primary cause of death was

15 hyponatraemia or fluid overload and 55 deaths where an

16 associated or secondary cause of death was hyponatraemia

17 or fluid overload. And as a result, Mr Chairman, you

18 wrote to the department seeking the number of deaths in

19 Northern Ireland in the last 25 years in which

20 hyponatraemia had been identified as a primary or

21 secondary cause of death. It also led to an

22 announcement by you, Mr Chairman, during a procedural

23 hearing on 3 February 2005, when you said:

24 "Another issue, which we want to address, is: what

25 is the frequency of death as a result of hyponatraemia

1 in Northern Ireland? Our understanding, from figures
2 which we have received recently from the department,
3 is that in the last 20 years there have been eight
4 deaths which have been registered as directly
5 attributable to hyponatraemia, but there have been 55
6 deaths registered with hyponatraemia as a secondary or
7 contributory factor, and 16 of those deaths were
8 registered in 2002 and 2003. We want to enquire whether
9 this is in keeping with equivalent figures for the rest
10 of the United Kingdom. We want to enquire whether this
11 is in keeping with other European countries and, whether
12 it is or is not equivalent to other countries, is there
13 any extent to which such deaths are avoidable?"
14 I will return to the Inquiry's investigation into
15 the incidence of hyponatraemia-related deaths in
16 Northern Ireland and how it compares with the rest of
17 the UK and Europe. Like other issues, it has not proved
18 straightforward to investigate. But another early broad
19 issue identified by you, Mr Chairman, was the extent to
20 which the risk of hyponatraemia and the matters
21 addressed in the hyponatraemia guidelines issued by
22 the department in 2002 were or could reasonably have
23 been expected to have been known to clinicians in
24 Northern Ireland at the time of the treatment and deaths
25 of Adam, Lucy and Raychel in 1995, 2000, and 2001

1 respectively.

2 You made it quite clear, Mr Chairman, at the
3 progress hearing on 23 June 2005 that you will also be
4 looking at the education and training and at the
5 continuing education and training of nurses and doctors.
6 I will deal later with how the Inquiry has pursued the
7 investigation into that issue.

8 I turn now to the progress of the work. A first
9 task for the Inquiry was to secure the relevant
10 documents. From December 2004, requests were sent out
11 to a large number of bodies and organisations: the
12 Department, of course, the Royal Group of Hospitals,
13 Sperrin Lakeland Trust, Altnagelvin, the coroner, Ulster
14 Television, the families of the children Adam, Lucy and
15 Raychel. And by February 2005, the Inquiry had received
16 over 80 lever arch files from those sources.

17 Thereafter, the Inquiry published its initial
18 procedures on the Inquiry's dedicated website dealing
19 with the procedure of the Inquiry and related matters,
20 interested parties and the context for the involvement
21 of experts. And in order to assist the Inquiry with its
22 work, a team of expert advisers was engaged and
23 international experts from America, Canada and Australia
24 were appointed to peer review their work. Their
25 professional details are included in the protocol number

1 4 on experts, which is published on the Inquiry's
2 website. But in summary, their expertise includes
3 paediatric anaesthesia, paediatric intensive care
4 nursing, health service management and patient safety.
5 One of the first tasks for the advisers was to assist
6 the Inquiry with the development of a list of issues to
7 guide the investigation necessitated by the terms of
8 reference as interpreted by you, Mr Chairman.
9 The first list of issues was published on the
10 Inquiry's website in June 2005. The scale of the
11 investigation indicated in them was evident and shaped
12 by the following factors. The first was the clinical
13 issues relating to the care and treatment of Adam, Lucy
14 and Raychel and the communications with their families.
15 The children were all admitted with different medical
16 conditions at different times and into different
17 hospitals and they all died in a period spanning from
18 November 1995 to June 2001.
19 A proper assessment of the care and treatment they
20 received on their admission, as required by the first
21 part of the terms of reference, could necessitate, in
22 some instances, considering their previous clinical
23 history, which in the case of Adam involves medical
24 notes and records going back to when he was just a few
25 months old and at the Ulster Hospital.

1 The second factor: the management and governance
2 issues relating to those clinical issues require the
3 practices, procedures and systems in place over
4 a lengthy period to be considered. In the case of the
5 education and training of the clinical staff treating
6 Adam, it amounts to a period from approximately 1975,
7 whereas in the case of the level of compliance with
8 guidelines on hyponatraemia, it involves a period
9 spanning 2002 to the present day.
10 In addition, and in relation to the events following
11 the deaths of the children, it meant investigating the
12 practices of three separate hospitals, their respective
13 trusts and area boards as well as the Department as
14 well. In particular, and as all three children ended up
15 at the Royal Belfast Hospital For Sick Children, which
16 is Northern Ireland's premier paediatric hospital and a
17 teaching hospital, it would mean at least investigating
18 the practices in place as at Adam's admission in
19 November 1995 up to the present day.
20 Furthermore, it would require an investigation into
21 the reporting and management structure within the
22 hospitals, trusts and area boards together with the
23 dissemination of information amongst clinicians in
24 different hospitals and the institutional linkages
25 between the different trusts, area boards, Department,

1 Chief Medical Officer, Coronial Service and the Medical
2 School at Queen's University Belfast.
3 If I move on to some other matters that ran
4 alongside or come across the early start of the
5 Inquiry's work, the first of those was PSNI
6 investigations. Shortly after the Inquiry was
7 established, the Police Service of Northern Ireland
8 commenced an investigation into Lucy's death.
9 In January 2005, Mr Chairman, the PSNI outlined the
10 position to you as, (i) it was estimated that their
11 investigations would be completed in time for the file
12 to be with the DPP by mid-April 2005. However, it was
13 explained that there were issues that might delay
14 progress such as uncovering evidence of an attempt to
15 pervert the course of justice, which would require
16 a more detailed examination of a very large number of
17 documents held by the Sperrin and Lakeland Trust.
18 (ii) the PSNI was concerned that the Inquiry's
19 investigation into the circumstances surrounding Lucy's
20 death might compromise their investigation and therefore
21 they wished the Inquiry to suspend its work on Lucy's
22 case pending the completion of that investigation. And
23 third, there were no plans to investigate the death of
24 either Adam or Raychel and therefore the PSNI had no
25 objection to the Inquiry's work continuing in those

1 cases. Mr Chairman, you therefore excluded from the
2 work of the Inquiry any investigation into the issues
3 concerning Lucy and the Inquiry continued with its work
4 into the other issues arising out of the terms of
5 reference.
6 But then on 26 July 2005, PSNI wrote to the Inquiry
7 to advise that (i) they were going to start an
8 investigation into Adam's and Raychel's deaths. (ii)
9 the PPS had confirmrd that no decision would be taken
10 about any prosecutions in Lucy's case until all three
11 files were with the DPP. (iii) they wished the
12 Inquiry (a) to remove from its website any information
13 which might be relevant to the police investigation, (b)
14 to provide them with all Inquiry witness statements and
15 (c) not to seek any outstanding Inquiry witness
16 statements or to generate any further such witness
17 statements. In short, they wished the Inquiry to
18 suspend its work for the time being.
19 As a consequence, Mr Chairman, a press release was
20 issued explaining the position and a public hearing was
21 convened for 7 October 2005. Mr Chairman, you announced
22 at that public hearing that the work of the Inquiry was
23 being suspended until you received, effectively, the
24 all-clear from the PSNI.
25 I now move on to what happened in the intervening

1 period. The intervening period was from 7 October 2005
2 until the Inquiry resumed its work in 2008, and there
3 were a number of significant developments during that
4 time. The first, of course, was the continuation of the
5 PSNI investigations. The PSNI investigations continued
6 in the three cases of Lucy, Adam and Raychel. In
7 addition, the cases of Claire and Conor also came to the
8 attention of the PSNI and they commenced investigations
9 into Claire's death in July 2005.
10 On 20 October 2006, almost exactly a year after the
11 Inquiry had suspended its work, the PPS took the
12 decision that the available admissible evidence was
13 insufficient to meet the test for a prosecution against
14 Dr O'Donohoe and others for gross negligence
15 manslaughter of Lucy and related offences.
16 Subsequently, they took the same decision in relation to
17 Adam's case, and on 1 February 2008 the PPS decided not
18 to proceed with any prosecutions against anyone involved
19 in Raychel's case.
20 In addition, the PSNI decided not to proceed further
21 with any investigations into Claire's death and
22 thereafter, in August 2008, the PSNI took the decision
23 not to pursue any further investigations into Conor's
24 death. Accordingly, neither of those cases was referred
25 to the PPS.

1 Also, in that intervening period, were GMC and NMC investigations. The Inquiry has operated alongside those

3 investigations from the General Medical Council and the

4 Nursing and Midwifery Council into the conduct of

5 certain clinicians involved in some of the children's

6 cases. Those cases proceeded whilst the Inquiry's work

7 was suspended and some of them are still ongoing. In

8 order not to fragment matters too much, I'll explain

9 matters here the current position in relation to those

10 cases even though some of the developments occurred

11 after the resumption of the Inquiry's work.

12 The first of those investigations was instigated by

13 a report from the Coroner to the GMC on 23 February 2004

14 following the conclusion on 19 February 2004 of the

15 inquest into Lucy's death. The referral concerned the

16 conduct of Dr O'Donohoe and Dr Malik and was prompted by

17 what the coroner described as "very serious concerns

18 about the quality of the medical care Lucy received

19 whilst a patient in the Erne Hospital".

20 The result of those investigations was that on

21 27 September 2008, the case against Dr Malik was

22 cancelled and on 30 October 2009, the Fitness to

23 Practise Panel of the GMC found Dr O'Donohoe guilty of

24 serious professional misconduct.

25 Then Mr and Mrs Ferguson made a formal complaint to

1 the GMC on 6 November 2004 about a number of clinicians
2 and officials. They are Dr Henrietta Campbell, who was
3 then the Chief Medical Officer; Dr Murray Quinn;
4 Dr Hanrahan; Dr John Jenkins; Dr Geoffrey Nesbitt and
5 Dr James Kelly. The Fergusons' complaint concerned what
6 they regarded as a failure of all those doctors to
7 reveal the truth in the investigations into Lucy's
8 death. They believe that the death of their daughter
9 Raychel could have been avoided if Lucy Crawford's death
10 had been properly and independently investigated in
11 2000.
12 The case against Dr Jenkins and that against
13 Dr Geoffrey Nesbitt were closed on 23 January 2009 and
14 3 December 2009 respectively, following decisions that
15 no further action should be taken. The case against
16 Dr Campbell was concluded on 27 May 2010 on the basis
17 that no further action should be taken but that she
18 should "reflect on this decision and the concerns
19 expressed by the complainants". The basis of those
20 concerns forms part of the Inquiry's investigations.
21 The cases against [REDACTED] Dr Kelly are
22 continuing, so I shan't be saying any more about them.
23 On 9 November 2011, the GMC informed the Inquiry
24 that Dr Murray Quinn had applied for voluntary erasure.
25 If granted, that would bring the case against him to an

1 end with no findings but that he would not, of course,
2 be able to practice in the UK. He could subsequently
3 apply to restore his name to the medical register, but
4 if he did so then any outstanding fitness to practise
5 issues would need to be addressed.
6 On 15 December 2011, the GMC refused that
7 application for voluntary erasure on the basis that it
8 was not in the public interest to dispose of his case
9 in that way. As a consequence, the case against
10 Dr Quinn is also continuing.
11 There have been two sets of complaints to the NMC
12 about the conduct of nurses. The first set concerned
13 complaints made in October 2004 by Lucy's parents
14 in relation to Bridget Swift, Sally McManus, Bridget
15 Jones and Teresa McCaffrey and their involvement in
16 Lucy's case. Those complaints were all investigated in
17 2007 and closed in January 2007 on the basis of there
18 being no case to answer.
19 The other complaint was made in December 2009 by
20 Conor's grandmother, Judith Mitchell, about Ruth Bullas
21 and her involvement in Conor's case. On 13 July 2011,
22 the Conduct and Competence Committee Panel of the NMC
23 found Ruth Bullas guilty of professional misconduct and
24 her fitness to practise impaired. The first of the
25 three charges concerned the failure to "document in the

1 nursing notes the reports that you received from patient
2 A's mother and grandmother that they had witnessed
3 patient A suffering from seizures". The second
4 concerned a failure to escalate to a senior member of
5 staff for a second opinion the reports of such seizure
6 activity. The panel accepted the evidence of Sister
7 Irene Brennan that no one had reported any seizures,
8 spasms or twitchings to her concerning Conor and that if
9 she had been informed of that type of activity, she
10 would have attended Conor herself. It found as part of
11 its reasons for the finding of impairment:
12 "Health care records are a tool of communication
13 within the team. You must ensure that the health care
14 record for the patient is an accurate account of
15 treatment, care planning and delivery. It should
16 provide clear evidence of the care planned, the
17 decisions made, the care delivered and the information
18 shared."
19 A striking-off order was made in respect of Ruth
20 Bullas and the panel stated as part of its reasons for
21 the sanctions imposed:
22 "Responsibility for the deficiencies in the care
23 provided to Conor at Craigavon Area Hospital should not
24 be born by her [that is Ruth Bullas] alone. The
25 evidence before the panel revealed further wide-ranging

1 and systemic deficiencies in Conor's treatment and care.
2 These included the fact that the registrant was
3 delegated responsibility for Conor's nursing care with
4 little or no ongoing support despite her lack of
5 experience and the fact that she had not yet completed
6 her preceptorship, inadequate handovers, briefings and
7 reporting processes, a failure to provide Conor with
8 nursing staff who were sufficiently and suitably
9 qualified, and a lack of timely access to paediatric
10 facilities and expertise."
11 Whilst, Mr Chairman, you have determined that the
12 Inquiry is not investigating the cause of Conor's death
13 and the conduct of the nurses or other clinicians in
14 relation to his demise, you have nonetheless determined
15 that the Inquiry is investigating the issue of record
16 keeping. Accordingly, the Inquiry will investigate the
17 significance, if any, of the findings and observations
18 made by the panel in Ruth Bullas' case in relation to
19 the knowledge of the nurses at Craigavon Area Hospital
20 of appropriate record keeping and the hyponatraemia
21 guidelines together with the systems that the hospital
22 instituted to introduce the guidelines, provide training
23 on them and then ensure that they were being followed.
24 I turn now to another development in the intervening
25 period, which is Alert No. 22. On 28 March 2007, the

1 National Health Service National Patient Safety Agency
2 issued its Alert No. 22 for one-month to 16 year-olds,
3 recommending the taking of action by 30 September 2007
4 to minimise the risk of hyponatraemia in children.
5 We can see that at 303-026-350.
6 That action by the NPSA was a culmination of
7 a process that had been instigated as far back as
8 25 September 2001 by Dr Taylor, who reported to its
9 predecessor organisation, Medicines Control Agency,
10 through the yellow card system, a suspected adverse drug
11 reaction in respect of intravenous Solution No. 18 and
12 the death of Raychel in 2001. It was welcomed by the
13 Medicines Control Agency as:
14 "An important early warning of previously
15 unrecognised adverse effects which allows us to take
16 appropriate action to improve the safe use of
17 medicines."
18 The progress of the investigation is summarised by
19 a Dr Katherine Cheng of the Medicines Control Agency in
20 a letter that she wrote to Dr Taylor of 26 November
21 2001. The Working Group on Paediatric Medicines
22 conducted a review of 4 per cent dextrose/0.18 per cent
23 saline and considered that although hyponatraemia is
24 a risk to children during the use of 4 per cent
25 dextrose/0.18 per cent saline, electrolyte imbalance is

1 a risk with the use of all intravenous solutions.
2 The working group noted at its meeting on
3 21 November 2001 that careful monitoring of children
4 after surgery is crucial and, in particular, care should
5 be taken not to overload patients with intravenous
6 fluids if they were oliguric or as part of the normal
7 response to surgery. However, the working group
8 considered that the issue of hyponatraemia related more
9 to clinical practice than to medicines regulation and
10 advised that there should be no changes to product
11 information.
12 Then in 2006, Way and others published in the
13 British Journal of Anaesthesia the results of a survey
14 that had been carried out to assess the practice of
15 postoperative intravenous fluid prescription by
16 paediatric anaesthetists. The results showed, amongst
17 other things, that 75.2 per cent of anaesthetists
18 prescribed hypotonic dextrose saline solutions in the
19 postoperative period. The authors suggested that
20 national guidance was required, and that led to Alert
21 No. 22 being issued.
22 Following on from the issue of Alert No. 22, on
23 27 April 2007 Dr Michael McBride, who was then the Chief
24 Medical Officer for Northern Ireland, Dr Norman Morrow,
25 who was the Chief Pharmaceutical Officer for Northern

1 Ireland, and Martin Bradley, who was Chief Nursing
2 Officer, sent a joint letter to the chief executives of
3 the trusts, informing them that:
4 "HSC organisations are required to implement the
5 actions identified in the alert by 30 September 2007.
6 Independent sector providers which administer
7 intravenous fluids to children will also wish to ensure
8 that the actions specified in the alert are implemented
9 in their organisations within the same time scale."
10 The actions identified involved the removal of
11 Solution 18 from stock and general use in areas that
12 treat children; the production and dissemination of
13 clinical guidelines for the fluid management of
14 paediatric patients; the provision of adequate training
15 and supervision for all staff involved in the
16 prescribing, administering and monitoring of intravenous
17 infusions; reinforcement of safer practice by reviewing
18 and improving the design of existing intravenous fluid
19 prescriptions and fluid balance charts for children; the
20 promotion of the reporting of hospital acquired
21 hyponatraemia incidents via local risk management
22 reporting systems; and the implementation of an audit
23 programme to ensure that NPSA recommendations are
24 adhered to.
25 Alert No. 22, the circumstances in which it came

1 about, and the response to it will be addressed in
2 detail later on. However, as can immediately be seen,
3 it went further than the hyponatraemia guidance in that
4 it recommended the removal of Solution No. 18 from stock
5 and general use in areas that treat children. And for
6 completeness, the Commission on Human Medicines recently
7 had a further review carried out of the use of Solution
8 No. 18 and the Inquiry awaits the publication of its
9 results and their implications, if any, for its
10 investigations.
11 The implementation required by Alert No. 22 is to be
12 found in the guidance published by the Department
13 in September 2007. We can pull that up, it's at
14 303-059-817. This has now gone further than just
15 hyponatraemia guidelines, this is:
16 "Paediatric parenteral fluid therapy (1 month to
17 16 years): Initial Management Guidelines."
18 I will not go through it all, it's in the documents
19 for you to see.
20 The title of that guidance was amended and the
21 guidance was reissued in February 2007 to:
22 "Parenteral fluid therapy for children and young
23 persons (aged over 4 weeks and under 16 years)."
24 That guidance is more comprehensive, as I've said,
25 than the hyponatraemia guidelines, and the introduction

1 of that guidance into hospitals in Northern Ireland and
2 the effectiveness of the systems in place for monitoring
3 compliance with it are matters being investigated by the
4 Inquiry. But again, for completeness, prior to the
5 publication of Alert No. 22, the Chief Medical Officer
6 had written on 8 July 2004 to Dr Jack McCluggage, who
7 was the Postgraduate Dean of Medicine at Queen's
8 University, to request that he consider training in
9 fluid management administration a priority.
10 Dr McCluggage forwarded that request on to the senior
11 trainers within paediatrics and other medical
12 specialities on 20 July 2004.
13 Dr McCluggage remained Postgraduate Dean until
14 October 2004 when he was succeeded by Dr Terry McMurray,
15 and he wrote on 14 June 2005 to all directors of
16 speciality training committees, all postgraduate
17 clinical tutors, all education coordinators and to the
18 director of postgraduate general practice education,
19 requesting evidence about training being delivered and
20 how it had changed. And then Dr Mc Murray again wrote on
21 21 May 2008 to all the heads and deputy heads of the
22 schools of many of the key areas of practice, including
23 foundation doctors, specifically referring to the fact
24 that:
25 "The development of hyponatraemia in previously well

1 children undergoing surgery or with mild illness may not
2 be recognised by clinicians."
3 He enclosed the Regional Paediatric Central Fluid
4 Therapy Chart developed by the Department of Health as
5 well as a "Workforce Competence Statement" developed by
6 the National Patients Safety Agency to assist in
7 implementing and embedding the training. Dr McMurray
8 stressed:
9 "It is very important that training in this area is
10 addressed by your specialty and I would be grateful if
11 you can inform me as soon as possible how you mean to
12 address this issue."
13 On 30 June 2008, the Associate Dean for Foundation
14 Training contacted all the foundation doctors and their
15 educational supervisors to advise them that completion
16 of the BMJ e-learning module on hyponatraemia was
17 mandatory and that proof would be required of completion
18 of the module within four weeks of starting their F1
19 post.
20 The precise communications, if any, amongst the
21 hospitals/trusts, the Department, the coroner and
22 university in relation to the risks associated with low
23 sodium and poor fluid management and their significance
24 is something that is being investigated by the Inquiry.
25 Then just finally to the intervening period, the

1 RQIA. The HPSS Regulation of Quality Improvment
2 Authority was established by an order of 2003. It has
3 a role in relation to the inspection, regulation,
4 investigation and review of performance within health
5 and social service organisations against five quality
6 themes: corporate leadership and accountability; safe
7 and effective care; accessible, flexible and responsive
8 services; promoting, detecting and improving health and
9 social well-being; effective communication and
10 information.
11 The RQIA was asked to carry out an independent
12 review to provide assurance to the minister with regards
13 to the implementation of recommended actions outlined
14 within that Alert 22. In addition, the dissemination of
15 the clinical guidelines and a wall chart through the
16 trusts and independent hospitals was also reviewed.
17 The RQIA review team reported in April 2008. They
18 had made a summary report following what they referred
19 to as "validational visits" to the trusts and
20 independent hospitals. And thereafter, it provided its
21 full report on reducing the risk of hyponatraemia when
22 administering intravenous fluids to children,
23 dated September 2008.
24 It was acknowledged in those reports that all the
25 health and social care trusts and independent hospitals

1 that had been visited had undertaken considerable work
2 to reduce the risks of hyponatraemia when administering
3 intravenous fluids to children, and evidence was also
4 found in all the areas visited of a commitment to
5 achieve full compliance with the regulations in
6 Alert No. 22 and to disseminate the paediatric
7 parenteral fluid therapy clinical guidelines and wall
8 charts.
9 However, some concerns were expressed, and these are
10 important for us. (1) the need to ensure that measures
11 are consistently applied in adult wards where children
12 are treated. (2) the continued presence of Solution No.
13 18 in stock on site. (3) that the provision of fluid
14 management training for non-paediatric staff caring for
15 older children on adult wards was poor across all
16 organisations visited by the review team. (4) that
17 there was little evidence of a reporting culture for
18 incidents relating to intravenous fluids and
19 hyponatraemia.
20 The RQIA published a follow-up report in May 2010:
21 "Report of actions taken by HSC trusts and
22 independent hospitals to implement recommendations ..."
23 They found that Solution No. 18 had been completely
24 removed from all clinical areas where children were
25 treated. In addition, they found that members of staff

1 were aware of the clinical guidelines and that nursing
2 staff had attended training in paediatric fluid
3 administration. There was some concern that generic
4 adult fluid balance charts were still being used for
5 some paediatric patients rather than dedicated
6 paediatric equivalents and over the continuing risk
7 associated with the administration of intravenous fluids
8 to children on adult wards and clinical areas.
9 That latter issue, which was referred to at page 15
10 of the May 2010 report, was a matter of concern in
11 Conor's case when, in May 2003, he was treated in an
12 adult unit at Craigavon Area Hospital. And the extent
13 to which Alert No. 22 has been implemented by trusts and
14 hospitals in Northern Ireland and how they have
15 responded to the reports of the RQIA are issues that are
16 being considered by the Inquiry.
17 THE CHAIRMAN: Just pause for a moment. The issue about
18 children on adult wards, does that come about because
19 there is no uniformity of approach about what age
20 children --
21 MS ANYADIKE-DANES: I think that's --
22 THE CHAIRMAN: At what age you stop being a child for the
23 purposes of --
24 MS ANYADIKE-DANES: That's correct.
25 THE CHAIRMAN: -- of going to a children's ward or an adult

1 ward.
2 MS ANYADIKE-DANES: That's correct.
3 THE CHAIRMAN: So if the training and the steps which have
4 been taken to improve matters seem to be reasonably
5 impressive on the children's wards, that's fine for the
6 children there, but it does not necessarily help the
7 slightly older children who are on adult wards if the
8 staff there have not received the training.
9 MS ANYADIKE-DANES: That's correct. It also is relevant to
10 ascertain exactly how they define a child, whether
11 they're defining a child by the child's chronological
12 age or defining a child by its physique. Conor was 15,
13 but he had, as it was described, the body habitus of
14 an 8 to 9 year-old.
15 THE CHAIRMAN: Thank you.
16 MS ANYADIKE-DANES: If I turn now to the work when the
17 Inquiry resumed in 2008. It formally resumed with
18 a progress hearing on 30 May 2008, and you announced
19 then, Mr Chairman, that there were to be no criminal
20 prosecutions in any of the cases and therefore the way
21 was clear for the Inquiry to resume its work.
22 Mr Chairman, you explained that the intervening
23 years had brought about changes in that the Inquiry team
24 had changed. Mr and Mrs Crawford did not wish the
25 Inquiry team to investigate Lucy's death and the work

1 of the Inquiry was to be expanded to include Claire's
2 case and aspects of Conor's case.
3 So I turn now to that, the addition of Claire and
4 Conor. In the exercise of your discretion, Mr Chairman,
5 you added the case of Claire and aspects of Conor's
6 case. Both deaths had come to your attention after the
7 start of the Inquiry. The inquest into Claire's death
8 took place on 4 May 2004 and hyponatraemia was found to
9 be a contributory factor in her death. The basis upon
10 which Claire's death was included in the work of the
11 Inquiry was explained by you, Mr Chairman, during
12 a public hearing on 30 May 2008. Although we can call
13 it up, it's probably just as quick for me to recite what
14 you said:
15 "In broad terms, however, my concern is about the
16 apparent conflict between the initial explanation given
17 to the Roberts family and the subsequent explanation
18 given to them after, but only after, they contacted the
19 Royal following the television broadcast. I am also
20 concerned whether more should have been learned from
21 Adam's death and inquest and whether there should
22 therefore have been better fluid management in the Royal
23 for Claire a relatively short time later."
24 Despite the fact that Claire's death is not included
25 in the terms of reference, her case is being

1 investigated, Mr Chairman, according to precisely the
2 same terms as those for Adam and Raychel. Therefore the
3 Inquiry is concerned to investigate (i) Claire's care
4 and treatment from her admission to the Royal Belfast
5 Hospital For Sick Children on 21 October 1996 until her
6 death in PICU on 23 October 1996. And as with the cases
7 of Adam and Raychel, special attention is being paid to
8 the management of Claire's fluid balance, for example
9 how often her serum sodium level was checked, whether
10 she should have received the particular type of fluid
11 she did at the rate that it was administered. However,
12 her treatment also includes other elements including,l
13 for example, the monitoring of her neurological symptoms
14 and her admission to PICU.
15 It also involves investigations into the way in
16 which the aftermath of Adam's death and his inquest were
17 handled and any impact on Claire's care and treatment at
18 the Royal that they might have had. It will be
19 appreciated that Adam died at the Royal in November 1995
20 and the verdict in his inquest was given in June 1996
21 which was, in the case of his death, almost one year
22 before Claire was admitted but, in the case of his
23 inquest, almost exactly four months before she was
24 admitted there.
25 The second part of the terms of reference requires

1 an investigation into the actions of the statutory
2 authorities, other organisations and responsible
3 individuals concerned in the procedures, investigations
4 and events that followed her death. At an immediate
5 level, it involves an investigation into what happened
6 immediately after her death, including therefore the
7 brain-only post-mortem that was carried out by the
8 hospital. However, it also extends to an investigation
9 into why it was that there was no inquest into Claire's
10 death until 2006, following the action of her parents to
11 raise the matter with the Royal in 2004 after the chance
12 viewing of the UTV documentary.
13 Then the third part of the terms of reference
14 concerns the communications with and explanations given
15 to Claire's family and others by the relevant
16 authorities. This area of investigation therefore
17 includes an investigation into the information provided
18 to Claire's family about her condition, the conduct of
19 a brain-only post-mortem as well as the information
20 given to them during the meeting at the Royal in
21 December 2004, following the airing of that documentary.
22 The inquest into Conor's death took place on
23 9 June 2004. It did not conclude that hyponatraemia
24 played a role in his death. Nevertheless, there were
25 criticisms of fluid management and the record keeping,

1 and concerns were also raised about the extent to which
2 hyponatraemia guidelines had been followed and the
3 significance of Conor being admitted to an adult ward.
4 Ultimately, on 4 February 2010, Mr Chairman, you
5 decided to include certain elements of Conor's case into
6 the Inquiry's work on the following basis:
7 "It is obviously a matter of concern if guidelines
8 which have been introduced as a result of a previous
9 death or deaths and which are aimed at avoiding similar
10 events in the future are not properly communicated to
11 hospital staff and followed. It is relevant to the
12 investigation to be conducted by the Inquiry whether and
13 to what extent the guidelines have been disseminated and
14 followed in the period since they were published.
15 Another matter of [concern] is whether the fact that
16 Conor was being treated on an adult ward rather than the
17 children's ward made any difference to the way in which
18 it appears that the guidelines may not have been
19 followed. Accordingly, the Inquiry will investigate the
20 way in which the guidelines have been circulated by the
21 Department, the way in which they have been made known
22 to the hospital staff and the steps, if any, which were
23 taken to ensure that they were being followed. While
24 this is an issue of general importance, it will be
25 informed by an examination of the way in which

1 guidelines have been introduced and followed in
2 Craigavon Area Hospital by May 2003."
3 Conor's case is therefore being investigated in
4 relation to issues concerned with the hyponatraemia
5 guidelines, for example issues such as the rate, choice
6 and volume of fluid administration appropriate to his
7 case, whether his fluid management was adequately
8 monitored and recorded and documented and whether, if
9 his fluid management was inadequate, what was done about
10 it, both at the Craigavon Area Hospital and in the Royal
11 from the perspective of governance and lessons learned.
12 Shortly after the Inquiry resumed and as a result of
13 the request from Mr and Mrs Crawford to have Lucy's case
14 removed from the work of the Inquiry for their own
15 personal reasons, the terms of reference were revised,
16 and it came about in this way. The then Minister of
17 Health, Michael McGimpsey, acceded to the Crawfords'
18 request, which required the removal of Lucy's name from
19 the terms of reference. In fact, we can pull up the
20 terms of reference, the revised ones, at 303-034-461.
21 THE CHAIRMAN: The amendment in effect is to remove Lucy's
22 name.
23 MS ANYADIKE-DANES: Exactly. As you see there, the named
24 children are simply Adam Strain and Raychel Ferguson.
25 In all other respects, the terms of reference remain the

1 same.

2 THE CHAIRMAN: Claire and Conor come in under (a) at the

3 bottom of the page, which gives me the discretion to

4 examine and report on any other matters.

5 MS ANYADIKE-DANES: That's correct. In fact, there was

6 a specific query, Mr Chairman, as to whether you

7 required the terms of reference to be revised to include

8 them, and you, Mr Chairman, took the view that you had

9 that power and there was no need for those terms of

10 reference to be revised simply to include Claire and

11 Conor, and that's exactly how the matter proceeded.

12 But that left what interpretation should be given

13 the revised terms of reference. The minister left that

14 matter entirely to you, Mr Chairman, and he was mindful

15 of the independence of the Inquiry and he was also

16 mindful of the fact that the Inquiry is investigating to

17 a certain extent the officials, past and present, of his

18 department. So he left that matter to you and, in

19 response to that, Mr Chairman, you published

20 a consultation paper, canvassing ways in which the

21 revised terms could be interpreted. It is correct to

22 say that a particular aspect of it is what, if any,

23 would be the significance in terms of the successive

24 deaths of the fact that Lucy's name was being removed.

25 Ultimately, Mr Chairman, you published your decision on

1 that and that is -- I think we can call it up at
2 reference 303-036-464. There you are. Those were the
3 options that you gave. If we go to 7(b), that actually
4 was your decision:
5 "The terms still permit and indeed require an
6 investigation into the events which followed Lucy's
7 death such as the failure to identify the correct cause
8 of death and the alleged Sperrin Lakeland cover-up
9 because they contributed, arguably, to the death of
10 Raychel in Altnagelvin. This reflects the contention
11 that had the circumstances of Lucy's death been
12 identified correctly and had lessons been learned from
13 the way in which fluids were administered to her,
14 defective fluid management would not have occurred so
15 soon afterwards (only 14 months later) in Altnagelvin, a
16 hospital within the same Western Health and Social
17 Services Board area."
18 So that was your decision, and that was the basis
19 upon which we were going to move forward and conduct the
20 work under the revised terms of reference.
21 So issues such as steps taken by the Royal Belfast
22 Hospital for Sick Children to ascertain the cause of
23 Lucy's death, why a coroner's post-mortem was not
24 carried out and the adequacy of the Erne Hospital's
25 investigation into her death were all matters to be

1 investigated by the Inquiry because of the possible
2 impact that they might have on the care and treatment
3 provided to Raychel at the Altnagelvin Area Hospital,
4 just over a year later, and her subsequent death at the
5 Royal.
6 THE CHAIRMAN: And just to pause there, the point here
7 is that Mr and Mrs Crawford do not want an Inquiry into
8 Lucy's death. The minister has accepted that request,
9 but we are trying to strike a balance because Mr and
10 Mrs Ferguson believe that had there been a proper
11 investigation into Lucy's death, Raychel's death a short
12 time later may have been avoided.
13 MS ANYADIKE-DANES: That is correct.
14 THE CHAIRMAN: So we are trying to respect as much as we can
15 the Crawfords' wishes and their privacy while at the
16 same time giving the best investigation that we can into
17 what preceded Raychel's admission into Altnagelvin and
18 her death.
19 MS ANYADIKE-DANES: Yes, that is the line we're trying to
20 strike. If we bring all those developments together,
21 the revised terms of reference and the exercise of your
22 discretion, Mr Chairman, in 2008 and 2010, that has
23 required the following matters to be investigated: the
24 care and treatment of Adam, Claire and Raychel,
25 especially in relation to the management of fluid

1 balance and the choice and administration of intravenous
2 fluids; the circumstances of the death of Conor Mitchell
3 in the context of the guidelines on fluid management in
4 children; the actions of the statutory authorities,
5 other organisations and responsible individuals
6 concerned with procedures, investigations and events
7 which followed the deaths of Adam, Claire, Lucy --
8 in the respect in which you have just said, Mr Chairman,
9 in relation to the failure to identify the correct cause
10 of death and the alleged Sperrin Lakeland cover-up,
11 the death of Raychel, and then Conor and
12 in relation again in the way that you have defined it,
13 in relation to the guidelines on fluid management in
14 children, and then also the communications with and
15 explanations given to the families and the
16 recommendations to the Northern Ireland Department of
17 Health and Social Services and Public Safety. All of
18 these are the matters that are now being investigated
19 and have been for some time by the Inquiry.
20 Those issues are reflected in the Inquiry's list of
21 issues. The list of issues is a working document, Mr
22 Chairman, and that is updated and revised as
23 appropriate. The current list of issues was published
24 by the Inquiry on 14 February 2012. If we take first
25 the clinical matters which are associated with the care

1 and treatment provided to the children, your
2 interpretation, Mr Chairman, of the revised terms of
3 reference has translated into the following way. And
4 I just give some examples of that so that people can
5 understand how we've been pursuing this. If one takes
6 the first as an example, the underlying principles, the
7 calculations and the assumptions made in relation to the
8 prescription of intravenous fluids before, during and
9 after Adam's renal transplant surgery. We can look at
10 that at 303-038-479. Maybe these can just come up.
11 1.2(3). That's how that issue was derived. Then
12 if we move on, there's the adequacy and frequency of the
13 tests undertaken during Claire's admission and the tests
14 which could have been carried out on her between 21 --
15 and just to give the reference as I'm speaking, it is
16 303-038-486.
17 The tests that could have been carried out on her
18 between 21 and 23 October 1996, include the blood and
19 urine tests, a CT scan, an electro-encephalogram, EEG
20 commonly known as, and MRI scan. These are just
21 examples of what the investigation means if you go to
22 those lists of issues and translate them into actual
23 lines of investigation.
24 Then, Mr Chairman, because you've mentioned Lucy, if
25 you look at how the cause of Lucy's death was

1 established and agreed, including how and when the
2 clinicians responsible for Lucy's treatment discussed
3 and agreed on a cause of her death, that being the
4 starting point of what was done thereafter or what could
5 have been done thereafter. One sees that at
6 303-038-492.
7 Moving on to Raychel to see how some of this
8 translates into a line of investigation for her.
9 That is 303-038-494. That is whether there was a delay
10 on the part of the surgical team responding to calls
11 from the nursing team to see Raychel and, if so, why
12 that delay occurred, whether nursing staff should have
13 taken any further steps to secure the prompt attention
14 of a member of the surgical team. Did any of that
15 impact adversely on Raychel's care? Those are lines of
16 enquiry in her case. Then if one goes to 159,
17 303-038-494, whether the nursing and medical teams who
18 cared for Raychel adequately monitored her condition,
19 whether they provided her with appropriate treatment
20 before and after she suffered a tonic seizure.
21 Then if we go down to Conor at 303-038-497, to what
22 extent the care and treatment which Conor received both
23 in Craigavon Area Hospital and the Royal was consistent
24 with the then teaching and training on fluid management
25 and record keeping, and in particular the guidelines.

1 That's the clinical side of it, but obviously,
2 Mr Chairman, there is also the management and governance
3 side of matters. That's meant a consideration of issues
4 at all levels, really, from the Department, including
5 the Chief Medical Officer, to the relevant trusts and
6 boards down to the management of the individual
7 hospitals and right down to the specific hospital
8 divisions and clinical directorates. Those
9 considerations deal potentially with a very broad
10 spectrum, including the formulation of policy and
11 guidance, the development of health strategy and the
12 establishment of governance structures, systems and
13 procedures so as to enable the standard of health care
14 being delivered to be properly monitored, audited,
15 evaluated and, of course, improved.
16 Examples of the extent of that range, if you go to
17 303-038-484, that's the procedures and practices that
18 existed in Northern Ireland at the time of the
19 children's deaths for the reporting and dissemination of
20 information to the department and the medical community
21 in general of unexpected deaths in hospitals and
22 outcomes of coroners' inquests.
23 Then if we move on to 303-038-483, we come on to
24 training and teaching, which is something that you had
25 earlier identified, Mr Chairman. The teaching and

1 training to medical students and student nurses in
2 Northern Ireland on fluid management with particular
3 regard to hyponatraemia and record keeping and drug
4 prescribing and administration as part of their
5 qualification and to doctors and nurses as part of their
6 induction, training and continuous professional
7 development.
8 And then if we go on to guidelines, I give an
9 example at 303-038-482. What I'm going to say now
10 applies across the board, really, but this is one
11 example taken from Adam. The guidelines, procedures and
12 practices that existed within the Altnagelvin Area
13 Hospital, Craigavon Area Hospital and the Royal Belfast
14 Hospital For Sick Children governing the provision of
15 information to the parents of paediatric patients.
16 And then just two final ones to see the span of it.
17 303-038-502. That is a system of protocols, procedures
18 and practices by which hospitals in Northern Ireland
19 code the causes of deaths and adverse incidents. Then
20 finally, 303-038-490, the accuracy and quality of
21 information provided by the treating physicians to the
22 pathologists for post-mortem.
23 Mr Chairman, that's the span of the issues. Then,
24 of course, one deals with the institutions and the
25 personnel involved. In order to appreciate the scope of

1 the investigation that has been and is being carried
2 out, one really needs to say something about those two
3 things. At the time of Adam's admission to the Royal
4 Belfast Hospital For Sick Children on 26 November 1995,
5 Northern Ireland was under a code of direct rule from
6 Westminster with the Secretary of State for
7 Northern Ireland responsible for the departments of the
8 Northern Ireland government. The Secretary of State for
9 Northern Ireland at that time was Sir Patrick Mayhew.
10 He was also in office at the time when Claire was
11 admitted to the Royal Belfast Hospital For Sick Children
12 on 21 October 1996. He was succeeded in 1997 by
13 Mo Mowlam, who was in turn succeeded in 1999 by Peter
14 Mandelson.
15 Under direct rule, the Northern Ireland Department
16 of Health was under the remit of the Parliamentary
17 Undersecretary of State of the Northern Ireland office.
18 The minister responsible for health care in Northern
19 Ireland at the time of Adam's admission was Malcolm
20 Moss. The structure of the Health Service in
21 Northern Ireland at the time of Adam and Claire's
22 admission to the Royal and their deaths there in 1995
23 and 1996 is shown in -- and I've just compiled
24 something, which hopefully will set that out. I've
25 called it up now at 303-039-505.

1 This is pre-2007. As some of you may have
2 appreciated, there was a reorganisation of the service
3 in 2007, but this is how it was when the children who
4 are at issue here were being admitted and treated. You
5 can see at the top, there's the Secretary of State for
6 Northern Ireland, cascading down to the minister, the
7 Department of Health, and then you see across the boards
8 and so forth, and into the trusts.
9 Mr Chairman, you'll appreciate that things changed
10 fundamentally, of course, with the Belfast Agreement on
11 10 April 1998, and it entered into force on 2 December
12 1999 and ushered in a period of devolution. The
13 significance of that so far as this Inquiry is concerned
14 is that it resulted in the Department's order of 1999,
15 which established the Department of Health and Social
16 Services and Public Safety as a devolved department.
17 The first minister of the department was Bairbre de
18 Brun.
19 Devolution has been suspended on four occasions,
20 starting with 12 February 2000. So the ministers
21 responsible for health and social care in
22 Northern Ireland from 1994 until the present day,
23 including through the periods of direct rule, are shown
24 in a chart which we've compiled, and I can call that up
25 at 303-041-507.

1 There you are, sir. Then you see there's Malcolm
2 Moss. Under his tenure, if I can out it that way, the
3 following occurred: Adam's death on 28 November 1995,
4 Adam's inquest, Claire's death. Then you have,
5 May 1997, Tony Worthington, still under direct rule.
6 July 1998, John McFall, still under direct rule.
7 Then 2 December 1999, Bairbre de Brun, and while she
8 was there, there was Lucy's death on 14 April 2000.
9 12 February 2000, George Howarth, and the following
10 occurred during his tenure. That was when Lucy's death
11 occurred on 14 April 2000.
12 Then you have Bairbre de Brun coming in on
13 30 May 2000, and you have Raychel's death in June 2001,
14 the production and publication of hyponatraemia
15 guidelines, and then you have another period of direct
16 rule, 14 October 2002, with Des Brown.
17 Over the page, to 508, is 2003. You have Angela
18 Smith. Quite a bit happens there. Raychel's inquest,
19 Conor's death, Lucy's inquest, Conor's inquest, and
20 of course, the Inquiry is established. Sean Woodward
21 comes in in 2005, the Inquiry is suspended for a period
22 there for reasons we've already heard about the PSNI.
23 2006, Paul Goggins, and during that period there's
24 Claire's inquest, Alert 22, and the requirement to
25 implement it by September 2007. All of that happened

1 during the period of direct rule.
2 Then we get back to devolved government on 8 May
3 20007, Michael McGimpsey, and the Inquiry resumed during
4 his tenure and is continuing under the tenure of Edwin
5 Poots.
6 The significance of those periods of direct rule, if
7 any, is a matter that the Inquiry will consider in terms
8 of its impact on any of the issues arising out of the
9 terms of reference or the revised terms of reference.
10 In June 2002, the Northern Ireland Assembly Executive
11 launched the review of public administration with a view
12 to putting into place modern accountable and effective
13 arrangements for public service delivery and the final
14 outcome was announced by the Secretary of State
15 in November 2005, and it led to a major reorganisation
16 of health and social care, which was to take place in
17 two phases. The first phase was the establishment of
18 five new integrated health and social care trusts,
19 effective from 1 April 2007. And they replaced the
20 trusts which had been in operation during the cases of
21 all the children. The original Health and Social
22 Services boards remained in place until the introduction
23 of the second phase in April 2009, and that involved
24 their replacement by the Health & Social Care Board.
25 In addition, seven local commissioning groups were

1 created in April 2007. They were ultimately reduced to
2 five with the boundaries aligned to those of the trusts
3 in 2009, and prior to that reorganisation, the four
4 boards had commissioned services from the trusts, and
5 the functions of the local commissioning groups was to
6 assess and plan for current and emerging health and
7 social care needs and to deliver the health and social
8 care to meet those needs. We can look at that structure
9 at 303-042-509.
10 There we see it. This is really showing you
11 pre-April and then post 2009, so you can see the
12 position in relation to the boards. If one looks at the
13 boards, you've got the four there and after April 2009
14 you have one. Then if we look at the health and social
15 services trusts pre that, you see the number of trusts
16 there and post-April 2007, you see that there's four.
17 Then if one looks at the acute hospitals --
18 THE CHAIRMAN: Five. Sorry, I think there are five.
19 MS ANYADIKE-DANES: There are five, sorry. I beg your
20 pardon. Failure of arithmetic. There's five.
21 Then if you go down to the local commissioning
22 groups and see the position previously, and then you see
23 it post-April 2009.
24 I think we can have a look at a map that also helps.
25 If we look at 300-002-002. Now you can see the position

1 when the commissioning bodies are not aligned.
2 If we call up 300-078-149. You can see there also where
3 the trusts are, the commissioning group boundaries, and
4 you see where the hospitals are.
5 In broad terms, the function of those organisations,
6 therefore their relevance to the work of this Inquiry,
7 because that's what's at issue here -- the Department of
8 Health has overall authority for health and social care
9 services in Northern Ireland and to allocate government
10 funding for that purpose. That authority includes
11 a formulation of policy and legislation for hospitals.
12 The Health & Social Care Board and its predecessor
13 regional boards are commissioners of health and social
14 services in large part. Five trusts, of which three are
15 particularly involved in the work of the Inquiry, are
16 responsible for the provision of the health and social
17 care services. Each trust manages its own staff and
18 services and controls its own budget. The Royal Group
19 of Hospitals Trust is, of course, particularly concerned
20 with the work of the Inquiry as it concerns the Royal
21 Belfast Hospital For Sick Children where all the
22 children received their final care and treatment and,
23 ultimately, died. And the structure of that trust, as
24 it was in 1995 and 1996, when Adam and Claire were
25 admitted, is shown in -- we can pull it up --

1 303-043-510.

2 You see at the top, a chairman. Then down to its

3 chief executive. Then you see the non-executive

4 directors and the executive directors. If we just move

5 to the medical side for the moment, you can see the

6 medical director off to the far right; Ian Carson. Then

7 you can see the directorates there, and for our

8 purposes, names we have already heard: Joseph Gaston,

9 anaesthetics theatre and intensive care. And you can

10 see others who look as if they might be relevant:

11 Medical, Professor Gary Love; radiology to some extent,

12 Dr James Laird; surgical, Mr John Hood; and paediatrics,

13 Dr Mulholland.

14 Then you can see a name that you have already heard

15 of. If we look at the medical administration and see

16 Dr George Murnaghan and see where he fits into the

17 picture. Just above "pharmacy".

18 THE CHAIRMAN: It's in the middle of the diagram.

19 MS ANYADIKE-DANES: That's exactly right. So there you see

20 how he fits into that. His name has been mentioned many

21 times and there he was as a director for medical

22 administration.

23 If we come out again, you can see nursing and

24 patient services is there with Miss Elizabeth Duffin.

25 She was also at that level of level, director of nursing

1 and patient services also.

2 So that's how it looked in 1995/96. The Royal Group

3 of Hospitals, therefore the Royal Belfast Hospital For

4 Sick Children and now within the Belfast Trust, the

5 structure of which is shown in a chart which we've

6 compiled to try and show the present day position.

7 That is at 303-044-511. Personalities have changed and

8 the structure is slightly different as well. If we go

9 to the far right side again, you can see now -- yes,

10 they have a medical director, but alongside of that,

11 director of cancer and specialist services, and that's

12 where nephrology is located.

13 THE CHAIRMAN: Thank you.

14 MS ANYADIKE-DANES: The hospitals within those trusts are

15 where the health and social care services are actually

16 delivered, of course, and the work of this Inquiry is

17 particularly concerned with five of those hospitals.

18 The Royal Belfast Hospital For Sick Children --

19 THE CHAIRMAN: Shall we just call it The Children's

20 Hospital?

21 MS ANYADIKE-DANES: We can. The Belfast City Hospital,

22 Erne Hospital, Altnagelvin and Craigavon. So those are

23 the institutions and then if we go to the personnel,

24 there are a large number of persons at the level of

25 clinicians, technicians and administrators involved

1 in the investigation of both the clinical issues and the
2 management and governance issues. Of particular
3 relevance to the work of the Inquiry are those who were
4 directly involved in the care of the children during
5 their final admission to their local hospital, and where
6 relevant, following their transfer to The Children's
7 Hospital, those who had the responsibility for
8 communicating with the children's families in respect of
9 consent, aspects of the children's case and/or the
10 reasons for their death, those who were involved in the
11 post-mortem investigations into the cause of the
12 children's death and for the provision of the reports on
13 autopsy or post-mortem reports on the children, those
14 who have the authority to require investigations into
15 and reviews of the care and treatment of the children
16 and of their deaths, and those who were actually
17 involved in any such investigations and those who were
18 in the coroner's office involved in any decision in
19 respect of the holding of an inquest into any of the
20 children's death and the coroner for the inquest into
21 each of the children's death and those who were and are
22 responsible for the development, implementation, audit
23 and evaluation and revision of health policy, guidance
24 and practice in the respects in which this Inquiry is
25 concerned.

1 A number of the clinicians and pathologists were
2 involved in more than one of the children's cases, and
3 that may be relevant for the investigation on lessons
4 learned and governance. And it raises its own issues,
5 which are matters that are being investigated by the
6 Inquiry as to who had relevant knowledge and experience
7 and the impact that that should have had on the care
8 provided to the children and also what happened in the
9 aftermath of their deaths. Those involved in that way
10 in the key disciplines of anaesthesia, neurology and
11 pathology are set out in a chart which we have compiled
12 to try and assist and that can be called up at
13 303-045-512.
14 Across the top are the children, and then you see
15 the anaesthetist. Dr Robert Taylor, consultant
16 paediatric anaesthetist as he was throughout the period.
17 If we expand a little bit. There, he was the consultant
18 for the renal transplant operation for Adam. He
19 examined Claire and he also examined Conor on a ward
20 round.
21 Staying with the anaesthetists, look at Peter Crean.
22 He was a consultant during the previous operations. He
23 assisted in drawing up the draft recommendations.
24 That's Adam. As for Claire, he's noted as consultant
25 for her case note discharge summary. He treated Lucy

1 when she was transferred to the children's hospital he
2 had overall responsibility for Raychel's care when she
3 was transferred and he also made the diagnosis of
4 brainstem death in her case.
5 If we just move up a little bit, we see Seamus
6 McKaigue. He is another consultant paediatric
7 anaesthetist. He assisted in drawing up the draft
8 recommendations for Adam. He was consultant on call
9 when Claire was admitted and he also examined Conor.
10 If you look at Anthony Chisakuta, he was senior
11 registrar in anaesthesia and was consultant from 1997.
12 He had previously anaesthetised Adam, not in relation to
13 his transplant surgery, but previously and some of that
14 may become relevant as we look into more detail in
15 Adam's case. And if we go across to Lucy, he made the
16 diagnosis of brainstem death. And if we go right
17 across, he accepted Conor for transfer to PICU in the
18 children's hospital.
19 If we now look at the neurologists, there is
20 David Webb. He carried out the brainstem tests on Adam
21 and he examined Claire on a number of occasions as the
22 consultant paediatric neurologist. If you look at
23 Dr Hanrahan, he treated Lucy and he made the diagnosis
24 of brainstem death in Raychel.
25 Over the page to 513. We can look at the surgeons.

1 He had previously assisted on some surgery on Adam, not
2 his transplant surgery, and he also had the care of
3 Raychel.
4 Go down to pathologists. Let's finally look at the
5 pathologists. Brian Herron, who is involved in three:
6 in Claire, Raychel, Conor. Dr Mirakhur, there's
7 an issue we're pursuing in relation to Adam. And also
8 in relation to Claire. And Dr Denis O'Hara, he was
9 involved in two: Adam and Lucy.
10 There is also a similar overlap in relation to the
11 management of the Royal hospitals, of which the
12 children's hospital, of course, forms a part. I single
13 out The Royal because it is the hospital which alone saw
14 and treated all the children immediately prior to their
15 deaths, and Mr William McKee was chief executive when
16 each of the children was admitted to the children's
17 hospital.
18 The position in relation to the medical director,
19 the nursing and patient services director, which were
20 both executive director positions, is a matter being
21 investigated by the Inquiry. So too is the position
22 in relation to the directors of the key directorates of
23 anaesthesia, theatre and intensive care, paediatrics,
24 surgery, neurosciences, laboratories, radiology and
25 medical administration. And that raises questions about

1 the unique opportunities that the Royal hospitals and
2 the children's hospital, in particular, had for lessons
3 learned and the dissemination of any learning which are
4 matters that the Inquiry is investigating.
5 In addition to those who were directly involved
6 in the sense that I have just outlined, there are
7 a number of others whose conduct and/or views are
8 relevant to the work of the Inquiry. An example of
9 those are those who acted as experts, whether during an
10 inquest or during the investigations by the PSNI, and
11 the evidence of all those involved will be provided in
12 a variety of ways: statements they provided to others,
13 whether to their employer, as some did, to the Royal;
14 depositions that have been given to the coroner;
15 statements given to the PSNI, together with any document
16 that they supplied, as some did, in support of their
17 position; depositions of experts given to the coroner
18 together with their reports, whether they were engaged
19 by the coroner, the families or PSNI; witness statements
20 given to the Inquiry, of which there is now
21 a considerable number and once again any documentation
22 that has been supplied in support of their views. And
23 of course, there's the reports of experts that the
24 Inquiry has engaged and then the testimony of those who
25 will give their evidence at these oral hearings.

1 How has the work of the Inquiry been carried out?
2 The legal team comprises me as senior counsel to the
3 Inquiry, Jill Comerton, Martin Wolfe, both junior
4 counsel to the Inquiry, together with David John Reid,
5 who is junior counsel, and he has provided what can only
6 be described as invaluable assistance.
7 In addition, Anne Dillon, who is solicitor to the
8 Inquiry, and Brian Cullen, who is the assistant
9 solicitor to the Inquiry. I have also had the
10 assistance, I should say, of other solicitors, in
11 particular Fiona Chamberlain, who was a solicitor to the
12 Inquiry prior to its resumption.
13 What is our role? The role of the legal team now
14 that the oral hearings is commenced is, in large part,
15 but not exclusively so, to focus on the evidence, to
16 ensure that the examination of witnesses is rigorous and
17 elicits all of the relevant evidence in a way which is
18 not just fair to the witness and range of views of the
19 core participants, but also bears in mind the public
20 interest. It is my duty to act impartially,
21 independently from you, Mr Chairman, and act in the
22 public interest, and the work of the legal team
23 in relation to the evidence has been and is being
24 determined by the Inquiry's revised terms of reference
25 and the list of issues that you, Mr Chairman, have

1 published and which may change from time to time.
2 It will be appreciated in what I've said so far
3 about the revised terms of reference that the expansion
4 of the Inquiry's work following the addition of the
5 cases of Claire and Conor and the translation of revised
6 terms of reference into a published list of issues, that
7 the consideration of issues of such breadth and depth
8 has been a huge undertaking for the legal team and has
9 taken time. Effectively, we have been pursuing five
10 interlinked enquiries or investigations into both
11 clinical and governance matters and it has been my job,
12 assisted by the other members of the legal team, to
13 investigate the evidence relating to the issues that
14 arise from the revised terms of reference. That is the
15 first part of our work, which roughly corresponds to
16 what was stages A, document gathering, and C, witness
17 statements, in the original general procedures which
18 were published on the Inquiry's website.
19 It has also included obtaining and analysing expert
20 reports, and this has been a particularly taxing
21 exercise where there have been differences of view
22 between eminent experts. Such differences have made it
23 necessary to test and probe not only the underlying
24 assumptions made by the experts but also the clinical
25 and evidential basis of their views. That is a crucial

1 process and it has been time-consuming. Unfortunately,
2 it is not yet complete and there are outstanding reports
3 from experts on both clinical as well as hospital
4 management and governance matters. They will be issued
5 when received in accordance with the procedures that
6 you have established, Mr Chairman.
7 It is a matter entirely for you, Mr Chairman, what
8 consideration and weight you place on the various forms
9 of documentary evidence that the legal team has
10 presented and will present to you, ranging from the
11 background papers which seek to provide a context to
12 some of the matters in question to publications and
13 guidelines that could or should have informed the
14 conduct of those involved, to contemporaneous records
15 and documents that may or may not have been accurately
16 recording what was happening, to statements of those
17 involved and the extent to which they are at variance
18 with each other or with previous evidence on those
19 persons, the reports of various experts, and again the
20 extent to which they agree with each other, disagree,
21 are consistent with the contemporaneous materials and/or
22 disagree with views expressed in the statements of those
23 who were actually involved, whether as clinicians or
24 managers.
25 And the second part of the legal team's work

1 requires testing that evidence through the questioning
2 of witnesses and experts during the oral hearings.
3 It is my task, assisted by the rest of the legal team,
4 to explore the issues during the oral hearings in
5 a probing manner. It is not the task of the legal team
6 to develop any particular theory of what happened or to
7 support any particular version of events. Rather, our
8 objective is to try and get to the bottom of what
9 happened and why and present the evidence to enable you,
10 Mr Chairman, to reach the most informed conclusions
11 possible and thereafter to be able to make
12 recommendations directed at improving matters.
13 Ultimately, Mr Chairman, it will be for you to make
14 determinations and findings on the issues arising out of
15 the revised list of issues in the light of all the
16 evidence. That, of course, is why it is crucial for me
17 and the rest of the legal team to properly adduce for
18 you all of the relevant evidence and to test it in
19 a rigorous and balanced way.
20 So if I just come now to concluding what I have to
21 say, I will say a little bit about document gathering.
22 The call for documents has been ongoing since the
23 resumption of the Inquiry's work. The search for
24 documents, which continues, has and is being informed by
25 guidance from the Inquiry's advisers, from our experts

1 and from the responses to our requests for witness
2 statements. To date, we have received over 140 files of
3 documents, and they include the children's medical notes
4 and records. We have reports, scans, X-rays,
5 photographs, correspondence and other documents
6 generated by the hospitals and authorities. We have
7 depositions from all the inquests and the reports
8 commissioned by the coroner.
9 We have the documents held by all the families and
10 the correspondence and transcripts from UTV. We have
11 statements from the PSNI investigations and the reports
12 they commissioned. We have the documents related to the
13 GMC in relation to Jarlath O'Donohoe's case and from the
14 NMC proceedings in relation to Ruth Bullas' case. We
15 have documentation from bodies such as the Department of
16 State Pathology, the National Patient Safety Agency,
17 Blood and Transplant, Royal College of Paediatrics and
18 Childcare and many, many more. Correspondence from the
19 DLS providing responses to our requests. Literally
20 a huge volume of correspondence.
21 We have also received the histological slides and
22 other materials in relation to some of the children and
23 we have provided those to the Inquiry's experts for them
24 to examine and provide reports. In addition to all of
25 that, we have received numerous publications from our

1 advisers, experts, witnesses and legal representatives,
2 and we have compiled a bibliography of all those
3 publications which is being updated as further
4 authorities are cited. We have also compiled
5 a bibliography of the relevant government and other
6 publications in respect of healthcare management and
7 governance that are relevant to the children's cases and
8 revised terms of reference.
9 And finally to say a little bit about the background
10 papers, which I've mentioned. The earlier concerns over
11 the content of education and training in relation to
12 fluid management and the incidence of paediatric death
13 in Northern Ireland from hyponatraemia were addressed
14 through commissioning certain background papers and they
15 have been published on the Inquiry's website.
16 Mr Chairman, you explained the purpose of doing so
17 in relation to education and training in the public
18 hearing on 9 March, and you said:
19 "The reason for commissioning these papers and then
20 circulating them is that we wanted to obtain a picture
21 of the extent to which nurses and doctors have been
22 taught about hyponatraemia and related issues over the
23 last 30 or so years. The picture, as you will see when
24 the receive the reports, the picture that emerges is a
25 bit patchy, but we wanted to do that because it helps to

1 set a background against which witnesses can be
2 questioned at the oral hearings about the extent to
3 which they were aware of hyponatraemia and what training
4 they had received. The Inquiry engaged a Dr Michael
5 Ledwith, clinical director of paediatrics, and professor
6 Sir Alan Craft, emeritus professor of child health to
7 provide a background paper on the training and
8 continuing professional development of doctors in
9 Northern Ireland and the rest of the United Kingdom and
10 the Republic of Ireland by way of comparison over the
11 period of 1975 to 2009."
12 Mr Chairman, I do not propose to cite extensively
13 from it, but to draw attention to some points that
14 emerge from it:
15 "Until recently, training was at the discretion of
16 individual lecturers and tutors and Solution No. 18 was
17 a commonly-recommended fluid in paediatrics.
18 Hyponatraemia and syndrome of inappropriate secretion of
19 antidiuretic hormone were understood, but regarded as
20 uncommon and there was no agreed protocol for the
21 management of children on intravenous fluids and there
22 were no recommendations for regular electrolyte
23 testing."
24 That is as the background paper has described.
25 More recently, though, teaching systems have become

1 more accountable, curricula have specific requirements
2 for the teaching of the management of intravenous fluids
3 in paediatrics. Medical students at Queen's are taught
4 the prevention of hyponatraemia in adults based on the
5 clinical resource efficiency support team guidelines and
6 alert 22 has specifically referred to the use of
7 Solution No. 18 and they're also taught about the
8 guidelines for the management of children in intravenous
9 fluids. That is where matters emerged from the
10 background paper on doctors' training.
11 In relation to that of nurses, Professor Mary
12 Hanratty, who was the former vice president of the
13 Nursing and Midwifery Council and Professor Alan
14 Glasper, professor of children and young persons nursing
15 at the university of Southampton, they were engaged to
16 provide a similar or comparable paper for the training
17 and education of nurses in Northern Ireland, the rest of
18 the United Kingdom and again in the Republic of Ireland,
19 over a period, slightly more extended this time, from
20 1975 to 2011.
21 The main points which emerged from that are that
22 they say that maintaining fluid balance was often part
23 of a pre- and post-registration nurse education
24 programme, but hyponatraemia itself was rarely
25 specifically mentioned. On the whole, there was little

1 attention paid to the Department of Health guidance on
2 the management of hyponatraemia that was circulated in
3 2002, and that that, they consider, led to the RQIA
4 assessment in 2008 finding that changes in practice were
5 patchy, and that every trust has since revised and
6 updated the prescription, administration instructions
7 and fluid intake and output documents, reflecting the
8 efforts to prevent the development of hyponatraemia in
9 children.
10 So that was as far as training went. In relation to
11 your concern, Mr Chairman, with the incidence of it and
12 how that compared with the rest of the United Kingdom
13 and, indeed, Europe, the Inquiry engaged Dr David
14 Marshall, who was a senior principal statistician at
15 NISRA on child hospital deaths in Northern Ireland from
16 hyponatraemia or fluid overload and compare that with
17 such deaths in the rest of the United Kingdom and
18 Western Europe, and he looked at the period 1979 to
19 2008, initially.
20 The salient points from his work were that there
21 were 111 registered deaths in Northern Ireland between
22 1979 and 2008, where hyponatraemia or fluid overload was
23 recorded as a cause of death. Of these, 13 were coded
24 as underlying cause of death, none of them were
25 children. For the remaining 98, hyponatraemia, or fluid

1 overload, is recorded as secondary cause of death and
2 five of those deaths were to children aged less than 15.
3 That was his first finding.
4 A second was that initial analysis indicates
5 a higher rate of child mortality in Northern Ireland
6 than in selected other European countries where
7 hyponatraemia/fluid overload is a factor in the cause of
8 death, but he cautions how that should be regarded
9 because he says:
10 "The analysis should be treated with care because
11 there is a small number of registered deaths in
12 Northern Ireland."
13 That's the first thing. He emphasises it's very
14 small:
15 "The fact that the numbers are based on death
16 certificate coding which can vary greatly from country
17 to country and the knowledge and awareness of the
18 condition can also vary from country to country."
19 The difficulties in statistical comparison
20 identified in those background papers were referred to
21 by you, Mr Chairman, at the progress hearing on
22 9 March 2011, and you identified that the issue of
23 concern which was really emerging was that of the coding
24 system for deaths, and a potential problem is the
25 accuracy and reliability of the coding system. Unless

1 the coding system is accurate and reliable, it doesn't
2 give you, whether in hyponatraemia or any other area,
3 a truly accurate report on the incidence of various
4 conditions, such as hyponatraemia, and the Inquiry has
5 taken that up and is investigating the issue of the
6 coding system in Northern Ireland.
7 Finally, there were two other specialist areas where
8 it was considered helpful to have an appropriate factual
9 context in which to receive and consider oral evidence
10 of witnesses. One of those relates to coroners and the
11 other to post-mortems. So Dr Bridget Dolan was engaged
12 on the system of procedures and practices in the
13 United Kingdom for reporting and disseminating
14 information on the outcomes or lessons to be learned
15 from coroners' inquests on deaths in hospitals.
16 I don't, again, want to cite extensively from that,
17 but just to highlight some of the points they made.
18 First, she pointed out that a coroner has the power to
19 report the circumstances of an inquest case to an
20 appropriate authority. That's rule 43 in England and
21 Wales; in Northern Ireland it's rule 23. In England and
22 Wales, there is no national procedure or policy for the
23 dissemination of those reports beyond the recipients,
24 and there was no central collation of reports pertaining
25 to healthcare issues by the Department of Health, nor

1 any review of the rule 43 reports. In Northern Ireland,
2 there were no central figures for rule 23 referrals.
3 She then went on to say that the amended rule 43
4 power in England and Wales, which came into effect in
5 2008, increased the effect of a rule 43 report:
6 "The coroner has a wider remit for issuing them and
7 anyone receiving a report must provide the coroner with
8 a written response which must be sent to the Lord
9 Chancellor and may be published. And the
10 Ministry of Justice now produces regular bulletins
11 collating all rule 43 reports in the previous six
12 months."
13 There were and still are no sanctions for failing to
14 respond to a rule 23 in Northern Ireland or a rule 43 in
15 England and Wales.
16 THE CHAIRMAN: Just to spell that out, that means that if
17 for instance Mr Leckey, as the senior coroner, had
18 concerns over Adam's inquest, he has the power to report
19 that to the department. That power has been more
20 developed in England, but neither in Northern Ireland or
21 the rest of the United Kingdom is there a sanction for
22 a failure to respond.
23 MS ANYADIKE-DANES: No, there is not as yet.
24 The final background paper was from Dr Jean Keeling,
25 the paediatric pathologist. She was asked to provide

1 a background paper on the system of procedures for the
2 dissemination of information gained by post-mortem
3 examination following an unexpected death of a child in
4 hospital. Some of the key points from her background
5 paper are:
6 "Apart from issuing the death certificate, there is
7 no standard practice in the United Kingdom for
8 disseminating the information regarding unexpected death
9 in a hospital to other hospitals and bodies. Likewise,
10 there is no common practice for internal analysis of
11 deaths by hospitals, although many hospitals have
12 meetings in which recent deaths are discussed, morbidity
13 and mortality meetings, for example."
14 But I think what she is highlighting is that there
15 is no standard practice for it:
16 "Coding is performed by clerks in hospitals based on
17 information received from doctors. The likely source of
18 an error in coding is from the doctors involved rather
19 than the coders. Inaccurate coding could affect
20 government-generated statistics."
21 But she thought it was unlikely to affect
22 an analysis such as the national confidential Inquiry
23 into peri-operative deaths, where information is
24 obtained on direct enquiry from consultants.
25 And finally she expressed the view that there are no

1 formal practices governing the dissemination of
2 information from coroners' inquests to hospitals, trusts
3 and educational establishments. It's not that it can't
4 happen; what she says is there are no formal procedures
5 for doing that.
6 Expert reports, just a little bit about them. The
7 Inquiry engaged experts to provide reports as advised by
8 its advisers to address both general issues, such as the
9 role of certain clinicians, as well as discrete issues
10 such as the interpretation of X-rays and CT scans. The
11 reports of the experts that have been received to date
12 in Adam's case have all been made available to the
13 interested parties and further reports, if they are
14 received, will be published in due course.
15 The investigation into the cases of Claire, Lucy,
16 Raychel and Conor is ongoing and the reports of the
17 experts involved in those cases will also be made
18 available and published in accordance with your
19 protocols, Mr Chairman.
20 Then witness statements. The Inquiry has requested
21 and received witness statements and supplemental witness
22 statements, sometimes more than just a single round.
23 The legal team has been guided in its questioning by
24 advisers, the medical notes and records and other
25 contemporaneous material, the subsequent documents

1 received, expert reports and the previous statements
2 made by the witnesses to whichever body and, of course,
3 the statements from other witnesses. The witness
4 statements that the Inquiry has sought and received
5 cover the range from those whose involvement in the
6 children's case is peripheral, but whose evidence is
7 required to establish some discrete point, to those
8 directly involved, whether in the provision of medical
9 care or in the management and governance of the
10 provision of such care.
11 It is entirely possible that the evidence provided
12 by a witness statement to be sufficient and particularly
13 where it's not contradicted by any other source or
14 challenged and to stand in lieu of oral evidence from
15 that person. The legal team has prepared a schedule in
16 the case of Adam of those witnesses that are not being
17 called and whose Inquiry witness statement is being
18 tendered as an unchallenged account. Similar schedules
19 will be prepared for each of the other children's cases
20 when that time comes.
21 Some, unfortunately, of the witnesses that the
22 Inquiry would wish to call have since died or are too
23 ill to give evidence. For example, the list of persons
24 involved that has been published for Adam's case show
25 that Dr Fiona Gibson is too ill to assist, regrettably

1 for her. She was the consultant anaesthetist at the
2 Royal Hospital who was asked in December 1995 to review
3 the processes and equipment used in the children's
4 hospitals' operating theatres.
5 In the event that the evidence of a witness is
6 recorded in a statement, whether it is a deposition or a
7 statement to the PSNI or an Inquiry witness statement,
8 such as Dr Gibson's PSNI statement, then Mr Chairman, it
9 will be a matter for you to determine what weight
10 you will afford it in the light of all of the other
11 evidence that you hear.
12 This really is the final thing. You will have
13 appreciated, Mr Chairman, as I have gone through this
14 opening that there have been a number of documents that
15 the legal team has compiled. Really, we've done it to
16 assist in distilling what is a vast amount of
17 information accumulated over the time, and some of the
18 documents that we have compiled are of general
19 application. For example, the maps showing the
20 positions of trusts and boards, and so forth, and I've
21 referred to some of those types of documents in the
22 course of this opening. But some of the documents
23 compiled relate solely to a particular child's case such
24 as the clinical chronologies, and I will refer to those
25 documents at the openings of each of the relevant

1 child's case. The current categories of documents that
2 are compiled or are being compiled are set out in an
3 appendix to this general opening, and since the
4 investigations are continuing, it is possible that
5 further such documents will be provided. But as it
6 stands at the moment, when this is published, there will
7 be a list of categories that we are working on and will
8 have completed.
9 Mr Chairman, the next thing ordinarily would be to
10 address the issue of the oral hearings. But I know,
11 Mr Chairman, that you wish to deal with that yourself.
12 So unless there is anything further that I can help you
13 with.
14 THE CHAIRMAN: Thank you, Ms Anyadike-Danes, for that very
15 comprehensive analysis of how the Inquiry has come about
16 and what we've been doing with others over the last
17 number of years.
18 What should now have happened and what we said
19 in the past would happen now is that once
20 Ms Anyadike-Danes had completed the general opening of
21 the Inquiry, which is what she has done over the last
22 two-and-three-quarter hours, she would move on to give
23 a specific opening to the Inquiry in relation to Adam
24 and the clinical issues arising in Adam's case.
25 You know from the report which I circulated last

1 week from Professor Kirkham and from the note that
2 I then circulated on Friday that there are now problems
3 about that. I want to come back to those after lunch.
4 We'll stop in a few minutes for lunch for approximately
5 one hour.
6 What I want to check is this: that when we were here
7 a few weeks ago, I asked if there were any parties who
8 wanted to make opening statements, and I understand
9 Mr McBrien, that you said you did. Mr Topolski, I think
10 you have said you want to, and Mr Shaw, I have now heard
11 that you have.
12 First of all, of course, I am quite happy to hear
13 opening statements, but I'm anxious to focus those today
14 on the opening in general statements, not on opening
15 statements specific to Adam clinical. Do you understand
16 that, Mr McBrien? Will you be making such a statement
17 after lunch?
18 MR McBRIEN: That was my intention, yes, sir.
19 THE CHAIRMAN: This is a general opening statement?
20 MR McBRIEN: Yes, sir.
21 THE CHAIRMAN: Mr Topolski?
22 MR TOPOLSKI: Yes, very general -- and about
23 three-and-a-half minutes.
24 THE CHAIRMAN: Even better. Mr Shaw?
25 MR SHAW: It's general. I can beat that. It might take

1 about 30 seconds.
2 THE CHAIRMAN: Is there anyone else who wants to make
3 a general opening statement? Okay. We'll do those
4 immediately after lunch. Mr McBrien, can you give us an
5 estimate?
6 MR McBRIEN: I'd have thought about five or ten minutes,
7 sir.
8 THE CHAIRMAN: I'm not rushing anybody, I'm just asking for
9 time indications. If those are adhered to, it will mean
10 that by 2.30, we will get to the issue which I issued
11 the note about on Friday. We could consider how and in
12 what way the Inquiry can then proceed as quickly as
13 possible to continue with the hearings into the clinical
14 aspects of Adam's treatment. Thank you very much.
15 We'll be back at 2 o'clock.
16 (1.00 pm)
17 (The Short Adjournment)
18 (2.00 pm)
19 THE CHAIRMAN: Thank you. Mr McBrien, on behalf of Adam's
20 mother, Mrs Slavin, and the Slavin family, do you want
21 to make an opening statement?
22 MR McBRIEN: If I may, sir. Shall I commence now?
23 THE CHAIRMAN: Yes.
24 Opening by MR McBRIEN
25 MR McBRIEN: First of all, for the benefit of the

1 stenographer, my name is David McBrien, counsel for the
2 family of Adam Strain, instructed by David Hunter,
3 solicitor, of Hunter Associates.
4 Mr Chairman, on the one hand, I wish to express
5 gratitude on behalf of the family of Adam Strain that
6 we have at last reached the start of the substantive
7 hearings. On the other hand, the stress and strain of
8 the unexpected postponement in the autumn of last year
9 has taken its toll on the family. Your determination to
10 have this Inquiry benefits not only the family of
11 Adam Strain, not only the other families represented in
12 this Inquiry, but also the local and, perhaps, even the
13 national community.
14 Although years have passed since the start of this
15 Inquiry, Adam's family understand that it has taken that
16 time to investigate in detail the issues which have
17 arisen. Much information has come to light, many
18 questions have been answered, much has been explained.
19 The amount of time and effort that has been expended
20 is considerable. However, it will have been worth it if
21 lessons can be learned. The truth is what matters.
22 Nevertheless, in examining the documents furnished by
23 the Inquiry, the family has experienced a whole gamut of
24 emotions: amazement, shock, disappointment and anger.
25 Moreover, in common with many others, Adam's mother

1 has always felt frustrated, annoyed and disappointed by
2 the fact that the Royal Group of Hospitals Trust
3 required her to settle proceedings against them, not
4 only without any admission of liability but also on the
5 basis that, and I quote:
6 "The terms of settlement shall remain confidential
7 and neither party shall disclose to any third party any
8 details concerning the settlement and, in particular,
9 she would not publish, cause to be published, nor
10 provide information in relation to this matter to any
11 third party or make any comment in relation to the
12 matter at any time to represent it to the newspapers,
13 television, journals, or any other publicity media."
14 Neither the trust nor any of its successors have
15 released her from this undertaking. It is only in the
16 context of this Inquiry that she is permitted to air her
17 true thoughts and feelings. Part of her is hoping that
18 the Inquiry will be able to ascertain just why this
19 confidentiality clause was required. Are we not
20 supposed to be part of an open society? If clinicians
21 or other staff have made mistakes, then does the public
22 not have a right to know?
23 She also feels some despair that it has taken both
24 a political and media campaign to bring these matters
25 out into the open. Why is there such a culture of

1 secrecy in hospitals? Where does it originate? Does
2 openness not encourage better practice? She hopes that
3 some of these questions will be answered.
4 In the press release of 1 November 2004, which is
5 Inquiry document 008-032-093, the minister set out two
6 very important issues, namely, one, that the general
7 public should have confidence in the Health Service and
8 in the standards of performance of all who work in it.
9 And, two, the fact that the death of a child is tragic.
10 Adam's family agree. His mother, Debra, has put on
11 record that the two reasons she has put herself and her
12 family through the pain of this Inquiry are to find out
13 what really happened to her beautiful only child and
14 also to try to help prevent any other family having to
15 go through what she has.
16 It is therefore important that not only all those
17 involved in this public Inquiry, but also those reading
18 the documents connected there with should remember that
19 it all started with the death of a little four year-old
20 boy. He may have been a case, but he was also Debra's
21 son. She has stated that the day he passed away, part
22 of her died too. She will never get over how
23 disrespectfully her little boy was treated. She was and
24 remains hurt by it. Her memories of him have been
25 tainted by what happened and the way in which she was

1 treated right after his death. The inquest and
2 subsequent civil proceedings should have brought closure
3 to her grief. They did not. There was no explanation,
4 just questions.
5 And then to find out that some other children have
6 suffered the same fate concerns her greatly. To have,
7 to hold your child when they die is the worst thing that
8 can happen to any parent. This is not how it is
9 supposed to be. The various issues arising were set out
10 somewhat prophetically in a letter dated 1 May 2002 from
11 the then medical director of the Altnagelvin Hospital to
12 Dr Henrietta Campbell, the then chief medical officer.
13 It is Inquiry document 006-002-252.
14 He wrote:
15 "Following the death of a child in Altnagelvin
16 Hospital, which was thought to have followed severe
17 hyponatraemia, many steps have been taken to ensure that
18 such an event does not occur again. We are all anxious
19 to learn from what was a dreadful experience and to
20 share vital information with others. Guidance issued
21 from your department will help in this regard and we are
22 grateful for the recent posters on the subject. I am
23 interested to know if any such guidance was issued by
24 the Department of Health following the death of a child
25 in the Belfast Hospital For Sick Children, which

1 occurred some five years ago, and whose death the
2 Belfast coroner investigated. I was unaware of this
3 case and am somewhat at a loss to explain why. I would
4 be grateful if you could furnish me with any details of
5 that particular case for I believe that questions will
6 be asked as to why we did not learn from what appears to
7 have been a similar event."
8 If families can be assured both that lessons have
9 been learnt and that changes will be made, then it may
10 ease their grief and give them both solace and closure.
11 Finally, Debra would like to adopt the minister's
12 words: I am grateful to John O'Hara for agreeing to
13 undertake this Inquiry and I know that he will pursue
14 a rigorous investigation of the issues. Thank you.
15 THE CHAIRMAN: Thank you, Mr McBrien. Mr Topolski?
16 Opening by MR TOPOLSKI
17 MR TOPOLSKI: Sir, thank you for inviting and permitting us
18 to make a very brief statement on behalf of the Ferguson
19 family. I wonder if we could please put up a photograph
20 of Raychel.
21 But for the treatment Raychel received at the
22 Altnagelvin Hospital in June 2001, she would have lived.
23 The neurological insult she suffered and which killed
24 her was a result of hospital-acquired hyponatraemia.
25 The insult was the result of the administration of

1 hypertonic infusions, specifically Solution 18. Those
2 three facts have been, we suggest, clearly established,
3 not least by the inquest verdict recorded
4 in February 2003.
5 The consequence of those three facts have haunted
6 and blighted the lives of her parents, her family and
7 her friends, and will continue to do so. Every day,
8 sir, Raychel's mother goes to her daughter's grave.
9 Every day. She has promised her countless times that
10 she and her family will not rest until they discover
11 what led to this tragedy. In its brief to its experts,
12 this Inquiry observes that it was a UTV insight
13 documentary called "When Hospitals Kill", broadcast in
14 2004, that was the impetus for this Inquiry.
15 At a time when journalism in all its forms is under
16 the most intense scrutiny, it is right that an example
17 of journalism at its most forthright should be
18 acknowledged. But it is not a chilling, eye-catching
19 title, it's not the assertions made in a TV programme
20 that will enable Marie Ferguson to fulfil her promise to
21 her daughter. It is and can only be the evidence
22 that is received, sir, by you, examined, tested and
23 finally pronounced upon by you that can do that.
24 The great institutions of state are a measure of its
25 strength and of its resilience. The National Health

1 Service is one such institution. When events such as
2 those that are the subject matter of this Inquiry occur
3 within them and with such devastating consequences,
4 it is a measure of the true strength and greatness of
5 the institution concerned that it is prepared to expose
6 itself to the most rigorous and fearless examination.
7 All our clients can ask is for this Inquiry to carry out
8 that examination rigorously and fearlessly. They have
9 every confidence it will do so because, bluntly, nothing
10 less will do. Our clients, we their legal team -- and
11 forgive me for not introducing myself, I'm Michael
12 Topolski, I'm instructed by Mr Desmond Doherty and
13 leading Mr John Coyle -- we are ready, as indeed are our
14 clients, to let the evidence speak. The task and duty
15 of this Inquiry, we suggest, is to follow wherever that
16 evidence leads.
17 May I just conclude this opening with three lines,
18 not of mine -- much better than mine -- they're from my
19 client in a statement she made and sent to this Inquiry
20 this very weekend:
21 "We can never bring Raychel back, but we owe it to
22 her to make sure that the way she died cannot be
23 repeated. The path to this Inquiry has been a long and
24 agonising one for myself and my family. We will not
25 rest until we have fulfilled this promise to the

1 daughter we love and miss to this day."
2 Thank you.
3 THE CHAIRMAN: Thank you very much, Mr Topolski. I think
4 Mr Shaw ...
5 Opening by MR SHAW
6 MR SHAW: Mr Chairman, my name is Stephen Shaw, senior
7 counsel for the department. Thank you for the
8 opportunity to make this statement.
9 The death of a child brings great pain and distress
10 to the bereaved family. The department wants to extend,
11 once again, its profound sympathy to all those who mourn
12 the loss of a child under investigation by this Inquiry.
13 This Inquiry was set up on 1 November 2004 by Angela
14 Smith MP, the minister then responsible for health and
15 personal social services in Northern Ireland. She and
16 her successors, including the present minister,
17 Mr Poots, have made it clear that they want this Inquiry
18 to address the issues of public concern raised by these
19 tragic deaths and to make recommendations, as you may
20 consider necessary and appropriate.
21 The department welcomes the fact that the Inquiry
22 has now started. We are confident that this independent
23 Inquiry will be rigorous and comprehensive in performing
24 its task. We look forward to the opportunity to play
25 our part and to respond in due course. The department

1 remains committed to protecting and improving the
2 quality of health and social care so that all the people
3 of Northern Ireland might benefit from a safe and
4 effective service.
5 The department recognises that the public must have
6 confidence in the safety, quality and standards of care
7 provided by our health and social care services. We
8 will, therefore, assist the Inquiry as fully as we can
9 and with total commitment to openness and transparency.
10 Thank you, sir.
11 THE CHAIRMAN: Thank you, Mr Shaw.
12 Now, ladies and gentlemen, let me turn to the issue
13 which you were notified of last week, in particular the
14 report that was circulated from Professor Fenella
15 Kirkham, a neurologist, and the note which I issued on
16 Friday.
17 There is nothing new in this Inquiry or any other
18 Inquiry about expert witnesses expressing different
19 opinions. We already have examples of differing views
20 in this Inquiry. For instance, about who should have
21 taken the consent from Adam's mother for his kidney
22 transplant or what the consequences are or may be of
23 certain uncertain aspects to the medical treatment. And
24 we were ready to proceed without necessarily having
25 unanimity between the experts because the Inquiry cannot

1 possibly wait until we have unanimity before we start.
2 In fact, it would be quite wrong to try to extract
3 unanimity from experts with different views and what
4 we'll hear in the weeks and months ahead are those
5 different views and the impact those different views
6 have on the opinions which have been formed about the
7 actions and conduct of certain individuals.
8 The difficulty which Professor Kirkham's report
9 raises is a rather different one. She has substantially
10 queried whether Adam died from hyponatraemia at all.
11 This is an issue about which there has been only very
12 limited debate since the inquest into Adam's death.
13 I think it's right to say that, apart from Dr Taylor, no
14 other person has held out against hyponatraemia at least
15 being a contributory factor to Adam's death, if not the
16 dominant factor. And even in his recent statement to
17 the Inquiry, in which Dr Taylor accepted that in some
18 respects his care of Adam was below expectations, he did
19 not move away from his position and he did not expressly
20 say that hyponatraemia had caused Adam's death.
21 I regret more than I can express the fact that
22 Professor Kirkham's report has come through so late.
23 You will recall that the hearings which were scheduled
24 to start last November were delayed because, as
25 I informed everyone at the time, I had received advice

1 from the medical advisers to the Inquiry that, in the
2 light of the ever-increasing volume of medical opinion
3 and documentation, it was necessary to obtain the views
4 of a neurologist.
5 That was put in train and Professor Kirkham was
6 asked to report to us. Her report was delayed by what
7 turned out to be the complexity of the issues, by her
8 request for further information and then by her request
9 for further reports from Dr Squier, such as the note
10 which is attached to the report circulated last week.
11 Now that that has been received, it seems to me that
12 there are two issues which we have to consider this
13 afternoon. The first issue is whether we can proceed
14 immediately with the scheduled hearings next week. The
15 second issue is: if we cannot proceed next week, what do
16 we do next? When do we start the hearings and how do we
17 start them?
18 On the first point about whether we can start next
19 week, you will understand from the note which I issued
20 on Friday that I think that everyone needs some time to
21 consider Professor Kirkham's report because, within it,
22 she raises queries which simply have to be addressed and
23 which I do not think can be simply addressed by her
24 coming into the witness box either at the start of the
25 oral evidence or later on in the oral evidence.

1 Perhaps more fundamentally, the basis upon which
2 witnesses are to be questioned is affected or may be
3 affected by her conclusions. For instance, it is not
4 clear from her report whether or to what extent she
5 calls into question the care which Adam received from
6 different individuals in 1995. Nor is it clear from
7 this report what she says should have been recognised in
8 1995 as opposed to today because those of you who have
9 had time to study her report will have noticed that she
10 talks about the fact that there is better neuro-imaging
11 available today than there was in 1995, and she has also
12 said that there is much greater awareness of PRES and
13 its risk factors today than there was in 1995.
14 Issues such as these all have the potential to alter
15 the contents of the Salmon letters, which I was to issue
16 last week, but which I withheld when I was alerted to
17 the fact that Professor Kirkham was likely to come
18 through with some substantially different positions.
19 And for those of you who are not immediately
20 familiar with what a Salmon letter is, a Salmon letter,
21 in effect, is a guarantee of fairness that means that
22 before any individual, for instance a doctor or a nurse,
23 comes to give evidence at the Inquiry, that doctor or
24 nurse is put on notice of any particular issues on which
25 he or she will be questioned and probed about the

1 actions which they took and whether those actions were
2 up to standard by the standards of the time.
3 We had clearly identified areas of questioning on
4 the basis of all of the documentation which
5 Ms Anyadike-Danes referred to in her opening address
6 this morning. In particular, we had identified areas of
7 questioning based on the reports from experts such as
8 doctors Coulthard, Haines and Gross. What we now need
9 to know is what, if any, additional or different
10 questioning witnesses might face on the basis of
11 Professor Kirkham. Is there to be a new line of
12 questioning or probing?
13 In this context, I should also say that on behalf of
14 Adam's family, his solicitors and counsel provided us
15 with warning letters -- effectively the equivalent of
16 Salmon letters -- in which they identified areas upon
17 which they thought witnesses would have to be questioned
18 and potentially criticised. It seems to me that in
19 light of Professor Kirkham's report, Adam's family's
20 legal representatives will have to consider whether they
21 want to add to or alter their warning letters for the
22 same reason.
23 In addition, I think it's inevitable that the
24 consultants and others who are going to face questioning
25 will want a little time before they give evidence in

1 order to allow them to appreciate what flows from
2 Professor Kirkham's analysis for each of them, and they
3 will, for instance, want to think through what the
4 consequences are of what Professor Kirkham says as
5 opposed to what various other experts have said, to see
6 whether that potentially adds to or takes away from any
7 potential criticism which they will face.
8 Subject to whatever anyone says to me over the next
9 few minutes, I think that the first issue which I have
10 identified, namely whether the scheduled hearings can
11 start next week, is fairly straightforward. Even though
12 it is massively disappointing for me to say this at this
13 stage, I do not think that the hearings can resume next
14 Monday with the start of the oral evidence. I will
15 invite observations on that in a few minutes.
16 Let me then turn to what I've identified as the
17 second question. If we don't start next Monday, when do
18 we start and what do we have to do in between? In the
19 note which was issued last week, I have outlined the
20 process which I propose to follow -- again, subject to
21 anything that is said to me in the next little while --
22 and we follow that process in the next week or week and
23 a half in order to minimise the delay and start the
24 hearings as soon as is ever possible.
25 I cannot contemplate a long delay and I say that not

1 just for my own reasons, but also because I understand
2 that for Adam's family, for Claire's family, for
3 Raychel's familiar and for Conor's family, the thought
4 of further delay, stretching out indefinitely into the
5 future is just beyond contemplation.
6 I also recognise that there are other people who
7 want the Inquiry to proceed sooner rather than later.
8 For instance, those individual consultants who have been
9 under scrutiny and who know they are going to face
10 probing and potential criticism must surely want that to
11 take place as soon as possible so that they have the
12 opportunity to say whatever they want to say to the
13 Inquiry in order to have their actions and conduct
14 properly understood.
15 But there is, beyond that, an even more important
16 reason for progressing sooner rather than later. That
17 reason is that one of the fundamental values of this
18 Inquiry is that if there are lessons which have not yet
19 been learned and if there are things which can be done
20 better in the future, the sooner that is recognised and
21 the sooner those lessons are learned the better, and
22 that may come eventually from my report to the minister.
23 It may also come from people who are involved in the
24 clinical world or involved in the management and
25 governance of the Health Service, hearing what has taken

1 place at the Inquiry and starting on their own
2 initiative to take steps to improve arrangements and
3 improve management without waiting for any report which
4 comes from me.
5 The efforts which we are making on the back of the
6 report from Professor Kirkham are to try to convene
7 a meeting, which Professor Kirkham will attend with
8 a number of the other expert witnesses to the Inquiry.
9 We have provisionally arranged such a meeting in
10 Newcastle, England, this Wednesday evening.
11 Professor Kirkham can attend that. The simple reason
12 why it might be in Newcastle is that Mr Coulthard and
13 Dr Haines are based in Newcastle and they can attend
14 such a meeting. We can also arrange for Mr Gross, from
15 Germany, and I think Dr Squier, who's based in Oxford,
16 to phone into that meeting. So there will be a meeting
17 of experts. If we can arrange for any of the other
18 expert witnesses to the Inquiry to attend either
19 personally or by phone, then we will.
20 The point about that, as we have explained in last
21 Friday's note, is to clarify the extent, if any, to
22 which the experts agree with each other and whether they
23 each maintain or reconsider their position in the light
24 of the contribution of the professor. It might be, for
25 instance, that Messrs Coulthard and Haines say: well, we

1 weren't entirely aware or as aware as Professor Kirkham
2 is of the advantages of neuro-imaging now or the risks
3 associated with and the potential for the development of
4 PRES and we want to reconsider our advice and our
5 evidence to the Inquiry in that light. It might also be
6 of course that they say: actually, we were well aware of
7 it, but it doesn't make any real difference to our
8 report.
9 What we are trying to achieve is having this meeting
10 on Wednesday. It'll be preceded, if our plan comes to
11 fruition, with the other experts other than
12 Professor Kirkham giving us an initial written response
13 to Professor Kirkham's report. The value of that is
14 that it will enable Professor Kirkham to understand and
15 for those other experts to understand, before they meet,
16 how far apart they are and, if they are apart, what the
17 basis of them remaining apart is.
18 Following on from that, we will try to have a record
19 produced. Certainly, we will have a record produced of
20 that meeting. We are considering whether the meeting
21 can be recorded or, at the very least, transcribed so
22 that instead of having to rely on a record prepared by
23 the Inquiry legal team who will attend the meeting,
24 we will be able to provide some form of transcript or
25 recording of it so that those who have different

1 interests can see how the discussion and conversations
2 developed during the meeting.
3 I would then propose, after the meeting, to allow
4 any of the experts a short time -- by which I mean just
5 a few days -- to add anything in writing, which they
6 feel they want to add in light of the discussions.
7 There may, for instance, be an expert who is in
8 discussion at the meeting and some point occurs to him
9 or her which he then wants to follow up with a written
10 note afterwards. That's the sort of thing I'm trying to
11 achieve. So not only is the Inquiry better informed,
12 but everybody is better informed.
13 Following on from that, on this proposal, which is
14 the proposal I'm throwing out to debate in the next few
15 minutes, I would like to reconvene here on Thursday
16 next -- I think that's Thursday the 30th -- to give you
17 an update and give you all an opportunity to express
18 your views on how we should or might proceed after that.
19 We were due to be here next week anyway and therefore
20 a reconvening on Thursday the 30th would not be,
21 I think, too much of a call on anyone.
22 It will have two consequences. The first is that
23 because I would have circulated all of the available
24 additional documentation in advance of that, you'll be
25 able to come to that meeting with a clearer idea of

1 where the experts stand and perhaps your own ideas of
2 how we can move forward.
3 Secondly, we can then discuss how and when the
4 evidence could start and the specific opening in Adam's
5 case might be made after that.
6 That is my proposal. It is inevitably outside the
7 scope of the procedures, which I've already outlined,
8 and I hope it's understood that it is outside the scope
9 because the position we've reached in light of this late
10 contribution from Professor Kirkham is something which
11 could not have been contemplated or provided for in the
12 procedures. The only other point, of course, about the
13 procedures is that I have always specifically retained
14 discretion to vary the procedures if needs be, if
15 circumstances dictate it, and I don't really think there
16 can be any dispute that the circumstances are dictating
17 some change to the procedures immediately, whether it is
18 the change which I'm proposing is a matter which we can
19 discuss.
20 That's all that I think I want to say just at the
21 moment. I think, perhaps, I'd like to break down the
22 discussion into two separate parts. The first part is
23 this: is there any representative who wants to contend
24 that, notwithstanding the issues that I've gone through,
25 that the hearings should resume next Monday the 27th?

1 Is there any party who adopts that position that we
2 should start next Monday?
3 MR MILLAR: Sir, my name is Robert Millar, counsel for
4 Mr Patrick Keane. I am instructed by Carson McDowell
5 solicitors. My instructions certainly extend to that
6 proposition, that one option which should be actively
7 considered by the Inquiry is continuing. We have
8 serious reservations about the usefulness of the
9 procedure that's being envisaged by the Inquiry.
10 I don't know whether it's better to develop the point
11 in the context of overall remarks or whether you --
12 THE CHAIRMAN: I'm keen to know how we could proceed next
13 Monday.
14 MR MILLAR: As we see it, if I could just preface this by
15 saying this. My client, Mr Keane, is one of three
16 neuro-oncologists in Northern Ireland. In November, he
17 absented himself for five weeks with a huge knock-on
18 effect on his operation list. He has done the same for
19 the Inquiry this time; he has taken a further five weeks
20 away from that post. And therefore, for that reason
21 alone, we're very keen that the Inquiry should proceed
22 as soon as possible. Now, the question is: what is "as
23 soon as possible"?
24 The contribution that's been made by
25 Professor Kirkham, as you said, sir, has come at a late

1 stage. I think that's one of the issues we'd want to
2 touch upon slightly. My note of the hearing back
3 in October of last year relating to the postponement of
4 the Inquiry at that time includes an indication by you
5 that you had been advised by some of your expert
6 advisers that there were two further reports required in
7 areas that were central to Adam's case.
8 Obviously, I'm not familiar with the ins and outs of
9 all the other cases, but in Adam's case you have a child
10 who developed cerebral oedema. Certainly, we find it
11 surprising, sir, that your advisers had not indicated at
12 a much earlier stage that a neurologist, who would seem
13 to be the most appropriate expert to advise in relation
14 to a case of cerebral oedema, had not been retained as
15 an expert witness by the Inquiry at a much earlier
16 stage. I appreciate that clearly you, sir, are very
17 much at the mercy of the expert medical advice that you
18 receive. But one would have thought that in a case of
19 that sort, it would have been fairly obvious to the
20 Inquiry's advisers that a neurologist should be part of
21 the expert team.
22 THE CHAIRMAN: Was there a neurologist at the inquest?
23 MR MILLAR: I'm not sure there was.
24 THE CHAIRMAN: As a matter of fact, there wasn't. And when
25 the expert statements were issued by the Inquiry

1 in October, did your client, or for that matter, any
2 other party in this Inquiry come back and say: you can't
3 be serious, you don't have a neurologist? No. For the
4 record, Mr Millar, not one person did.
5 MR MILLAR: I accept that entirely for the record. What I'm
6 saying, sir, is in a case involving cerebral oedema one
7 might have thought that the experts advising the Inquiry
8 would have suggested that that expertise should be
9 obtained at an earlier stage. And the same applies to
10 Dr Squier, who is the neuropathologist -- who I
11 understand as the second -- that was the second
12 outstanding report as of October 2011.
13 THE CHAIRMAN: No. I think you should actually know from
14 the papers that Dr Squier was already engaged
15 before October 2011.
16 MR MILLAR: Was it the neuroradiologist then, sir? Am I
17 misunderstanding?
18 THE CHAIRMAN: Mr Millar, I'm not going to get into
19 discussions. I have deliberately avoided telling the
20 parties which experts have been retained or even the
21 speciality in which they've been obtained because I did
22 not want that information to be commonly known before
23 I received back reports from experts. Okay?
24 MR MILLAR: I appreciate that. We did enquire at the time,
25 sir, and you did give us that response.

1 THE CHAIRMAN: And it stands.
2 MR MILLAR: In any event, one has to then ask at this stage,
3 if we were to have a meeting involving
4 Professor Kirkham, there seem to be three sort of
5 obvious possible outcomes of that. One is that
6 Professor Kirkham may change her mind, and I suppose
7 that would be a significant development. The second
8 is that the others may change their minds, and if that
9 were to happen there would be, one would have thought,
10 fairly fundamental consequences for the Inquiry.
11 I think you said yourself in your note, sir, the
12 very inclusion of this case in the Inquiry is based on
13 the premise that for Adam, the cause of his cerebral
14 oedema was hyponatraemia. I think it's in the fourth
15 paragraph of your note:
16 "The belief that he died of hyponatraemia is
17 fundamental to his death being included in the Inquiry
18 in the first place."
19 THE CHAIRMAN: Yes.
20 MR MILLAR: Obviously, if there is now a serious question
21 mark as to whether that was the cause of death, one has
22 to ask where we go from here. Is it a matter of the
23 entire case being referred back to the coroner, for
24 example? In the other cases that I'm not so familiar
25 with, might there be similar questions raised at this

1 late stage by someone like Professor Kirkham in relation
2 to the cause of death of any of the other children?
3 Leaving Conor aside for the moment, where it doesn't
4 apply. Has a neurologist been retained in connection to
5 the other deaths? I assume that Professor Kirkham is
6 dealing only with Adam.
7 THE CHAIRMAN: I think this is your second, if not your
8 third, effort to get me into a discussion over what
9 experts are being retained in other cases or Adam's
10 case. I'm not getting involved in that. I'm intrigued
11 by the idea that if you're now suggesting that this
12 raises issues about whether Adam's case should be
13 referred back to the coroner, you're nevertheless
14 submitting that the oral hearings should start next
15 Monday.
16 MR MILLAR: It is a question of what can usefully be done
17 this week. One can see very readily that one needs to
18 digest what Professor Kirkham's had to say. At this
19 stage, I have no idea whether Professor Kirkham's report
20 has been circulated to the other experts --
21 THE CHAIRMAN: It has.
22 MR MILLAR: -- whether any of them have commented at this
23 stage --
24 THE CHAIRMAN: Not yet.
25 MR MILLAR: -- whether any of them consider themselves

1 qualified to comment.
2 Quite often, when you have a meeting between
3 experts, what you're doing is putting together people
4 with different expertises, so the surgeons will speak to
5 the surgeons, the nephrologists to the nephrologists.
6 So far as I know, she is the only paediatric neurologist
7 or the only neurologist of any sort who's involved in
8 the case. So one wonders what she's usefully going to
9 discuss, say for example with Professor Forsythe or
10 Mr Rigg who are surgeons.
11 It's probably less clearly so when it comes to the
12 nephrologists and the anaesthetists, but she is a very
13 specialised person as one can see from her CV and from
14 her report and one has to wonder what level of
15 discussion can take place between her and persons who
16 come from entirely different disciplines and
17 specialisations.
18 So it may be that a very brief exchange between the
19 experts would result in the other saying: look, we're
20 just simply not in a position to have a useful dialogue
21 with Professor Kirkham because she's a neurologist and
22 we come from entirely different disciplines. It may
23 then be a matter of whether a second neurological is to
24 be obtained.
25 THE CHAIRMAN: In that event, it'll be a very short experts'

1 meeting.
2 MR MILLAR: But one wonders, sir, whether they need to have
3 a meeting to have that level of communication with one
4 another. As I understand it, everything that has
5 happened to date between the Inquiry and the experts has
6 been done on paper. I've certainly seen many follow-up
7 requests for information, obviously drafted by the
8 Inquiry's legal team, asking for questions, probing
9 various questions in an entirely appropriate manner.
10 And one wonders why a similar procedure could not be
11 adopted on this occasion, which may foreshorten the
12 period of delay in getting on with the oral hearings.
13 But I think, sir, that our main concern is the
14 overwhelming likelihood is that if there is a meeting or
15 exchange of views, there will remain important
16 disagreements between the experts and the quicker we
17 move to having those different positions articulated
18 publicly so they can be probed in public, the better.
19 THE CHAIRMAN: I don't disagree with you to this extent,
20 Mr Millar, that I would be astonished if the outcome of
21 the meeting of the experts was that they all suddenly
22 agreed. But what I think would be valuable to know
23 would be the extent to which, if any, the other experts
24 conceded that Professor Kirkham might be right or the
25 extent to which she considered that they might be right.

1 In other words, do they rule out her analysis
2 entirely or do they accept that this raises another
3 possibility in a very complex case? And I think that
4 it would be very helpful to know that before the
5 questioning of witnesses starts. Because when people
6 like your client or Dr Taylor or Professor Savage are
7 giving their evidence, they will want to know the basis
8 upon which they're being questioned. And it might
9 ultimately be that they have to be questioned on the
10 basis that (a) he did die of hyponatraemia or (b) on the
11 basis that he didn't.
12 What we don't quite have in Professor Kirkham's
13 report is, although she's given an alternative cause of
14 death, it's not at all clear from that whether she says
15 that that represents any blameworthiness on the part of
16 any of the individuals. Is that not an issue which
17 we would want to know?
18 MR MILLAR: That's the type of issue that might be best
19 followed up, sir, by a written Inquiry of
20 Professor Kirkham rather than it being between experts
21 and it's difficult to foresee how long it's going to
22 take her to express those views. I accept that.
23 I accept that entirely. But what one has to foresee is
24 this: if the meeting does have the type of outcome that
25 you have indicated may well be the most likely outcome,

1 and that is that there is only some limited agreement or
2 Professor Kirkham seems to have fixed her guns, so to
3 speak, where does the Inquiry go then?
4 You are then left in the position then where you
5 have one paediatric neurologist, whose opinion is going
6 to carry a considerable amount of weight, one would have
7 thought, in diagnosing a cause of cerebral oedema in
8 a child, ranged against a number of other people whose
9 disciplines are not really precisely that. Is the
10 Inquiry not then going to be forced to either just go
11 with her view because she is the expert who's been
12 retained by the Inquiry specifically in that area or do
13 you have to contemplate a second neurologist, a third
14 neurologist? Where does one go?
15 THE CHAIRMAN: I don't think we're going to run down the
16 list of neurologists in the UK or beyond, Mr Millar.
17 MR MILLAR: I appreciate that what I'm saying is actually
18 not directed specifically to your point about whether we
19 say that there shouldn't be some postponement. I don't
20 think we would suggest for a minute that there shouldn't
21 be any window of time given to allow some of these
22 issues to be explored, and I appreciate that many of the
23 things that I've said point towards there being
24 a window. It's just how one goes about it and perhaps
25 I can be allowed to come back to that when we deal with

1 the issues of procedure.
2 THE CHAIRMAN: I think Mr Millar was the only one that
3 wanted to speak on the question of whether the hearings
4 should not go ahead on Monday 27th. Then let's go on to
5 the second issue, which is the proposal which I've set
6 out in the note on Friday, which I have just added to
7 over the last few minutes with -- we will have this
8 meeting of as many experts as are available, hopefully
9 on Wednesday evening. We will have a record or minute
10 produced of that, and we will also try to have
11 a recording of it, whether an audio recording or
12 a stenographer, whichever can be arranged. And then
13 report back, circulate back whatever documentation
14 emerges from that and then report back with a progress
15 hearing next Thursday, Thursday the 30th.
16 Sorry, 1 March. Thursday, 1 March. Okay.
17 Mr McBrien, do you want to go first on this?
18 MR McBRIEN: On which particular point, sir?
19 THE CHAIRMAN: I have outlined a possible way forward to try
20 to deal as quickly as possible with the circumstances.
21 MR McBRIEN: We're in agreement as regards the meeting.
22 We're in agreement as regards some form of recording.
23 On the issues of transparency because I'm sure it's
24 anticipated or realised between the parties that it'll
25 be in the interests of some but not the interests of

1 others, depending upon which way one's views may go.
2 Therefore, if a particular expert witness were to be
3 seen to change his or her opinion, and that result
4 simply being formulated in a minute, then it would leave
5 matters up in the air and issues could arise there from.
6 Accordingly, from our perspective, we wholeheartedly
7 support the recording aspect and we would hope that it
8 was a bit -- if it could be a bit more advanced than
9 a pure transcription because whilst a transcription is
10 helpful, it is sometimes better if one can actually get
11 the flavour of what's taking place.
12 THE CHAIRMAN: I entirely agree with that because then you
13 get the impression of nuances or delays or hesitations
14 or whatever. I cannot guarantee that, Mr McBrien, but
15 I will make enquiries about if and how that can be done.
16 MR McBRIEN: I think that's all we can ask for.
17 THE CHAIRMAN: Then reporting back, circulating, hopefully
18 by next Monday, all available documentation, and
19 reviewing matters next Thursday, the 1st?
20 MR McBRIEN: Yes, sir. Just one logistical thing has
21 crossed my mind, and one would wish the experts, when
22 they meet, to be relatively fresh. You may or may not
23 be aware from the papers, sir, that one of the key
24 issues in the Adam Strain case was the fact that the
25 clinicians themselves were tired at the time of the

1 surgery.
2 THE CHAIRMAN: Yes.
3 MR McBRIEN: If it's to be an evening session, it may be
4 a short matter, it may be a long meeting, but I don't
5 know how important Professor Gross will be to the
6 affair, but it should be remembered if he's phoning from
7 Germany, they're one hour ahead.
8 THE CHAIRMAN: As I understand it, the provisional
9 arrangement, which has not been confirmed, pending this
10 afternoon's hearing, is that it should be at 6 o'clock.
11 MR McBRIEN: That'll be 7 o'clock for --
12 THE CHAIRMAN: It will be. There are some people who are
13 not available at all during the day because they have
14 other commitments or are working. Some of the experts
15 are retired from practice, some are still working.
16 We are trying to get the earliest possible time for
17 exactly the reason you suggested.
18 MR McBRIEN: That's extremely helpful, sir.
19 Then if there could be feedback in that period by
20 Thursday 1 March, that would be helpful because we could
21 then review -- in fact, all parties I'm sure can review
22 the feedback. Each party has its own particular agenda
23 and we might be looking for different issues. But
24 Thursday 1st seems to be, on the one hand, sufficient
25 time for somebody to produce something and at the same

1 time to give people a chance to consider it.
2 THE CHAIRMAN: Right.
3 MR McBRIEN: So I would support that, sir.
4 THE CHAIRMAN: Okay, thank you very much. Mr Quinn?
5 MR QUINN: My name is Stephen Quinn. I appear for both the
6 Roberts family and the Mitchell family. I appear with
7 Mr McCrea in the case of Claire Roberts and I have
8 already given my junior's appearance in the other case.
9 I didn't make an opening statement. I didn't want
10 to waste any more time because time is of the essence
11 here. Both the families, I spoke to them, and they
12 wanted to emphasise two things. They wanted to say very
13 briefly how much they appreciated lead counsel for the
14 Inquiry opening the case very directly and very
15 succinctly. They also wanted to express appreciation to
16 yourself for you trying to get on with the case as
17 quickly as possible. They wanted me to make two or
18 three points in relation to this delay.
19 They've been waiting a long time. Mr and
20 Mrs Roberts waited -- not only did they wait for
21 everything else, they've waited 10 years for the inquest
22 and they're waiting again. There's been delay of
23 15.5 years since Claire Roberts died. Conor Mitchell's
24 mum, Joanna, has been waiting nine years. What both
25 these families wanted from this is they wanted to see

1 what went wrong with the system. So in a way, the
2 report that we've just had from the professor is not of
3 great relevance to them.
4 What they want to do is they want to move this case
5 on as quickly as possible, but they both recognise that
6 they want to get at the truth, and one of the issues
7 that you raised yourself, Mr Chairman, was that someone
8 may want to ask the question on behalf of the Inquiry
9 team as to what went wrong with the system and that
10 hasn't been addressed in Professor Kirkham's report.
11 Because at the end of the day, what they want to do,
12 these families want to ensure that this does not happen
13 again. So in a way, I've been allowed my opening
14 address in a roundabout way and I have already made the
15 point that they don't want any delay that is
16 unnecessary. They see that this has to happen.
17 THE CHAIRMAN: It's particularly relevant to Mr and
18 Mrs Roberts.
19 MR QUINN: It is.
20 THE CHAIRMAN: Because if Adam died of hyponatraemia and
21 Claire died of hyponatraemia, what was learned or
22 what was missed, if anything, in the Royal between 1995
23 and 1996 --
24 MR QUINN: Exactly.
25 THE CHAIRMAN: On the other hand, if Professor Kirkham's

1 right, and Adam did not die of hyponatraemia, it
2 changes -- it obviously doesn't mean that things may not
3 have gone wrong with Claire, but to some extent it may
4 change the prologue to Claire about what was -- was
5 there something missing that might not have been missed
6 and so on?
7 MR QUINN: I didn't want to get into the same field that
8 Mr Millar got into because I didn't want the same
9 response from you, Mr Chairman. Therefore, I didn't
10 want to ask the question about what experts were going
11 to be employed, but I expect that there will be a very
12 thorough enquiry into both Conor's and Claire's case and
13 the proper experts will be involved. I do see the link
14 between Claire's case. I don't want to delay it any
15 more, save to say that both the families want this case
16 to commence as soon as possible.
17 One last point, Mr Chairman, there has been some
18 time left aside in various weeks where there have been
19 rest weeks, so perhaps we need to look at using some of
20 those weeks.
21 THE CHAIRMAN: Well, thanks for raising that. There's
22 a particular period -- we've got a start date, which is
23 today, and we've got an end date, which is November.
24 I should make it clear now that as far as I'm concerned,
25 at the risk to everybody's diaries and holidays,

1 including my own, as far as I'm concerned, whatever
2 happens, we will hit the end date.
3 If things were moved about so that -- for instance
4 there's a 10-week summer break, which wasn't actually
5 a 10-week summer break, so if I have to eat
6 substantially into that because we start something late,
7 I will do that, and I will change whatever -- I will be
8 as flexible and accommodating as I can between now
9 and November. But I have to finish this in November for
10 everybody's sake. Okay?
11 MR QUINN: I'm very grateful for that indication because
12 that's what the families want. They both want this case
13 to go on, they want to see justice done. They want the
14 system to be explored as much as we possibly can, but we
15 want to finish.
16 THE CHAIRMAN: Yes, thank you, Mr Quinn. Mr Topolski?
17 MR TOPOLSKI: Sir, could I make one or two I hope practical
18 suggestions? Where, in the jurisdiction with which I'm
19 most familiar, there are a number of experts about to
20 give evidence in a criminal trial, there are now
21 routinely experts' meetings. So we have quite a bit of
22 experience over in England of these, as I imagine you do
23 here in some respects.
24 THE CHAIRMAN: We do. I don't want to get into the area of
25 negligence cases, but if there was a medical negligence

1 case in the High Court, the protocol now is that the
2 experts must meet in advance. It's not optional.
3 MR TOPOLSKI: Exactly, so we are familiar. May I then
4 commend from, no doubt, those meetings, sir, which with
5 you are familiar and your counsel will be familiar, this
6 by way of a suggestion? One of the things that gets
7 experts focused is if there can be some focused
8 questions formulated before the meeting starts in order
9 that the experts can consider what they may be. May
10 I give you but one example, and I'm prepared to put it
11 in writing if it will help, but it'll be on the
12 transcript now, for the saving of time.
13 It seems to us that one of the very interesting
14 things that Professor Kirkham does not deal with is what
15 the consequence was on Adam of the infusion into him of
16 significant quantities of fluid. Let me tell you
17 exactly what I mean. The blood volume in a child is, as
18 we understand it, 18 mils per kilo. Adam weighed
19 20.2 kilos. He was given at least 1,500 mils of
20 dextrose saline, so there's very nearly a 100 per cent
21 dilution of his blood volume.
22 Question, Professor Kirkham: what effect, if any,
23 could that have on the reversibility of the syndrome you
24 identify? For she describes the syndrome, doesn't she,
25 as a reversible syndrome, which means, as we understand

1 it, that it could be reversed, but wasn't in Adam's
2 case. Could it not have been reversed perhaps because
3 he had infused into him -- my phrase, maybe nobody
4 else's -- significant quantities of, effectively, water?
5 That's a simple question. It may permit a very simple
6 answer, "That's the most ludicrous question I've ever
7 been asked", but nonetheless it arises. That sort of
8 thing. There are others one can consider, reading her
9 report, but if there were some focused questions, it
10 might assist.
11 THE CHAIRMAN: In that particular question, it's saying that
12 it might be that her analysis is correct, but that
13 doesn't mean that Adam's death does not result in
14 hyponatraemia.
15 MR TOPOLSKI: You have my point. Did his infusion aggravate
16 the condition that she has uniquely, in this case so
17 far, identified? Again, a very simple question; there
18 may well be others. Sir, that is the only contribution
19 we want to make. We would urge, again from experience,
20 a recording of the meeting.
21 THE CHAIRMAN: I'll do my best. Thank you very much.
22 Mr Lavery?
23 MR LAVERY: Just for the benefit of the stenographer, my
24 name is Michael Lavery. I am junior counsel instructed
25 by the directorate of legal services and I appear for

1 the various hospital trusts, alongside Mr Gerry Simpson
2 QC and Mr Gerry McAlinden QC.
3 Could I just say, Mr Chairman, that we do welcome
4 the commencement of the Inquiry and, like everybody else
5 here, we're also disappointed that this unexpected
6 development last week will lead to an inevitable delay
7 in the Inquiry proceeding. That is going to cause some
8 effect in terms of scheduling witnesses, for example,
9 and many of those witnesses, as you know, have to travel
10 from England. There will be a knock-on effect in that
11 regard, but that's something that we'll have to deal
12 with.
13 THE CHAIRMAN: I know that you will help us as best you can
14 with that. On no front is this delay going to be
15 anything but difficult, and we'll need as much
16 co-operation as we can, both from DLS and the trusts and
17 the individuals to get back on the best possible
18 schedule, whenever that time comes with the witnesses.
19 MR LAVERY: Yes. You can rest assured that the Directorate
20 of Legal Services will endeavour to provide the fullest
21 of co-operation in that regard.
22 THE CHAIRMAN: Thank you.
23 MR LAVERY: Could I just say, Mr Chairman, that the delay
24 obviously has taken its toll on the family, but it's
25 also taken its toll on the clinicians and nursing staff,

1 and they've had this hanging over them as well. I think
2 I made that point at a previous hearing.
3 THE CHAIRMAN: I accept that, that if somebody's facing
4 criticism, he or she will want to face up to that and
5 give their best possible response to that sooner rather
6 than later. I don't suggest the upset is all on one
7 side.
8 MR LAVERY: Just finally, Mr Chairman, could I use this
9 opportunity to extend the condolences of the trust on
10 behalf of all of the staff, the trust and the clinicians
11 and to the families of all of the children? Thank you.
12 THE CHAIRMAN: And you have no specific points to make about
13 what we're discussing for Wednesday and so on?
14 MR LAVERY: I think it's inevitable, Mr Chairman, that
15 there's no way round that at this stage. It's
16 a development we'll have to deal with.
17 THE CHAIRMAN: Mr Shaw? Before I come back to Mr Millar to
18 resume our exchanges, is there any other representative
19 of an individual doctor or nurse or any other person who
20 wants to make a point? Miss Linton?
21 MISS LINTON: Leigh Linton. I am representing Dr Armour.
22 Just to add to what Mr Lavery has just said --
23 undoubtedly, as you'll be aware, we came in to the
24 Inquiry on behalf of Dr Armour at a very late stage and
25 had shoehorned counsel in and around other diary

1 commitments. I think it would be helpful if, after next
2 week's meeting, we hopefully will have a clearer idea of
3 the degree of delay that's likely to be caused and
4 I think, at that stage, when we're aware of when to
5 resume, if we could get timetabling for witnesses sorted
6 out as quickly as possible, because I think for both
7 sides that will help people co-operate with the Inquiry
8 to get things into diaries because I know, for example,
9 that my client does have a number of significant
10 criminal trial commitments, particularly in March
11 and April.
12 THE CHAIRMAN: I think she's due to be a witness in criminal
13 trials in England.
14 MISS LINTON: That's correct. So she's very keen to assist
15 the Inquiry and we have, in fact, identified a number of
16 spare days she does have. However, by the very nature
17 of her work, those days are likely to fill up quickly,
18 so we would be keen to get something into the diary for
19 her as soon as possible.
20 THE CHAIRMAN: I take that. Thank you very much.
21 MR UBEROI: Good afternoon, if I may add on behalf of
22 Dr Taylor, we are happy to reconvene next Thursday and
23 take the matter on from there.
24 SPEAKER: On behalf of Dr Terence Montague, we're happy to
25 convene next Thursday and take the matter from there.

1 THE CHAIRMAN: He's based in Dublin now; is that right?
2 SPEAKER: That is correct, he is based in Dublin, but he is
3 happy to travel up when necessary.
4 MR BROWN: Stephen Brown. We are happy to convene next
5 Thursday. We would add that if we could have an audio
6 recording, that would be clearly preferable.
7 THE CHAIRMAN: I agree. Thank you very much.
8 Mr Millar?
9 MR MILLAR: We're very keen on the recording idea. The only
10 other point I would raise just for thought is this.
11 We are all familiar now with meetings between experts in
12 various contexts, clinical negligence claims and, no
13 doubt, criminal trials. What we're not so familiar with
14 is expert meetings attended by lawyers. I wondered to
15 what extent that's something that you have given
16 consideration to. I think the proposal is that the
17 meeting will be led by Inquiry counsel.
18 THE CHAIRMAN: Yes.
19 MR MILLAR: I don't take any exception to that. But it's
20 certainly an unusual feature for any lawyers to be
21 present. Normally what one does is one produces an
22 agenda with perhaps focused questions of the kind that
23 have been suggested and let the experts get on with it.
24 If they're going to be recorded, they're recorded. More
25 usually, there would be a minute of their meeting with

1 points of agreement and points of disagreement. It is
2 unusual, sir, to have lawyers involved. I appreciate
3 that counsel to the Inquiry is in a unique position --
4 THE CHAIRMAN: -- because she doesn't have a line to push,
5 whereas lawyers are typically excluded from meetings
6 because they do have a line to push.
7 MR MILLAR: Exactly. I think there are two factors. One is
8 excluding people who might have a line to push, but also
9 sometimes lawyers, even neutral lawyers being present,
10 might have an inhibiting effect on the type of
11 discussion that the medical experts might have. In
12 order for a relatively simple discussion for them to be
13 comprehensible to us, that can have quite an impact on
14 the nature of the dialogue whereas if they're allowed to
15 get on with it, they can probably cover a lot more
16 ground more quickly and hopefully reduce things to
17 a form which can be communicated to a lay Inquiry.
18 THE CHAIRMAN: In what I think are the unique circumstances
19 here, I think I do want Ms Anyadike-Danes to be there.
20 You'll be able, if you have any complaints about the way
21 she behaves, you'll be able to pick it up from the
22 minute or the transcript.
23 MR MILLAR: It is an unusual feature.
24 THE CHAIRMAN: I understand. Okay, thank you very much.
25 I think there is a reluctant and unhappy consensus

1 that we do not start the oral evidence next week, that
2 we have opened the Inquiry today and that we will have
3 a meeting. I will confirm for you who's going to be
4 there physically, who's going to be there by phone link
5 and how the meeting will be recorded. We'll get back to
6 you on that.
7 If I could follow up on Mr Topolski's point. If
8 anybody has a specific issue which they want the experts
9 to address, could they let us have it by, let's say,
10 2 o'clock tomorrow? I'm not necessarily asking for long
11 lists because I think the Inquiry team is at least as on
12 top of this hearing as any other team here, but if
13 you have any particular points which you want to be
14 raised with the experts, please let us have them. I'm
15 not guaranteeing every point will be raised, but it will
16 help us shape an agenda or formatting of the meeting.
17 I think really that, subject to that, that brings an
18 end to today's proceedings. We will certainly make
19 available every additional document which we have for
20 you by close of business on Monday and we will then
21 reconvene next Thursday. If I have any clear idea about
22 how I see the way forward, I will circulate that to you
23 on either Tuesday evening next or Wednesday morning.
24 Wednesday by noon so that you have an idea of where we
25 think the Inquiry might be going and when.

1 In the meantime, thank you all very much for coming.
2 I'm glad that at least in some way we have started the
3 Inquiry today, and I repeat what I said to Mr Quinn
4 a few minutes ago: I wanted the Inquiry to get off to
5 the smoothest possible start. We have been tripped up
6 slightly already. This Inquiry will finish in November
7 and between now and then we will hear all the evidence
8 that we have to hear, let everybody say that they have
9 to say and then I will do a report to the minister.
10 Thank you very much.
11 (3.10 pm)
12 (The hearing adjourned until Thursday 1st March 2012)
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