1 Friday, 31 May 2013
2 (10.00 am)
3 THE CHAIRMAN: Good morning.
4 MS ANYADIKE-DANES: Can I call Dr Dara O'Donoghue, please.
5 DR DARA O'DONOGHUE (called)
6 Questions from MS ANYADIKE-DANES
7 THE CHAIRMAN: Have a seat, please, doctor. Thank you for
8 coming.
9 MS ANYADIKE-DANES: Can I check you have your CV there by
10 you?
11 A. Yes.
12 Q. Thank you. We had received notification from the DLS
13 that there was in fact a family relation between
14 yourself and Dr Jarlath O'Donohoe at the Erne; is that
15 correct?
16 A. Yes.
17 Q. You are first cousins once removed; is that right?
18 A. I think that is the genealogical relationship.
19 THE CHAIRMAN: In Northern Ireland that means you're?
20 A. Second cousin, possibly.
21 THE CHAIRMAN: It's not particularly close?
22 A. No.
23 THE CHAIRMAN: Go on ahead.
24 A. My father's first cousin.
25 THE CHAIRMAN: More to the point, did you know him?

1 A. No.
2 THE CHAIRMAN: Thank you.
3 MS ANYADIKE-DANES: Dr O'Donoghue, I'm going to take you to
4 the various statements that you have made in relation to
5 this case and then ask you if you adopt them, subject to
6 anything that you say today in your evidence. We have
7 a statement that you made to the PSNI on 4 March 2005.
8 The reference for that is 115-036-001. Then you made
9 another short statement to the PSNI of the same day.
10 That was really just concerning whether there had been
11 any communication in relation to the provision of the
12 death certificate to put pressure on you. That short
13 statement, the reference for that is 115-037-001.
14 You have made two statements for the inquiry. They
15 bear the series 284. The first is dated
16 7 November 2012, the second is 22 January 2013. Do you
17 wish to adopt those statements as your evidence?
18 A. Yes.
19 Q. Thank you. Then if we go to your CV. The reference for
20 that is 315-011-001, but if we can go to 003 of that and
21 pull up 004 alongside it. There we are. You had been
22 a doctor for about seven years by the time of Lucy's
23 admission; is that right?
24 A. Yes.
25 Q. If we look to the right-hand side of 004, you see that

1 you had been, by the time of Lucy's admission, an SHO
2 for about five years, from February 1995
3 to February 2000. You were an SHO, slightly over that,
4 by the time Lucy came?
5 A. Yes, and three years as an SHO in paediatrics.
6 Q. Yes. That's the next point I was going to point out, in
7 paediatrics. In terms of that, if we look to the
8 left-hand side, 003, we see that you really started your
9 paediatrics in August 1997, and then you started to act
10 as a registrar in February 2000; is that right?
11 A. Yes.
12 Q. So you were acting as a registrar when Lucy was
13 admitted?
14 A. That's correct. SHO in lieu of registrar, so acting
15 registrar, yes.
16 Q. Well, I'm just looking at what you've put here on your
17 CV.
18 A. Yes, that's right.
19 Q. If I ask you about your duties on the 13th and 14th,
20 when did you come on duty on the 13th? This is in PICU
21 at the Children's Hospital.
22 A. I can't recall exactly, but normally it would be
23 approximately a quarter to 9 to start ward rounds at
24 about 9.15.
25 Q. Who were you answerable to as registrar on that day?

1 A. Generally, in intensive care, I would have been
2 answerable to the consultant intensivist, so usually the
3 anaesthetists, and also answerable to the paediatricians
4 or surgeons responsible for any admissions to the
5 intensive care unit. So I was responsible both to the
6 intensivists, the intensive care consultants, and also
7 the consultant paediatricians or consultant surgeons
8 under whom admissions to the intensive care unit came
9 in.
10 Q. In Lucy's case she came in, admitted under the name of
11 Dr Crean, but, as we have heard evidence, that's because
12 all children would come in admitted under his name.
13 Apparently, that's how it worked. Were you familiar
14 with that?
15 A. I was not familiar with that in particular. What I was
16 familiar with was that each day there would have been
17 a different intensivist doing the ward round in
18 intensive care but I was not familiar with admissions
19 coming in under any particular single intensivist.
20 Q. And insofar as 13 April was concerned, that's the
21 Thursday, Lucy was admitted at about 8 o'clock in the
22 morning. So she would already have been there, I take
23 it, when you came on duty?
24 A. I presume so.
25 Q. And who was the consultant intensivist or paediatric

1 anaesthetist who you regarded yourself as being
2 responsible to on that day?
3 A. On that day, it is likely to have been Dr Crean from the
4 ward round note, because he had a dictated ward round
5 note in the chart.
6 Q. Yes. Did you accompany him on that ward round?
7 A. It is likely that I did.
8 Q. Do you recall if you did or you didn't?
9 A. I do not recall.
10 Q. Is it possible that you didn't?
11 A. I think it's likely that I did, because I have written
12 in the prescription chart for drugs and also in the
13 fluid chart for fluids.
14 Q. Could you not have written in that because you were
15 directed to?
16 A. Usually I would have been directed to on the ward round.
17 Q. I understand. If you had attended at the ward round,
18 would you usually have made your own note?
19 A. It varied between consultants. Different consultants
20 had different ways of preferring recording in the notes.
21 But usually, myself or perhaps the registrar in
22 anaesthetics who may have been on the ward round or
23 another SHO would have recorded, made a record in the
24 notes of a ward round.
25 Q. Yes. In fact, when we look at the ward round note, it's

1 Dr Crean's note, typed up and inserted subsequently. We
2 see it at 061-018-065. That is the ward round note,
3 isn't it?
4 A. Yes. That would have been unusual that Dr Crean, as far
5 as I am aware and recall, would have been the only
6 consultant intensivist who dictated his ward round. The
7 other consultants would have a more conventional way of
8 recording the round in that one of the junior medical
9 staff would have recorded what happened during the ward
10 round.
11 Q. If there were directions being given during the ward
12 round as to what the various trainees were to do, if I
13 can put it that way, given that by the time he's
14 dictated it, it's typed up and put in the note, that may
15 well be after the event of when he wanted any of those
16 actions to commence, did you not make your own note as
17 to what you were being told to do during that ward
18 round?
19 A. Well, as Dr Crean had made his note, it would have been
20 unlikely that I would have made notes, additional notes,
21 because there was already a record of the ward round.
22 Q. No, no, so that you've got your own note of what to do.
23 The record of the ward round by the time it's typed up
24 isn't going to actually get inserted, as in fact is the
25 case, until sometime after the event. It's not

1 inserted until after 13.50 on that day, even though it
2 relates to a ward round that took place at about
3 9 o'clock that morning.
4 A. Yes. If I was given tasks, jobs to do, then it's likely
5 I would have made a list of those.
6 Q. You would have made a note?
7 A. Likely.
8 Q. And what would have happened to that note?
9 A. That would have been usually on a piece of paper that
10 would have been discarded.
11 Q. I see. If I just make sure I have understood you
12 correctly, you would have regarded yourself as certainly
13 answerable to him as the consultant intensivist. Lucy
14 didn't have a surgeon.
15 A. No.
16 Q. So there isn't another consultant in the category that
17 you gave us before?
18 A. The other consultant that would fulfil that category
19 would have been Dr Hanrahan because he was the
20 consultant that was involved from another specialty.
21 Often, as you are likely aware, children come into the
22 paediatric intensive care unit with dual ownership, with
23 the intensivist and another doctor. As I'd said
24 earlier, a paediatrician or a surgeon, in this case it
25 was a neurologist. So I would have been answerable to

1 Dr Hanrahan in this case.
2 Q. Answerable equally to both of them?
3 A. Yes, I consider so.
4 Q. So if one consultant was directing you to do something,
5 does that mean that you would be informing the other one
6 of what's happening?
7 A. No. They would issue separate directives, depending
8 on -- for instance, the intensivist would be directing
9 medication, prescription of fluids, ventilation, the
10 neurologist would not have the specialisation to direct
11 ventilation. So we would take directives from the
12 neurologist on perhaps other types of medication and any
13 neurological specialisation that the patient required.
14 Q. So they're really using their expertise to address
15 different aspects of her care if I can put it that way?
16 A. That's right, because they're specialists in separate
17 areas.
18 Q. Exactly. So if you were trying to draw together and get
19 a view as to her condition, you'd be speaking to both of
20 them?
21 A. Yes, but depending on what the specific problem was, it
22 may be one consultant more than the other. As
23 I mentioned, as an example, ventilation, if it was
24 ventilation I would have spoken to -- not myself, the
25 junior medical team would have spoken to the intensivist

1 in that case.
2 Q. No, I meant an overall view as to the cause of her
3 condition and that sort of overall view, you'd need to
4 be speaking to both of them to get the benefit of both
5 of their expertise?
6 A. The intensivists would consider themselves as doctors in
7 intensive care who were concerned with ventilation,
8 fluid management and keeping children alive. Whereas
9 the neurologists would have the neurological expertise
10 and would go beyond that to take a more holistic view of
11 the patient. So the intensivists would mostly be
12 directed on maintaining life as much as possible and
13 diagnostic categorisation and specific specialised
14 treatment would be issued and overseen by the
15 specialist, in this case the neurologist.
16 Q. If you had wanted to get an insight into her fluid
17 regime, for example, as you have mentioned the fluids is
18 one of those particular areas within the specialism of
19 the anaesthetist, you'd be speaking to your consultant
20 anaesthetist or, sorry, the paediatric consultant
21 anaesthetist to whom you were answerable?
22 A. The intensivist or paediatric consultant anaesthetist
23 would have more specialist knowledge on fluids.
24 Q. And that's who you should be going to if you were trying
25 to understand something in that area in relation to

1 Lucy?
2 A. I understand that to be the case.
3 Q. Thank you. When you accompanied Dr Crean -- well, you
4 believe you accompanied him, so let me put it in that
5 way. If you were accompanying Dr Crean, what
6 preliminary investigations would you do in relation to
7 Lucy so that you could provide any information, any
8 documentation, that would be helpful to the doctor
9 carrying out his rounds?
10 A. I would look at the admission note from the doctor in
11 intensive care, who in this case I believe to be
12 Dr McLoughlin.
13 Q. So you'd have seen Dr McLoughlin's note?
14 A. Yes, I would likely have spoken to Dr McLoughlin.
15 Q. And if you were speaking to Dr McLoughlin what would
16 you have been wanting to know from Dr McLoughlin?
17 A. Time of admission, presentation, present condition and
18 investigations.
19 Q. If you were looking at her note, you would have seen on
20 the bottom of it -- we don't need to pull it up, but the
21 reference for it is 061-018-059, the Erne notes
22 requested for further information. So you would have
23 known at that time, would you, that the Erne notes
24 hadn't come through but they had been requested?
25 A. I can't recall specifically, so I cannot know if that's

1 the case.
2 Q. Well, do you remember seeing the notes from the
3 referring hospital, if I put it that way?
4 A. I can't remember being on the ward round on that day.
5 Q. Ah. Do you remember seeing her notes at any point?
6 A. Yes, I've seen them subsequently.
7 Q. I meant at any point on either 13 April or 14 April.
8 A. I would have seen the notes because I likely, almost
9 certainly, would have been on the ward round.
10 Q. So you would have seen them?
11 A. It's likely that I would have seen them.
12 Q. Thank you. Apart from your attendance on the ward round
13 and the tasks that followed from that -- and there is
14 a note of what they might be, a handy reckoner for it is
15 a chronology that we were provided by the Trust. I'm
16 going to pull up two sheets side by side and you can
17 help see if this is accurate. It's 061-039-125 and,
18 alongside it, 126.
19 Starting with 125, you can see on 13 April:
20 "Reverse of the fluid balance sheet indicates that
21 the fluids were prescribed by."
22 And then there's four people in that list and you're
23 one of them.
24 A. Yes.
25 Q. Have you subsequently looked at that and satisfied

1 yourself that they've got that right, that you did
2 prescribe?
3 A. Yes, that was my signature.
4 Q. Thank you. Then if we look on the other page, the 126,
5 we see halfway down, 13 April, 13.20:
6 "Intravenous posterior pituitary hormone
7 administered. Believed to be Dr Dara O'Donoghue."
8 Is that you?
9 A. Yes.
10 Q. Did you do anything else other than those two entries?
11 A. Those are the only two entries I can see in the notes
12 that I've made other than the -- in the 13th and the
13 14th.
14 Q. Yes. We're going to come on to the death certificate in
15 due course, but in terms of actually administering to
16 her or doing something in relation to that, the two
17 entries is that you prescribed fluids as directed and
18 you also administered that hormone; is that correct?
19 A. Yes.
20 Q. Did you actually administer it or prescribe it?
21 A. It is likely that I did both. There are some
22 medications that nursing staff are unable to give and
23 I believe that may be one of them.
24 Q. Would I be right in saying that apart from attending on
25 the ward round, if you did do so, that's the height of

1 what you did in relation to Lucy's care?
2 A. Yes.
3 Q. Thank you. Did you examine Lucy yourself?
4 A. I cannot recall if I examined her and there's no record
5 in the notes.
6 Q. If you had, would you have made a record of it? Let me
7 put it another way, if you had, should you have made
8 a record of it?
9 A. Yes.
10 Q. When did you last see Lucy? You attended the ward
11 round, you administered, you believe, the hormone, which
12 is recorded there at 13.20.
13 A. Yes.
14 Q. When did you last see her?
15 A. I cannot recall when I last saw her, but I think it is
16 very likely that I was on the ward, as evidenced by the
17 prescriptions on both days.
18 Q. On both days?
19 A. I think it is likely that I would have been there on
20 both days. I was there every day in intensive care
21 apart from the weekends.
22 Q. Is there any indication that you actually saw her on the
23 14th?
24 A. There's no record in the notes.
25 Q. Can you remember seeing her on the --

1 A. I cannot remember seeing her on the 14th.
2 Q. Is it possible you didn't see her on the 14th?
3 A. I think it's likely --
4 THE CHAIRMAN: Sorry, doctor, it must follow that he
5 possibly saw her but he can't remember. He's in
6 intensive care on Thursday and Friday.
7 A. Yes. So I think it's very likely that I did see her and
8 that it is likely that I would have been on the ward
9 rounds on both days because the full team would have
10 accompanied the leading intensivist every morning and
11 sometimes afternoon ward rounds as well.
12 MS ANYADIKE-DANES: Does that mean that you think you
13 attended the ward round on the 14th?
14 A. Yes.
15 Q. Dr Chisakuta has given evidence as to who he
16 thought was on that ward round and your name is not
17 included.
18 A. Yes.
19 Q. So you might not have been?
20 A. I think it is likely that I was. I cannot account for
21 Dr Chisakuta's recollection.
22 Q. But in any event, there's no record of you doing
23 anything in relation to her on the 14th.?
24 A. No, but that does not necessarily mean I wasn't on the
25 ward round.

1 Q. No, I understand that. You say that at some stage you
2 saw her notes.
3 A. Yes.
4 Q. If you saw her notes, you would have seen at least at
5 some point after about 9.50, if you saw her notes, you
6 would have seen not only the notes that were being
7 recorded while she was in PICU, but you would have seen
8 her notes from the Erne?
9 A. I think on the 13th it's likely I would have seen what
10 accompanied Lucy.
11 Q. The transfer letter?
12 A. Yes. And from the notes and from Dr Crean's ward round
13 note --
14 Q. And by -- sorry.
15 A. -- waiting for further notification from the Erne, but
16 it's likely that I would have looked through the notes.
17 Q. That may be what you saw on the 13th, but by the 14th,
18 if you were there, and certainly by the time that you're
19 completing the medical certificate of cause of death,
20 you'd have seen all her notes?
21 A. I would likely have seen her -- I obviously did see her
22 Royal notes and it's likely I would have seen her
23 Enniskillen notes as well.
24 Q. Can I ask you if you saw her notes what you understood
25 from them in terms of her condition and its cause?

1 A. I cannot recall what I understood or specifically what
2 I thought when I read the notes and when that occurred.
3 Q. Maybe let me help you with this. If you'd looked at her
4 notes, you would see on them that she started off with
5 a capillary refill, initially, of greater than two
6 seconds. What would that have meant to you?
7 A. That there was reduced perfusion likely secondary to an
8 infection, shock, dehydration, so that her perfusion was
9 sub-optimal.
10 Q. Could that have indicated to you that she might be
11 dehydrated?
12 A. It could.
13 Q. Yes. Then if you had seen thereafter, and this is
14 indicated on the transfer letter, that after an infusion
15 of fluids her capillary refill was back to a normal
16 range, which is less than two seconds, in fact it was
17 back there by 3.30 in the morning, so that would have
18 connoted to you, would it, that that particular problem
19 had been addressed?
20 A. That it was resolving or was improving.
21 Q. And you would have noted that her weight on her
22 admission at the Erne was 9.14 kilograms, that is how
23 it's recorded, and then subsequently it's recorded by
24 the nurses in the Children's Hospital as 9.8 kilograms.
25 A. I cannot recall looking and comparing the weights.

1 Q. But that's there.
2 A. Yes.
3 Q. So if you were noting that she'd had fluids, noting that
4 she had developed cerebral oedema, then you might be
5 interested in any change in weight?
6 A. That would be of interest.
7 Q. Yes. You would have noticed that at the Erne she had
8 a clear chest X-ray.
9 A. Yes.
10 Q. And that might be relevant if you were trying to see
11 what sort of thing could have caused her collapse, was
12 there anything infectious going on, something of that
13 sort, you might be interested to see what the state of
14 her chest X-ray was?
15 A. Yes, but the chest X-ray may not rule out respiratory
16 infection completely.
17 Q. No, it may not, but it's a start if it's not there?
18 A. Certainly.
19 Q. And then you would have noted that her initial serum
20 sodium was 137, and that's normal?
21 A. Yes.
22 Q. So you might be interested to see if it remained normal,
23 just as one of the parameters that you look at to try
24 and understand what's happening?
25 A. Yes.

1 Q. And you would have seen, even from her Royal notes or
2 the notes in PICU, that it didn't, it went to 127, and
3 would that have been significant to you that she'd had
4 a fall from 137 to 127?
5 A. It would have been notable and --
6 Q. What would that have meant to you if you'd noted it?
7 A. Well, 137 is in the normal range and 137 millimoles per
8 litre -- and under 136 would be sub-normal or low, so
9 I would have noted that the sodium level would have
10 fallen by 10 millimoles per litre.
11 Q. Yes. What I was asking you is: how significant would
12 you have regarded that to be, that it had fallen by 10
13 millimoles?
14 A. I think that would have been significant because it's
15 likely I would have been aware from the notes that Lucy
16 had presented with a vomiting illness and also developed
17 loose stools or diarrhoea, so that would have been
18 important to be aware of that in terms of loss of sodium
19 especially.
20 Q. How serious is a serum sodium level of 127 in your view?
21 A. It is low, as we said, it's under the normal range, but
22 in my experience of paediatrics -- and likely at that
23 stage as well, I would likely have seen quite a few
24 children with sodium levels of 127, 128 millimoles per
25 litre who had not come to any harm.

1 Q. If I put it to you this way: we asked a similar question
2 of Dr Stewart in her witness statement for the inquiry.
3 She says at witness statement 282/1, page 4 in answer to
4 a question number 4:
5 "My understanding of the definition of hyponatraemia
6 [at that time, 2000 when she was a registrar] was as
7 follows: mild hyponatraemia, if the sodium level was
8 below 135. Severe hyponatraemia if below 130."
9 Would you agree with that?
10 A. Yes, but I had seen and was aware of children very often
11 having sodiums as low as that and not having come to
12 harm, very often with gastroenteritis or with chest
13 problems resulting from inappropriate antidiuretic
14 hormone release.
15 THE CHAIRMAN: And that's why you give them replacement
16 fluid, to bring those levels up again?
17 A. Yes, in the case of gastroenteritis, yes.
18 MS ANYADIKE-DANES: So it is low. If I now put another
19 point to you. Is it relevant to you how quickly, or
20 would it have been relevant to your consideration, if
21 I put it that way, how quickly she got that low?
22 A. The time frame of how clinical incidents would have been
23 important, yes.
24 Q. Dr Crean, when he was giving his evidence to
25 the coroner, the reference for it is 013-021-074, and he

1 says:
2 "The drop from 137 to 127 would ring alarm bells.
3 There is no reason ..."
4 He goes on to talk about that he would like to see
5 her notes. That's principally what he's talking about.
6 What he focuses on there is that rate of fall, if I can
7 put it that way. To you is that significant?
8 A. At this time?
9 Q. Then, in 2000.
10 A. At that time I'm not aware if that would have rung alarm
11 bells to me personally.
12 Q. Is it something you might have wanted to discuss with
13 somebody more senior or somebody who had more experience
14 in that area?
15 A. It is something that I would have assumed would have
16 been discussed probably amongst the consultants that
17 would have been looking after her care or overseeing her
18 care, in this case Dr Crean and Dr Hanrahan.
19 Q. Well, let me just put to you Dr Jenkins. Dr Jenkins
20 gave evidence to the coroner as well. He was at that
21 time a senior lecturer in child health and a consultant
22 paediatrician. His evidence is at 013-032-120. Maybe
23 that's worth pulling up so that you see it:
24 "Although the sodium level of 127 is not in itself
25 usually associated with severe problems, it is light to

1 be the rate at which the sodium falls rather than the
2 absolute level, which can cause problems in this
3 setting. While no definite conclusions can be drawn
4 regarding the cause of the child's deterioration and
5 subsequent death, there is certainly a suggestion that
6 this was associated with a rapid fall in sodium
7 associated with intravenous fluid administration causing
8 hyponatraemia and cerebral oedema."
9 Would you have known that in 2000?
10 A. I'm not sure if I would have known that in 2000.
11 Q. Would you have known even that that is an area that you
12 could be discussing with a consultant if for no other
13 reason that your own education?
14 A. We would have discussed as part of the intensive care
15 ward round, it would have been routine to focus on
16 ventilation, fluids, medication, in a systematic way.
17 Q. Yes. At the time when Dr Crean conducted his ward round
18 at about 9 o'clock on the 13th, he may not at that time
19 have had the information that there was a fall from 137
20 to 127. It's not clear. The note inserted in the
21 record shows 9 o'clock. So he might have it and we're
22 going to ask him about that obviously. But if he had
23 that information that's the sort of thing that you think
24 could be being discussed during the ward round, the
25 significance of it?

1 A. That could have been discussed in the ward round.
2 Q. Thank you. Then if one turns, since I've started on
3 that, to her fluids, if you'd been looking at her notes
4 you would have seen that her IV line is recorded as
5 having been inserted at 2300 hours and that she's
6 administered Solution No. 18 at 100 ml an hour. If you
7 had seen that, what would that have meant to you about
8 her fluid regime?
9 A. It would have suggested to me that she was receiving
10 more than maintenance fluids.
11 Q. Yes. If she was receiving more than maintenance fluids
12 and bearing in mind that you might have noted that she
13 had been a little bit dehydrated when she came in, would
14 you have any views about or had any thoughts at that
15 time about the wisdom of using Solution No. 18 to also
16 replace losses?
17 A. I don't recall specifically that consideration.
18 Q. Let me put it this way: did you know at that time that
19 Solution No. 18 was not a fluid to be used for
20 replacement purposes?
21 A. From what I recall at that time, and from my training,
22 was from an APLS course, acute paediatric life support
23 course, the teaching was that bolus fluids should be in
24 the form of normal saline.
25 Q. So is that a way of saying you would have appreciated

1 that Solution No. 18 shouldn't be used to replace
2 losses?
3 A. It was my understanding that they should be replaced
4 with normal saline.
5 Q. Exactly. So if you had seen that and you'd formed the
6 view that she's getting more than is her maintenance
7 requirement and therefore it would seem that she might
8 be having Solution No. 18 by way of replacing some of
9 her losses, that would have suggested to you that her
10 fluid regime might be inappropriate?
11 A. I can't recall that specifically.
12 Q. I'm putting it to you in that way. If you had seen
13 that, would that not have suggested to you her fluid
14 regime could be inappropriate?
15 A. That potentially it may have. I cannot recall.
16 Q. And then that would be an issue that you would
17 presumably want to see: why was she on that regime?
18 A. It would have been an issue, as Dr Crean has said in his
19 note, that would have been addressed by the intensive
20 care team, and with the lead in that being the
21 consultant. I was the senior house officer, so I was
22 really at the bottom of the chain.
23 Q. You were acting as registrar at that time.?
24 A. Yes, but specifically my title was senior house officer.
25 I had not got a specialist training number in

1 paediatrics, so legally I was a senior house officer.
2 Q. Well, actually I'm a little more interested in your
3 experience, but what does it mean to be acting as
4 registrar?
5 A. In the developmental progress of the paediatric career
6 or any medical career in medicine, surgery, you start as
7 a junior house officer, go to senior house officer, then
8 registrar. It's slightly different in paediatrics and
9 obstetrics where the bottom rung in the ladder is senior
10 house officer and then progress to registrar. So
11 it would have been seen by me as being progress to apply
12 to be an acting registrar. So I wanted to improve and
13 progress my paediatric career, so I applied for this
14 post, but specifically I would have been a senior house
15 officer acting as a registrar, so doing registrar's
16 duties under the supervision of the consultant team.
17 Q. But you were carrying out registrar's duties?
18 A. As a senior house officer.
19 Q. Yes, and presumably you wouldn't be allowed to carry out
20 registrar's duties unless somebody thought that you had
21 reached that degree of expertise and competence?
22 A. Yes, I had been in that post as an acting registrar for
23 two months, I believe.
24 Q. That's a post that you applied for?
25 A. Yes, it was competitive.

1 Q. Thank you. But in any event, at that time, you would
2 have recognised that that was a regime that, to you,
3 might raise a query as to why she was on it?
4 A. The fluids were very important in all children in
5 intensive care and they would have been discussed on the
6 ward round.
7 Q. Sorry, I'm just asking you, at that time that is a fluid
8 regime that, to you, would have raised a query with you?
9 A. It would have raised a query with the ward round and the
10 team in intensive care.
11 Q. And you?
12 A. As part of that team.
13 Q. Yes, thank you. And then you would have seen that she
14 started her fluids, having started her fluids at
15 2300 hours, 11 o'clock in the evening, with that regime
16 that I have just mentioned to you, that she'd had
17 effectively a fit at 3 o'clock in the morning. So not
18 very many hours afterwards she had a fit and her pupils
19 were noted to be fixed within about half an hour of that
20 and she does not appear, from the notes that you would
21 have seen from the Erne, to have ever really recovered
22 from that fit that's noted at about 3 o'clock. All that
23 you would have seen on the notes. So something fairly
24 catastrophic happened at that time of 3 o'clock?
25 A. Yes.

1 Q. And if you were looking through to see what she had
2 received from when she came in when her -- with the
3 exception of being slightly dehydrated, a bit pyrexic,
4 but apart from that not apparently seriously ill, and what
5 she had received was her fluids, essentially, all that
6 she'd received.
7 A. Yes.
8 Q. Would that therefore have focused you a little bit on
9 her fluid regime to see whether that might be implicated
10 in what had happened?
11 A. There would have been a holistic view of all potential
12 causes of seizures and fluids would have been part of
13 it.
14 Q. That would have been part of it. And you would have
15 noted that her pupils having been first noted at 3.30,
16 whether that was actually when they became fixed and
17 dilated isn't clear, and that couldn't be clear to you
18 from the notes because it isn't, but you would have seen
19 that that's when they were first noted, and from then on
20 there's no record at all of her having any neurological
21 improvement. You'd have seen that from her notes?
22 A. Yes.
23 Q. And there was no sign of any improvement certainly at
24 all by the time she gets to -- from when she's admitted
25 to PICU?

1 A. No.
2 Q. So if you've gone through that exercise of looking at
3 her notes, what would have been your view as to, insofar
4 as you could do it, some of the things that you might be
5 concerned that were responsible for her deterioration?
6 A. As the junior member in the medical team on intensive
7 care, I would have been part of the ward round and part
8 of the discussions along with Dr Crean and also
9 Dr Hanrahan. It's clear from Dr Hanrahan's initial note
10 that there was a lack of clarity about the diagnosis at
11 that stage, and that was evidenced by the broad
12 differential diagnosis that was stated by Dr Hanrahan,
13 starting with infection and the possibilities of
14 encephalitis, possibly metabolic disorders contributing
15 to the potential of seizures. Also, encephalopathy as
16 a result of possible haemorrhagic ischaemic origin and
17 cerebral oedema, query is the last line in that
18 differential diagnosis. So the differential diagnosis
19 is very broad, and it was certainly not clear the cause
20 of the seizures and catastrophic neurological
21 decompensation.
22 Q. Yes. Cerebral oedema for some other cause is something
23 that's flagged there potentially. Sorry, the pagination
24 for this is 061-018-063. And you said that you would
25 have been party to and listening in on the discussion

1 from both disciplines, if I can put it that way, both
2 from Dr Crean and having the benefit of his views, and
3 presumably Dr Chisakuta, the next day, who has taken
4 that ward round, as well as Dr Hanrahan, bringing his
5 neurological perspective to bear?
6 A. Yes, possibly not for the whole -- all of the contact
7 time that both consultants would have had because there
8 were obviously other patients in intensive care. So
9 it's likely I would have been party to some of the
10 discussion but likely not all of it. That would have
11 been okay if there was a single patient, but we would
12 have had other duties as the junior members of the
13 medical staff.
14 Q. I understand. But you'd have heard some of it and what
15 you perhaps didn't hear directly might be communicated
16 to you by other members of the team who had been there
17 because there would be some interest in finding out why
18 a child who had come in an essentially moribund state,
19 remained moribund, what had happened?
20 A. Yes.
21 Q. When Dr Chisakuta gave evidence the day before yesterday
22 and Dr Stewart, who you also had contact with, both of
23 them formed the view that really, at that time, in PICU,
24 the clinicians had appreciated that Lucy's fluid
25 management had been inappropriate and that had been

1 a contributory factor in the development of her fatal
2 cerebral oedema. Were you aware of that?
3 A. I wasn't aware of that specifically.
4 Q. Well, what do you mean by specifically?
5 A. I was on the ward round, but I was not aware of concerns
6 at that time. I cannot recall being aware of concerns
7 at that time.
8 Q. Were you aware of those sorts of concerns at any time?
9 A. Yes, subsequently, certainly, yes.
10 Q. By subsequently, do you mean after the 14th?
11 A. No, over the last few years. So, yes, after the 14th.
12 Q. So you weren't aware, even at the time that Lucy died
13 and when you were going to have to complete a medical
14 cause of death certificate, that at least two of the
15 clinicians who had been treating Lucy directly were of
16 the view that the clinicians in PICU recognised that
17 Lucy's fluid regime at the Erne had been inappropriate
18 and very likely contributed to her demise? You weren't
19 aware of that?
20 A. I was not aware of Dr Chisakuta and Dr Stewart having
21 those concerns, they had not been communicated to me,
22 but that would not always be the case.
23 Q. Were you aware of those --
24 THE CHAIRMAN: Sorry. Just to make it clear, it's not the
25 evidence of Dr Chisakuta or Dr Stewart that those were

1 just their concerns.
2 A. Yes.
3 THE CHAIRMAN: It is their evidence that those were the
4 concerns generally held.
5 A. Yes.
6 THE CHAIRMAN: But I understand you to be saying that that's
7 not something that you can remember being aware of at
8 that time.
9 A. That's correct.
10 THE CHAIRMAN: Thank you.
11 MS ANYADIKE-DANES: Sorry, just because you have answered
12 in that way, what you actually said is that you don't
13 remember them communicating that to you. So just for
14 certainty, I was going to ask you: does that mean
15 that -- are you intending to say you don't remember
16 those sorts of concerns, irrespective of whether those
17 particular individuals communicated it to you?
18 A. Yes.
19 Q. You weren't aware of those sorts of concerns?
20 A. No.
21 Q. Did you have those sorts of concerns yourself when you
22 went down and looked through the notes as you have said
23 in your evidence you had to do for the purposes of
24 completing that medical cause of death certificate? Did
25 you form any concerns yourself?

1 A. My concern was in completion of the death certificate
2 and the sources of information that I needed to complete
3 that were a few. There were a number of sources.
4 Q. Mm-hm.
5 A. Firstly, the body of the notes from the Children's
6 Hospital, including Dr Crean's admission note,
7 Dr Hanrahan note and the subsequent records in the
8 notes. Also, consideration of the clinical presentation
9 to Enniskillen, where it was felt there was initially,
10 as you're aware, vomiting and subsequently diarrhoea,
11 and dehydration, as evidenced by the raised urea level
12 at 9.9 millimoles per litre, as well as the low sodium
13 level, as you have mentioned, at 127 millimoles per
14 litre. I also had regard -- I had seen in the notes,
15 it's likely I had seen in the notes the anatomical
16 summary from Dr O'Hara, from the post-mortem, from the
17 autopsy, and that would have been obviously important in
18 forming a cause of death. So I had seen the -- it's
19 likely that I didn't actually read the whole autopsy
20 report, it's likely that I just read the summary that
21 Dr O'Hara had written. And as you're aware, he had
22 said, "Brain swelling, cerebral oedema,
23 bronchopneumonia, vomiting and diarrhoea", but had not
24 mentioned hyponatraemia specifically. And whenever
25 I was tasked with writing the death certificate -- as

1 a junior member of staff, I did not feel I could do that
2 without senior assistance.
3 Q. Sorry, pardon me. I'm going to come on to that and ask
4 you specifically in that order. It's very helpful that
5 you were setting out what you looked at, if I can put it
6 that way. You have in your evidence said you looked at
7 her notes. I didn't understand when you were providing
8 the inquiry with that evidence to suggest that they were
9 selected bits of her notes, you had her notes available
10 to you, isn't that right?
11 A. Yes, sorry, I was just focusing on the particular parts
12 I thought were relevant.
13 Q. You did also say you spoke to Dr Stewart and one of the
14 reasons you went to speak to Dr Stewart, she's
15 a registrar, you saw her entries in Lucy's notes and she
16 seemed like an appropriate person for her to have
17 a discussion with, if I can put it that way; would that
18 be right?
19 A. Certainly as the junior member of the neurology team,
20 yes.
21 Q. And if you were looking at the post-mortem, then
22 available to you was her autopsy request form? That was
23 in the notes?
24 A. It was in the notes, yes.
25 Q. Yes. And the helpful thing about it is that she'd

1 summarised for you, not for you personally, she was
2 summarising it for the pathologist, but she'd summarised
3 what the clinical problems were. We can see that at
4 061-022-075. You're quite right, she has got the
5 vomiting and diarrhoea that you had picked up from her
6 earlier notes. She's got the dehydration that you'd
7 picked up as well from the notes. And she's got
8 hyponatraemia.
9 A. Yes.
10 Q. And one of the reasons she's got hyponatraemia is
11 because there was hyponatraemia. Lucy's serum sodium
12 level, when she was at the Erne at a particular point,
13 was 127.
14 A. Yes.
15 Q. And so she's put that in there. Then she's got the
16 seizure, that's what happened next, and then the
17 unresponsiveness leading to brainstem death.
18 A. Yes.
19 Q. She's a little bit more senior than you because she's an
20 actual registrar?
21 A. Yes.
22 Q. And has been in that position for two years and you're
23 acting in that role. She has picked out what's there to
24 be seen, which is that Lucy was hyponatraemic.
25 A. Yes.

1 Q. Is there is any reason why you didn't pick that out or
2 at least ask her about it as to how significant she
3 thought it was?
4 A. No, this autopsy request form, as you can see on the
5 second line of the page, this list will enable the
6 pathologist to produce a more relevant report. So this
7 was the request form for the pathologist to enable him
8 to formulate his final autopsy report. I don't feel
9 that I would routinely have looked at request forms,
10 I would have looked at the final output, which would
11 have been the pathology report. To do otherwise, if
12 I can make an analogy to, say, a chest X-ray. If I want
13 to get a chest X-ray for a child who has potential lung
14 disease, I won't look at the chest X-ray request form to
15 find out what is subsequently wrong with the chest, the
16 radiological findings, I'll look for the radiological
17 findings as reported by the consultant radiologist.
18 Q. Yes.
19 A. So I do not feel that I would routinely look at
20 a request form whenever I want an investigation.
21 Q. Yes. I see that. The difficulty about that is that
22 pathologists will say that those sorts of changes in
23 serum sodium levels or electrolyte changes and
24 disturbances are not something that you see the evidence
25 of in the pathology when they're conducting their

1 autopsies. And that's one of the reasons why they wish
2 the clinicians to set out what they as clinicians see as
3 being relevant in the treatment and condition of the
4 child. In fact, if you had looked at the first page of
5 the autopsy request form, 061-022-073, you have
6 dehydration, in terms of the clinical diagnosis now, so
7 what you would have seen from Dr Hanrahan previously
8 when he was setting out his differential diagnoses, now
9 when it comes to the clinical diagnosis to be sent off
10 to the pathologist you have dehydration and
11 hyponatraemia. Then you have cerebral oedema with acute
12 coning and brainstem death.
13 If she's operating in the way that you do as an
14 acting registrar, discussing things with her consultant
15 before she reaches a view that she's going to transmit
16 to somebody else, it might be reasonable to think that
17 that actually might be the most recent view, if I can
18 put it that way, as to the clinical diagnosis.
19 A. I'm not sure of the discussions that Dr Stewart had with
20 Dr Hanrahan.
21 Q. I appreciate that.
22 A. With regard to that. But that was not communicated by
23 Dr Stewart to me. As I said, the request form was to
24 aid the pathologist, so I would not routinely have
25 looked to read that or sought that out.

1 Q. So is the short answer you probably wouldn't have looked
2 at the request form?
3 A. Yes, because the autopsy request form, as far as I was
4 aware, was to aid the pathologist as mentioned on the
5 second line of the previous page.
6 Q. I understand that. But what has happened is that she is
7 providing to the pathologist the views of the
8 clinicians, if I can put it that way. The views of the
9 clinicians, as she summarises them, is dehydration and
10 hyponatraemia. That's the point I'm putting to you.
11 A. Yes.
12 Q. So if you were trying to get a sense of what the
13 clinicians thought was the problem, then that might be
14 an indication of what they were thinking at the time
15 even though you can't specifically remember any
16 discussion with you.
17 A. To get a feeling of what clinicians and all the
18 clinicians would have felt at the time, I would have
19 referred predominantly and exclusively, perhaps, to the
20 body of the paediatric notes, where all of the
21 paediatricians, intensivists and nursing staff, indeed,
22 contribute. So to get a feel and an overall picture for
23 what was going on, I would have looked at the body of
24 the paediatric notes and not at request forms for
25 certain procedures.

1 Q. I'm sorry, I don't think you've understood what I was
2 saying. I was taking that as an indication -- she's
3 writing that as an indication of what the clinicians may
4 well have been thinking at that time, not saying that
5 you would be -- I have taken your point that you say
6 that you wouldn't be looking at a document like that,
7 but as something reflective of what might have been
8 being discussed and what people thought at the time.
9 That's why I was asking you, would you not think that
10 that was reasonable if she's writing that to --
11 MR McALINDEN: This really has taken some time. It seems
12 that the witness has made is quite abundantly clear that
13 in order to get an impression of what the clinicians
14 were thinking at the time, rather than looking at
15 a referral letter to the pathologist, he's going back to
16 the original source material, the notes and records, to
17 get that impression. I think he has made that perfectly
18 clear.
19 THE CHAIRMAN: In a sense, he's actually going further than
20 Dr Stewart did because Dr Stewart's autopsy request form
21 is itself a summary. So rather than take Dr Stewart's
22 summary, he goes back --
23 MR McALINDEN: He goes back to the original records.
24 THE CHAIRMAN: He goes to the records which were available
25 and then he gets Dr O'Hara's autopsy report and he goes

1 to the summary of that.
2 MR McALINDEN: Yes.
3 MS ANYADIKE-DANES: You also discussed with Dr Stewart
4 before you completed that medical cause of death form?
5 A. Yes.
6 Q. What was the purpose of discussing with Dr Stewart?
7 A. Well, whenever -- I understand there was a phone call to
8 the intensive care on 5 May from a representative of the
9 family. Subsequently, in looking at my note, I think it
10 was likely to be the undertaker, the funeral director,
11 and there was a request, they had phoned up to say that
12 there had been no death certificate issued. So as
13 a member of the junior medical staff, I felt I would get
14 information from the relevant clinician and to approach
15 the relevant team, which was the neurology team,
16 I bleeped or paged Dr Stewart, the registrar in
17 neurology to ask her for information about this because
18 I was aware from the notes that Dr Hanrahan had been in
19 discussion with the coroner and therefore I felt it
20 relevant to inform the neurology team about this
21 request, as I felt there were in a much better position
22 to deal with this than I was.
23 Q. And did you want to discuss anything else with her apart
24 from just to tell her that the family were concerned
25 about the failure of -- not having yet received the

1 death certificate?
2 A. Well, I wanted to move forward and action this as there
3 had been a significant delay in the production of the
4 death certificate, so I wanted her opinion about this as
5 I felt she likely would have had some information and
6 would have been likely some discussion between
7 Dr Stewart and Dr Hanrahan. So I wanted to inform them
8 so they could take this further. So I spoke to
9 Dr Stewart and she informed me that she was waiting or
10 the neurology team was waiting for the results of the
11 autopsy, they were waiting for a report of that.
12 Q. And what happened after that? What did you do with that
13 information?
14 A. With that information I then sought to sort out a report
15 to see if a report had been produced. I was not aware
16 of it being received in the intensive care unit, so
17 I looked through the notes. From my record, I appear to
18 have found the autopsy report in the front flap of
19 Lucy's notes. So with that information I then contacted
20 Dr Hanrahan as the consultant paediatric neurologist and
21 relayed the same information to him, that there had been
22 a request from, likely from a representative of the
23 family, for a death certificate, that a death
24 certificate had not been issued, and it's likely that
25 I let him know that the autopsy report was in the notes

1 and to get his opinion.
2 Q. Why did you contact Dr Hanrahan?
3 A. He was the consultant who had interaction with the
4 coroner and I could see that from looking through the
5 notes. So I felt that he was the most relevant person.
6 I think it's also likely, however, that I would have
7 spoken to the intensivist in intensive care on that day
8 as everything went through them and goes through them,
9 indeed, in intensive care.
10 Q. Who would that have been?
11 A. I'm not sure who that intensivist would have been that
12 day, but it's likely that they would have advised me to
13 approach the neurology team because they had really been
14 overseeing Lucy's care, Lucy's medical care,
15 neurological care in intensive care.
16 Q. I'm going to ask you now a little bit about what
17 experience and training you had to complete death
18 certificates. What did you have?
19 A. I cannot recall any training in completing death
20 certificates, but I have spoken to classmates from
21 university to ask them if they can recall our experience
22 of training in completion of death certificates. They
23 had informed me that part of a pathology lecture that
24 we would have received in third year was devoted to
25 completion of death certificates. But other than

1 that -- and I cannot recall that specifically, but there
2 was no postgraduate training that I'm aware of, having
3 received in completion of death certificates.
4 Q. Were you aware that there was guidance for doing that?
5 A. I'm not sure if I was aware of guidance at that time.
6 Q. We'll come on to what happened when you actually did it.
7 Who did you think was able to complete a medical cause
8 of death certificate?
9 A. A medically qualified individual who had treated the
10 deceased in the 28 days preceding their demise. I felt
11 as an active member of the junior medical staff in
12 intensive care that I would have fallen into that
13 category.
14 Q. Dr Hanrahan was asked about that in his witness
15 statement of 289/1, page 19. He says:
16 "Dr O'Donoghue was to my knowledge the clinical
17 fellow in PICU where Lucy was pronounced dead, even
18 though he may not have treated Lucy. I did not consider
19 it inappropriate for him to complete the death
20 certificate."
21 He doesn't seem by that to have thought that you
22 treated Lucy.
23 A. Can I just say that I was not a clinical fellow as
24 alluded to in that, I was the acting registrar, as I've
25 mentioned previously.

1 Q. But he doesn't seem to have considered you to have
2 treated Lucy.
3 A. I wrote up -- there's a record of.
4 THE CHAIRMAN: We've just ascertained this morning that
5 Dr O'Donoghue did treat Lucy.
6 MS ANYADIKE-DANES: If we look at the guidance -- admittedly
7 this guidance that I'm going to pull up for you is
8 guidance that was published by the department in 2008.
9 The law governing this aspect has not changed since you
10 would have been completing the death certificate.
11 In that guidance, it deals with who can complete the
12 death certificate. I start with the guidance so that
13 you see what it is, 315-008-001. Then just so one
14 recognises the significance of what is being done, it
15 goes on at 008:
16 "Why do we have certification?"
17 It deals with two matters, one for the family
18 obviously, and then for society:
19 "It is important that one has accurate information,
20 statistically, because that is used to monitor, evaluate
21 and determine health policy."
22 And you'd appreciate all of that?
23 A. Yes.
24 Q. And if we go to 010, it talks about who can complete the
25 medical certificate of cause of death. It starts off:

1 "The registered medical practitioners have a legal
2 duty to provide, without delay, a certificate of cause
3 of death if, to the best of their knowledge, that person
4 died of natural causes for which they had treated that
5 person in the last 28 days."
6 Then it goes on as to how it's a statutory legal
7 duty and in hospital it recognises the very point that
8 you've been mentioning, that there may be several
9 doctors in a team caring for the patient who will be
10 able to certify the cause of death:
11 "It is ultimately the responsibility of the
12 consultant in charge of the patient's care to ensure
13 that the death is properly certified."
14 If I pause there. Who did you think was in charge
15 of Lucy's care? The consultant, I should say.
16 A. The prime consultant I would have considered to be the
17 neurologist, Dr Hanrahan, with input, as I have
18 mentioned earlier, from the consultant intensivist.
19 Q. That is obviously going to be something that we need to
20 take up with him, because he sees it the other way
21 around, he considered himself to be providing specialist
22 input.
23 A. Okay.
24 Q. But in any event, from your point of view, you
25 considered him to be the consultant in charge of Lucy's

1 care?
2 A. I felt certainly in certification of death.
3 Q. It doesn't actually say that. It's not in charge of
4 certification of death. It's the responsibility of the
5 consultant in charge of the patient's care. So when you
6 were being asked to do that, who did you regard, if you
7 think yourself back to that time in April 2000, as being
8 the consultant in charge of Lucy's care?
9 A. I would have considered Dr Hanrahan to be in charge.
10 Q. Okay. If we go over, leaving aside the elements of
11 general practice which don't apply, it says:
12 "A doctor who had not been directly involved in the
13 patient's care at any time during the illness from which
14 they died cannot certify the cause of death, but he
15 should provide the coroner with any information that may
16 help to determine the cause of death."
17 Now, did you think about that at all when you were
18 being asked to complete the medical cause of death?
19 A. I cannot recall if I thought about that specifically,
20 but with regard to that statement, a doctor who had not
21 been directly involved in the patient's care,
22 I considered myself to have been directly involved as
23 I administered a hormone directly to the patient, so
24 I considered that to be very active in directly
25 administering care to the patient. So I felt that

1 I would have fulfilled those criteria.
2 Q. And were you aware of that at the time, that that's what
3 you had to be, you had to be someone who had been
4 directly involved in her care?
5 A. I cannot recall, but I think it is likely, because
6 I would not have completed the death certificate without
7 that being the case.
8 THE CHAIRMAN: In other words, if you'd been asked to help
9 to complete a death certificate of a patient who you
10 knew nothing about, you would have said, "This isn't
11 a job for me"?
12 A. I'd have said, "Go away".
13 THE CHAIRMAN: But in Lucy's case, you had been involved in
14 her care, therefore you were in a position to work on
15 the completion of the death certificate, but by
16 reference to Dr Hanrahan?
17 A. Yes.
18 THE CHAIRMAN: Thank you.
19 MS ANYADIKE-DANES: I just want to ask you something about
20 timing. Because if you see the first paragraph I read
21 out to you, it says that it is a legal duty to provide
22 without delay a certificate of cause of death. Now, you
23 were being asked to do that, I think it's 17 April you
24 were being asked to do that, and you went to find out
25 whether one had been issued because you met the query

1 from the family member, and what the position was.
2 Is that correct?
3 A. Sorry, I don't think it was 17 April.
4 Q. I beg your pardon, I may be wrong about that. I'm so
5 sorry.
6 THE CHAIRMAN: It was later?
7 A. I think it was 5 May. 4 or 5 May.
8 MS ANYADIKE-DANES: Yes, after the receipt of the
9 post-mortem. So actually some time afterwards?
10 A. Yes.
11 Q. Did that concern you, that there had been that kind of
12 lapse of time without the issuance of a death
13 certificate?
14 A. I can't recall at the time if it concerned me, but
15 certainly on reflection it was a significant delay, yes.
16 Q. We have asked about that because the inquiry's expert,
17 Professor Lucas -- have you had an opportunity to see
18 his report?
19 A. Yes, I have.
20 Q. Then you'll see that he has been quite exercised, not
21 just by the delay, but by the fact that the medical
22 cause of death certificate comes after the autopsy
23 report, which he -- in his view that's the wrong way
24 round. It shouldn't happen in that way. And the reason
25 is because, if it's not going to be a coroner's case,

1 the clinician should be able to write the medical cause
2 of death certificate. That's his view. If you can't,
3 if there's a problem about that, then that's something
4 that should really be being addressed with the coroner.
5 So that we have the point that he makes, one sees it
6 at 252-003-011 of his report, having earlier described
7 it as irregular. He says that doing it that way round,
8 after the post-mortem, perverts the whole coronial
9 referral system for unnatural death, for following
10 a consented autopsy more people, including the
11 pathologist, could more readily conspire to hide
12 a genuine unnaturally death from public notice.
13 He's not for one minute suggesting that anyone was
14 doing that in this case, but he's explaining why that's
15 the order of things, to make sure that the usual
16 process, the natural death certificate for referral to
17 the coroner makes the doctors think promptly about why
18 someone died and what to do next, and this is a very
19 serious issue and should be examined in more detail.
20 That is why he believes it has to be done in that order,
21 because the doctors have to be able to bring their
22 expertise to bear on the cause of the child's death and
23 they have to be able to recite that, and, if they can't,
24 that is an indication that the matter is probably one of
25 those that should be being taken up by the coroner.

1 Now, can you help us with what your experience was
2 at the Children's Hospital at that time of how death
3 certificates were issued? Because I think you have said
4 that you had issued by this time a number of them.
5 A. Yes. With respect, if I could go back to the point
6 about Professor Lucas' report.
7 Q. Yes.
8 A. My reading -- and not as a pathologist -- is that there
9 appeared to be some variance in the opinions of
10 pathologists in that the Dr Keeling paper that is on the
11 front page of the inquiry website says that when
12 a post-mortem has not been instructed as in it's not
13 a coroner's case, is what I believe that to mean,
14 a death certificate may be issued by the clinician on
15 instruction from the coroner or by the clinician, taking
16 into account information from the pathologist when
17 a post-mortem has been performed. So my interpretation
18 of that from Dr Keeling's expert report is that the
19 clinician who had been in contact could issue a death
20 certificate after the autopsy report. I am not
21 a pathologist, so I don't know about the minutiae of
22 that, but there does appear to my eyes to be some
23 variance between the expert witnesses.
24 Q. You're quite right, and that is a point that we're going
25 to have to take up, but I was putting to you his concern

1 about the order of things and therefore I was asking you
2 what your experience was in the Children's Hospital at
3 that time of the order of things, if I can put it that
4 way. But you're absolutely right about the difference,
5 yes.
6 A. The order of issuing the death certificate?
7 THE CHAIRMAN: If there was to be -- we've been told that
8 there were not very many children's post-mortems.
9 A. Yes.
10 THE CHAIRMAN: Did you have any experience of where there
11 were children's post-mortems whether a death certificate
12 would be issued without delay, as is suggested in the
13 departmental guidance, or whether it waited for the
14 post-mortem?
15 A. I had no experience of that.
16 MS ANYADIKE-DANES: You hadn't any experience?
17 A. Of that sequence, that particular sequence of events.
18 Q. It's correct to say that Dr Hicks, who you would have
19 been aware of?
20 A. Yes.
21 Q. In her witness statement for the inquiry, we asked her
22 a similar question, and she said:
23 "It would not be acceptable practice to await the
24 full result, as that would make any weeks and delay
25 burial. What was usually done is that the clinician

1 would speak to the pathologist immediately after the
2 initial procedure to ascertain what had been found at
3 that stage and then complete the death certificate
4 accordingly."
5 Now, so far as you were concerned, what was it that
6 you were looking at?
7 A. At what stage, sorry?
8 Q. At the stage what you were completing the medical cause
9 of death certificate.
10 A. I was looking through the body of the paediatric notes.
11 Q. Sorry, I meant from the pathologist.
12 A. Sorry, yes, the autopsy report. It's likely that
13 I would not have read right through the report, but
14 would have looked at the summary report from Dr O'Hara.
15 Q. The date of the certificate that you issue is 4 May.
16 The full report is dated 13 June. And I think there's
17 an anatomical summary that comes ahead of that, which,
18 as soon as I find it, I'll point out to you. Did you
19 think that you might have any discussion with the
20 pathologist since you wouldn't have had his full report
21 by the time you were issuing that certificate?
22 A. I don't feel as the very junior member of staff in the
23 intensive care unit that I would have had a discussion
24 with the pathologist, that any discussion with the
25 pathologist would have been carried out by the

1 consultant, either in intensive care or by the
2 consultant neurologist.
3 Q. Well, I'm just trying to see what exactly you could have
4 had from the coroner in time -- sorry, from the
5 pathologist in time for you to have completed a death
6 certificate on 4 May. Because this report, the report
7 itself, seems to be dated 13 June 2000. Sorry, so that
8 you have it, we can pull it up, 061-009-016, alongside
9 it 061-009-017. So that would have come too late. So
10 can you help us with what you think you saw to have
11 assisted you? Because the only other thing that I can
12 see is this, it's dated 17 April, and that is what I was
13 thinking of when I put it to you before, it's
14 061-009-032.
15 This is the only other thing that has been issued by
16 the pathologist before you issue the medical cause of
17 death certificate.
18 A. Yes.
19 Q. This is the provisional anatomical summary, so it
20 doesn't go into the commentary, which is presumably what
21 everybody's waiting for from the pathologist, and part
22 of the reason why they wanted a hospital post-mortem
23 done in the first place. What it does is it provides,
24 as it says, this provisional anatomical summary, and so
25 you have the history, 7 and 8 are matters that you would

1 have known in any event because they're coming from the
2 medical notes and records. And then there's relatively
3 little congestion, he notes. There's a swollen brain.
4 You would have known about the swollen brain because you'd got
5 the CT scan. And then the heart given for valve
6 transplantation purposes. That wouldn't have assisted
7 you.
8 So what was it there that you were gaining
9 assistance from to complete the medical cause of death
10 certificate?
11 A. I cannot recall if that's the specific document, but
12 it is likely that it is because, as you point out, the
13 other report was not available at that stage.
14 Q. That's why actually I asked you whether you had thought
15 to contact the pathologist because there wouldn't
16 appear to be very much there to help you.
17 A. Well, the provisional anatomical summary was what we had
18 available at that time. That's the information that
19 I would have passed to the neurological team.
20 THE CHAIRMAN: I understand that, but can you tell us from
21 your perspective -- I think the original question
22 was: what assistance do you get from that to complete
23 the death certificate?
24 A. First of all, there were a number of sources of
25 information of which this was one, and point 7, vomiting

1 and diarrhoea illness with dehydration, which I would
2 have been aware of from the body of the clinical notes,
3 and the dehydration, as evidenced by the elevated urea
4 level at 9.9 millimoles per litre, and drowsiness, the
5 history of seizure, which I'd be aware of. There was
6 a clinical history of gastroenteritis. So potentially
7 that would fit with some distension in my eyes,
8 distension of the large and small intestine with gas.
9 Then swollen brain, which was seen on the CT scan, as
10 you say.
11 MS ANYADIKE-DANES: So that's what I was asking you. In
12 fact, the reference to the distension and gas, you don't
13 need to go to that because that's actually in the
14 transfer letter and that's in her notes from the Erne
15 about that.
16 A. Yes.
17 Q. In fact, if I just complete that, if you had gone to the
18 transfer letter you'd see that they did a chest X-ray
19 and they also did an X-ray of her abdominal area and
20 that's what actually showed the gas and distension.
21 There's a helpful little diagram by Dr O'Donohoe making
22 that helpful point at 061-017-047. So what did you get
23 that added to any of the knowledge that you would have
24 gleaned from the medical notes and records from that
25 provisional anatomical summary to assist you in issuing

1 the medical certificate of cause of death?
2 A. There was little extra information as I can see in the
3 notes. It had been indicated that the coroner had been
4 contacted by Dr Hanrahan and the coroner, as recorded by
5 Dr Stewart, had said that a post-mortem was not required
6 but would be useful to establish the cause of death, so
7 I was looking to the summary to get extra information on
8 the cause of death, and there was not very much extra
9 information on that.
10 Q. No, because it won't come in that. This is the very
11 first thing that emanates from the pathologist, just as
12 provisional as it says, summary, and what everybody else
13 is waiting for is the commentary?
14 A. Yes.
15 Q. And certainly at that stage, 17 April, there wouldn't
16 have been fixation of the brain, so you wouldn't have
17 any of that material at all, that's all going to come
18 later on?
19 A. Yes.
20 Q. So if you wanted to get an early indication of what the
21 pathologist's thinking might be, to the extent they had
22 advanced anything from what was there by the time you're
23 doing your job in early May, you'd really have to be
24 phoning up the pathologist to ask them?
25 A. I don't feel as the junior member of the medical team

1 that I would have been doing that.
2 Q. I didn't suggest you would be. I am saying if you
3 wanted to get any more information, assuming that they
4 had advanced matters from April to 5 May, when you were
5 doing it, that's the only way, because there is nothing
6 in that summary that you couldn't get from her medical
7 notes and records?
8 A. That's right.
9 Q. Yes.
10 THE CHAIRMAN: Can I take it then, doctor, that on thinking
11 back to what happened in 2000, that this document
12 doesn't actually help at all in the completion of the
13 death certificate?
14 A. It confirms ...
15 THE CHAIRMAN: Confirms what's already in the notes?
16 A. Yes.
17 THE CHAIRMAN: But it doesn't take it any further?
18 A. It doesn't give very much more information.
19 THE CHAIRMAN: And the reason why -- however satisfactory or
20 otherwise the contact with the coroner was, the reason
21 why a hospital post-mortem was being carried out was to
22 identify what the cause of death was?
23 A. Yes. As recorded by Dr Stewart in the notes to
24 establish the cause of death.
25 THE CHAIRMAN: So this note doesn't take things further. So

1 if a death certificate is then going to be completed on
2 foot of the enquiry from the undertaker in Fermanagh,
3 it would be completed on the basis of the existing notes
4 and records?
5 A. And confirmed with confirmatory evidence on the
6 provisional anatomical --
7 MS ANYADIKE-DANES: As the chairman has put to you, it's the
8 information that is being reflected in those medical
9 notes and records that has led the clinicians to feel
10 that they need an autopsy to help them with working out
11 the cause of death? In fact, Dr Stewart when she gave
12 evidence on that the day before yesterday was quite
13 clear that the purpose of getting the hospital
14 post-mortem was to assist in identifying the cause of
15 death.
16 A. Yes.
17 Q. But you're being asked with no further information to
18 actually issue a document that will recite the cause of
19 death?
20 A. I don't agree that there's no further information.
21 There is further information in that there's an
22 anatomical summary, so it does not change the
23 information that we have, but it is further information
24 and I think to build up, to construct a death
25 certificate, there's many forms of information

1 potentially possible needed to be looked at.
2 Q. But that information was sufficient for Dr Hanrahan and,
3 for that matter, Dr Stewart to feel that that wasn't
4 enough for them to determine the cause of death. So
5 that information, as recited there in the anatomical
6 summary, which is in itself just reflecting what is
7 in the notes, wasn't enough for Dr Hanrahan to be able
8 to recite the cause of death. That's why he wanted
9 a post-mortem, the results of which you haven't yet
10 received. So what I'm asking you is: how were you able
11 to make the step on 4 May, when you were doing it, that
12 Dr Hanrahan apparently hadn't been able to do on
13 14 April when he formed the view he needed the
14 assistance of a post-mortem?
15 A. I presented the available information to the neurology
16 team at that time and I was given the causes of death by
17 the consultant neurologist, who must have felt that he
18 was able to formulate the causes of death that he gave
19 to me.
20 Q. When Dr Stewart recorded in the notes, 061-018-067, that
21 apparently a coroner's post-mortem was now not
22 required -- you would have seen that in the notes
23 because you said you went to the notes?
24 A. Yes.
25 Q. But a hospital post-mortem would be useful to establish

1 the cause of death and rule out other diagnoses. So
2 that was the thinking then. Dr Hanrahan's thinking,
3 Dr Stewart's thinking to the extent that she was having
4 an independent thought about it, as opposed to just
5 reciting Dr Hanrahan's position. So then if you're
6 seeing that and Dr Hanrahan is asking you at the
7 beginning of May to issue the death certificate and is
8 having a discussion with you about what is the
9 appropriate cause of death, are you not asking him, "How
10 do we know what it is now?", it seems that it wasn't
11 known on 14 April, what more have we got?
12 A. I'm asking him as the junior member of staff, I'm asking
13 him as the consultant paediatric neurologist, one of
14 only two in Northern Ireland, to give me information
15 about the death certificate. So I was passing on what
16 information I had received to him to formulate, to get
17 his advice as the senior medical colleague on the cause
18 of death, and that is what I did.
19 Q. But are you not interested to know, even just to advance
20 your own knowledge, as to what extra did they have from
21 14 April that enabled them to then know what the cause
22 of death was when they didn't appear to be confident
23 about what it was on 14 April?
24 A. I took the information that I had available and passed
25 it on a person who I felt responsible for making the

1 decision about --
2 Q. Sorry, that wasn't my question.
3 A. I didn't really understand your question.
4 THE CHAIRMAN: Let me see if I can get at it this way. On
5 14 April, or in the days immediately afterwards, there
6 was no death certificate issued.
7 A. Yes.
8 THE CHAIRMAN: And a death certificate would be issued if
9 Lucy's cause of death was known.
10 A. Yes.
11 THE CHAIRMAN: So subject to any evidence which I'll hear
12 over the next few weeks, a death certificate wasn't
13 issued because there was uncertainty about why Lucy
14 died.
15 A. Yes.
16 THE CHAIRMAN: And that ties in with the note which is on
17 the screen in front of you where, after some sort of
18 discussion with the coroner or his agent or
19 representative, it was decided that a hospital
20 post-mortem would be useful to establish the cause of
21 death.
22 A. Yes.
23 THE CHAIRMAN: The autopsy report doesn't come through
24 until June.
25 A. Yes.

1 THE CHAIRMAN: But there's an enquiry on behalf of the
2 Crawford family through the undertaker for the death
3 certificate to be issued in early May.
4 A. Yes.
5 THE CHAIRMAN: At that point you look through the notes and
6 you speak to Dr Hanrahan.
7 A. Yes.
8 THE CHAIRMAN: Dr Hanrahan can do one of two things. He can
9 either say, "Well, we can't complete that because
10 we haven't got the autopsy report".
11 A. Yes.
12 THE CHAIRMAN: Or he can say, "Well, this is the cause of
13 death", and give you A, B, C, D?
14 A. Yes.
15 THE CHAIRMAN: And did he take the second route and give you
16 A, B, C, D?
17 A. Yes.
18 THE CHAIRMAN: And that's what you put into the death
19 certificate?
20 A. It was quoted in the notes and then transcribed into the
21 death certificate.
22 THE CHAIRMAN: Yes. Our curiosity or our concern is how he
23 could do that in early May if he didn't know around
24 about 14 April why Lucy died and was waiting for
25 a post-mortem report which did not come through

1 until June. Can you help with that?
2 A. I think that question is best addressed to Dr Hanrahan,
3 to consider his feelings, his thought processes at that
4 time.
5 MS ANYADIKE-DANES: Did you regard yourself therefore as
6 really just taking down what he said, he's the
7 consultant so if that's what he thinks is the cause of
8 death, that is what I'll recite on the certificate?
9 A. There were some thought processes in between those two
10 actions.
11 Q. Which were?
12 A. Well, to consider what Dr Hanrahan had recorded and then
13 to transcribe that.
14 Q. If you were considering it then, does that not mean
15 you have to ask yourself that question: how have we got
16 from a position with apparently no further information
17 from when Dr Hanrahan didn't think he could issue
18 a death certificate to one where he's now telling me
19 what to put down? If you're having a further thought,
20 is that not a thought you have?
21 A. Possibly on the result of the provisional autopsy
22 report, Dr Hanrahan may have felt that he was able to --
23 that it was extra information, not necessarily
24 additional beneficial information, but --
25 Q. But that's what he's requiring, isn't it?

1 A. Yes.
2 Q. He's requiring additional information.
3 A. Yes.
4 Q. He's already got that information and that information
5 hasn't assisted him in being able to certify a cause of
6 death and he hasn't got any more information.
7 A. Well, he has got more information in that he's received,
8 or the hospital, the intensive care unit has received
9 the anatomical -- that is additional information because
10 it's not information that was available at the time of
11 Lucy's demise, so it is additional information.
12 THE CHAIRMAN: Your point on that is that even if it's
13 information which confirms what's in the notes, since
14 the notes aren't always entirely accurate or certain,
15 the fact that there is confirmatory information is some
16 step forward?
17 A. Yes.
18 THE CHAIRMAN: Thank you.
19 MS ANYADIKE-DANES: You appreciate that what you were doing
20 in signing that, issuing that medical cause of death
21 certificate, is something that's governed by the GMC,
22 your actions in doing that?
23 A. Yes.
24 Q. Yes. And the relevant GMC good medical practice is in
25 1998 that covered that particular period, and it has

1 a section on signing certificates. 315-002-019. It
2 says:
3 "Registered medical practitioners have the authority
4 to sign a variety of documents, such as death
5 certificates, on the assumption that they will only sign
6 statements they believe to be true. This means that you
7 must take reasonable steps to verify any statement
8 before you sign a document. You must not sign documents
9 which you believe to be false or misleading."
10 I'm not for one minute suggesting that you signed
11 a death certificate believing it to be either false or
12 misleading. But what I am interested in is what steps
13 you took to satisfy yourself that what you were then
14 going to record on that death certificate was accurate.
15 A. The sources available to me at that time were the body
16 of the notes, the transfer letter from Enniskillen, so
17 I was aware of the vomiting, dehydration, the
18 post-mortem, albeit provisional, summary, anatomical
19 provisional summary report, and then the advice from the
20 senior -- my senior colleague Dr Hanrahan, consultant
21 paediatric neurologist. So those were the three broad
22 sources of information that I was considering in
23 formulating or, rather, Dr Hanrahan formulated the cause
24 of death and I looked through those. And as you're
25 aware, number 1, the cerebral oedema. 2, dehydration

1 and, 3, gastroenteritis. I was aware from the clinical
2 history in Enniskillen and also from the CAT scan and
3 the clinical presentation of Lucy in intensive care that
4 that would be consistent with cerebral oedema, and that
5 was confirmed, I believe, in the final anatomical --
6 sorry, in the provisional anatomical summary. The
7 dehydration was confirmed with the clinical history and
8 also the raised urea level, as we've said already, and
9 the gastroenteritis was confirmed in the clinical
10 history and rotavirus subsequently.
11 In constructing the death certificate, it does --
12 I'm not sure as to the scrutiny to which I subjected the
13 pathway or sequencing or possibilities in terms of
14 physiological possibilities of one leading to another,
15 but at that time each of the discrete medical entities
16 that I was told by Dr Hanrahan I believed to be true.
17 Q. When you are thinking about dehydration, as that's
18 something you say you were thinking about, that's
19 a fluid issue.
20 A. Yes.
21 Q. In the sense that it's a deprivation. And you had
22 already given your evidence to say if you wanted to be
23 clear on fluid issues, then that was something that is
24 more likely to be within the provenance of somebody like
25 Dr Crean, who you had recognised as a consultant that

1 you were answerable to and also had joint care or at
2 least also had care at consultant level of Lucy. Did
3 you not think, "This is a serious thing I'm about to do,
4 issue this death certificate, maybe I should discuss the
5 cause of death also with him"?
6 A. I think when I received the call in intensive care from,
7 likely, the funeral director, the first port of call
8 would usually have been to approach the consultant
9 intensivist in intensive care at that stage. I haven't
10 recorded that in the notes, but that would be the usual
11 sequence of events. So I believe it is likely that
12 I would have spoken to the intensive care consultant who
13 was on duty that day.
14 Q. If I pause you there just a moment because that wasn't
15 quite what I asked you. Unless that intensivist was
16 either Dr Crean or Dr Chisakuta that person wouldn't
17 have been involved in Lucy's care.
18 A. Yes.
19 Q. So unless you're trying to --
20 MR McALINDEN: He should complete his answer, because it's
21 quite clear from the impression I gained from his
22 evidence earlier that in order to ascertain what he
23 should do in relation to the completion of this death he
24 contacted the consultant anaesthetist in the ICU
25 department, who directed him to the neurology team.

1 Now, the point that my learned friend is now making
2 in relation to this doctor's duties is to suggest that
3 this doctor had a positive duty to contact Dr Crean.
4 I would submit it's perfectly plainly obviously here
5 that if this junior doctor contacts a consultant in the
6 ICU department about who to contact about a death
7 certificate, it would be the duty of that consultant in
8 the ICU department to suggest that he speaks to Dr Crean
9 if it's appropriate or to speak to Dr Hanrahan if it's
10 appropriate, and it would appear that the advice he got
11 was to speak to Dr Hanrahan. I cannot see how this
12 witness can be quizzed further then about whether it was
13 appropriate for him to go and seek out Dr Crean as
14 opposed to take the steps that he's already stated he
15 took.
16 MS ANYADIKE-DANES: I understand that. If I could put it in
17 this way, which is what I meant. Dr O'Donoghue had been
18 on a ward round with Dr Crean. Lucy was only in
19 intensive care on two days: one was the 13th and you
20 were on a ward round with Dr Crean on the 13th and you
21 think you were on a ward round with Dr Chisakuta on the
22 14th. Both those two are consultant intensivists who
23 were directly responsible for that element, if I can put
24 it that way, of Lucy's care.
25 A. Mm-hm.

1 Q. So what I was asking is when you had got yourself to the
2 position, and nobody would know you were going to have
3 a view that one of the essential elements in the cause
4 of her death was dehydration, but when you had got that
5 in and you recognised that that is a fluid issue, at
6 that stage did you not think that it might be worth
7 discussing that with one or other of the two
8 intensivists who had had direct involvement in Lucy's
9 care?
10 A. In completion of the death certificate or in order to
11 facilitate that, I contacted Dr Hanrahan and likely the
12 intensivist on duty that day and I would have expected
13 that they would have undertaken that consideration.
14 Q. That would, of course, have required the intensivist on
15 the day to have known that you were thinking about
16 a fluids issue and to have known that Dr Crean and
17 Dr Chisakuta had been directly involved in her care.
18 THE CHAIRMAN: Sorry, I think we have to be careful about
19 how critical we potentially are of Dr O'Donoghue, who
20 was at that time a junior doctor, even though one of
21 some experience.
22 MS ANYADIKE-DANES: Mr Chairman, I'm not trying to be
23 critical of him at all.
24 THE CHAIRMAN: Ms Anyadike-Danes, we have a doctor who
25 certainly referred -- when the issue of the death

1 certificate arose, he didn't take it on himself, he
2 referred the issue, he thinks he likely spoke to an
3 intensivist, he certainly spoke to Dr Hanrahan, and with
4 Dr Hanrahan's guidance he completed the death
5 certificate which he signed. To the extent that there's
6 a real concern about the adequacy of that death
7 certificate, I think the responsibility for that real
8 concern lies elsewhere.
9 MR McALINDEN: Mr Chairman, one further point I could raise
10 at this stage. 4 May was a Thursday and 5 May was
11 a Friday. If this happened on the 4th, it would have
12 been Dr Crean who would have been the consultant in the
13 PICU. If it was the 5th, it would have been
14 Dr Chisakuta.
15 MS ANYADIKE-DANES: That's very helpful, thank you very much
16 indeed.
17 Dr O'Donoghue, I'm not trying to be critical of you,
18 I'm trying to tease out the steps that you took and your
19 thought process in doing what you did do. It's not my
20 job and certainly not my intention to be critical of
21 you.
22 A. Could I just point out, the document Good Medical
23 Practice? Part of that is good clinical care, and
24 I think the reference for that is 250-016-004. It says:
25 "In providing care, you must recognise and work

1 within the limits of your professional competence."
2 And then this is reiterated again in good medical
3 practice in paediatrics, published by the Royal College
4 of Paediatrics and Child Health in 2002. I think the
5 reference for this is 250-005-007. Under the duties and
6 responsibilities of a paediatrician, it emphasises the
7 importance of recognising the limits of your
8 professional competence at that reference, and then,
9 below that, 250-005-009 and 010, section 2(d), it
10 states:
11 "Advice from a more experienced doctor must be
12 readily available and taken when needed."
13 And then sections 3(a) and (b) say:
14 "Recognise and work within the limits of your
15 professional competence."
16 So I just wanted to bring that to the inquiry's
17 attention.
18 Q. Thank you very much.
19 THE CHAIRMAN: Let's take a break for 15 minutes. When we
20 come back, doctor, we'll finish your evidence before
21 lunch and hopefully start with Dr Auterson.
22 (11.53 am)
23 (A short break)
24 (12.10 pm)
25 MS ANYADIKE-DANES: If we now go to the actual medical

1 certificate of cause of death that you issued.
2 013-008-022. When you were giving evidence earlier, you
3 said that you had spoken to Dr Hanrahan, you made some
4 notes as a result of your discussion with Dr Hanrahan
5 and then you came and you wrote up this medical
6 certificate; is that correct?
7 A. Yes.
8 Q. So he wasn't physically with you when you did this?
9 A. I think it was over the phone.
10 Q. Thank you. If we go to the guide that I had taken you
11 to earlier, there's actually a step-by-step in terms of
12 filling this in. If we can start at 315-008-030.
13 Sorry, can we pull up the preceding page, 028? There
14 we are. Do you have your medical certificate there in
15 front of you? I see you have some documents.
16 A. No, sorry I don't.
17 Q. Because we can't get this up on the screen all at the
18 same time, you will see that point 9 is:
19 "Whether seen after death by me."
20 And then you can answer that. And depending on what
21 that answer is, there's a point 10:
22 "Whether seen after death by another medical
23 practitioner."
24 Bearing in mind the evidence you have already given,
25 had you seen Lucy after her death?

1 A. I believe that I did see her after her death.
2 Q. When did you do that?
3 A. After her death, I'm not exactly sure when. Likely in
4 the intensive care unit because, often, in the rooms in
5 intensive care nursing and medical staff would be in and
6 out of rooms writing things up, getting things,
7 communicating, so it's likely that I would have seen her
8 and, if I've -- it's very likely that I saw her after
9 her death, yes.
10 Q. Can you remember the circumstances of that?
11 A. No, I can't remember specifically, no.
12 Q. But enough so that you felt that you could identify the
13 fact that you had as opposed to indicating any other
14 practitioner who would certainly have seen her?
15 A. Yes.
16 Q. Thank you. Then if we go back to where I had taken you
17 to, which is 030. This goes through a step-by-step, and
18 you see part 1 is the sequence leading to death, and it
19 says in the guidance down the side:
20 "You have to start with the immediate, direct cause
21 of death on line 1(a)."
22 Can we see if we can possibly get alongside it the
23 medical certificate of cause of death? We can still
24 probably read that if you can put that up alongside it.
25 013-008-022. Thank you.

1 So you start on 1(a) with the immediate and direct
2 cause of death. You had, with the assistance of
3 Dr Hanrahan, determined that as cerebral oedema?
4 A. Yes.
5 Q. And then we go to:
6 "Then to go back through the sequence of events or
7 conditions that led to death on subsequent lines, until
8 you reach the one that initiated the fatal sequence. If
9 the certificate has been completed properly, the
10 condition on the lowest completed line of part 1 will
11 have caused all of the conditions on the lines above
12 it."
13 So working through the sequence, you have cerebral
14 oedema, which you have determined was due to or as
15 a consequence of dehydration. Can you help with how you
16 thought and/or Dr Hanrahan guided you that dehydration
17 had caused Lucy's cerebral oedema?
18 A. On reflection, I feel it's very unlikely that the
19 cerebral oedema would have resulted from the
20 dehydration.
21 Q. And what do you think did cause the cerebral oedema?
22 A. The second line in the revised death certificate, which
23 was dilutional hyponatraemia.
24 Q. But if you were staying with your -- was that something
25 that you think you could have worked out at the time you

1 were issuing the certificate?
2 A. It wasn't the subject of -- it was not what I was told
3 and it wasn't ... The relevance of hyponatraemia I was
4 unsure of because the sodium level in the subsequent
5 electrolyte profile, although Lucy, as we'd said earlier
6 was 127, and I had seen a number of children with sodium
7 levels at that level and not have problems, so whenever
8 I was told the causes of death and it did not include
9 hyponatraemia, then --
10 Q. If you pause there for a minute, when you say that you
11 had seen children before who had had serum sodium levels
12 of 127, had those same children reached 127 from 137 in
13 a relatively few number of hours?
14 A. I can't recall that specifically.
15 Q. Well, do you think it's likely that you had seen anybody
16 like that, who had had a relatively speedy fall?
17 A. It's possible. I don't think it's beyond the bounds of
18 possibility.
19 Q. I see. But in any event, if you hadn't -- if for some
20 reason dilutional hyponatraemia was not something that
21 came to your mind, nonetheless you would have
22 appreciated, even then, that dehydration doesn't cause
23 cerebral oedema?
24 A. On reflection, I feel that it's very unlikely that
25 cerebral oedema would --

1 Q. But do you have to reflect on it? Because in a way
2 Dr Stewart had much the same sort of response and
3 ultimately, when she was asked, I think it was the
4 chairman put it to her that it really didn't make
5 medical sense that if you have a child who you say is
6 dehydrated that that can actually cause something which
7 relates to otherwise a swelling, which is the cerebral
8 oedema, and ultimately she agreed with that.
9 A. Yes.
10 Q. And she agreed that it didn't make sense. Dr Chisakuta
11 said it wouldn't have taken him very long to see that it
12 doesn't make sense and the inquiry's experts, not that
13 I'm putting you at that level, just said it was simply
14 illogical.
15 A. Yes.
16 Q. So when you in 2000, acting as registrar, are about to
17 put that cerebral oedema was due to or as a consequence
18 of dehydration, do you not ask yourself and pause and
19 think, "Hang on, how does that work?"
20 A. I asked myself likely that, do these causes of death
21 that I have been told by my senior colleague -- were
22 they present? And on looking at the cerebral oedema,
23 there was evidence of that, there's evidence of the
24 dehydration and evidence of the gastroenteritis.
25 Q. That's a slightly different answer. I don't want to

1 interrupt you, but you are answering a slightly
2 different question. What I'm looking at is the
3 connection between these things. I haven't asked you
4 whether cerebral oedema was present, whether dehydration
5 was present or whether gastroenteritis was present.
6 A. Sorry, I was coming to that.
7 Q. Then I being your pardon for interrupting you, but what
8 I would like to bring you to is whether, at the level of
9 experience you had in 2000, you could see that
10 dehydration in and of itself wasn't going to cause
11 cerebral oedema. What could cause cerebral oedema is an
12 inappropriate response or treatment of the dehydration.
13 That could cause a cerebral oedema. Could you have
14 appreciated that in 2000?
15 A. It's hard for me to say if I could have appreciated that
16 in 2000, but it is likely if I had scrutinised it in
17 greater detail, the sequencing and flow of diagnoses,
18 that it would have become apparent that that does not
19 make physiological sense.
20 Q. Yes, but that's what you're required to do. You're
21 about to issue a death certificate.
22 A. Yes.
23 Q. Which has important consequences.
24 A. Yes.
25 Q. And so it's very important, quite apart from your

1 obligations in terms of GMC, you have statutory
2 obligations, as you complete this. So it is important
3 that you scrutinise it and make sure that it's correct
4 and, if it's being told to you by your consultant that
5 you understand it, because ultimately you're going to
6 sign it.
7 A. Yes. And I did scrutinise each line, but it's the
8 sequencing that I could have scrutinised in greater
9 detail.
10 Q. And do you not think you could have scrutinised the
11 sequencing because that's what the cause of death box
12 requires you to do?
13 A. Yes.
14 THE CHAIRMAN: So the information which is on the document
15 is accurate, but there's a missing step?
16 A. That's right.
17 THE CHAIRMAN: Thank you.
18 MS ANYADIKE-DANES: Now, that missing step, if you had
19 scrutinised it, do you think you're likely to have been
20 able to work out that that missing step might be the
21 treatment of the dehydration?
22 A. The missing step, possibly. I can't say, looking back
23 at that period of time, but possibly, yes.
24 Q. If that missing step is not in itself a natural event,
25 then do you appreciate that there is a difficulty in

1 signing a death certificate like that without referring
2 the matter to the coroner?
3 A. Yes, but I had been told this, I'd sought to get advice
4 on this as a junior member of staff, I'd sought to get
5 advice from the person most likely able to give me that
6 advice, and I trusted and respected that advice and took
7 that advice subsequently. And on reflection, it has
8 become apparent that I should not have taken that advice
9 so readily and that I should have stress tested it in
10 more detail. Although I did look at each individual
11 diagnosis and appreciated and confirmed that each was
12 present, the sequencing and follow-up of one --
13 follow-through of one to another, I should have look at
14 in greater detail.
15 Q. I understand, thank you for that. Does that mean now
16 that if you had done that in greater detail, do you
17 accept that if you had seen that there was an
18 intervention that wasn't a natural one, that would have
19 caused a problem and you would have had to ask about the
20 referral to a coroner in that event?
21 A. Could you rephrase the question, please?
22 Q. If you had realised that the cause or relationship
23 between the cerebral oedema and the dehydration in fact
24 involved a non-natural event, human intervention,
25 treatment, that that would have required a referral to

1 the coroner?
2 A. I think that's a hypothetical situation, so I don't know
3 what my thought process would have been at that time
4 12 years ago.
5 Q. Do you know what your obligations are in terms of
6 referring a death to the coroner?
7 A. Yes.
8 Q. And do you know that if you form the view that the death
9 is not a natural death, that it's due to a medical
10 intervention, if I can put it that way, that that is
11 a category that requires to be notified to the coroner?
12 A. Yes, but I was not thinking in that way at that time and
13 I was aware that the coroner had been informed by
14 Dr Hanrahan and I assumed appropriate steps and
15 communication had been ongoing, so I was aware
16 the coroner had been informed by Dr Hanrahan at that
17 stage.
18 THE CHAIRMAN: Can I ask you just one more element of that.
19 You said you'd previously seen a few children whose
20 sodium reading was as low as 127.
21 A. Yes.
22 THE CHAIRMAN: And one of the reasons why that in itself
23 didn't particularly concern you is because those
24 children had not died or even suffered serious damage.
25 A. Yes, they were all very well. What I hadn't appreciated

1 subsequently was the timing of the intervention of the
2 sodium chloride bolus of 500 ml that was given in
3 Enniskillen. It certainly wasn't clear to me at the
4 time, and even subsequently the exact timing has not
5 been totally elucidated, as far as I'm aware.
6 THE CHAIRMAN: There are two points. The first point is
7 that 127 may very well not be the lowest reading that
8 Lucy had at all.
9 A. Yes.
10 THE CHAIRMAN: Because if it's a reading taken after she has
11 received the bolus of normal saline, there may be some
12 debate about how much she came up. But it seems at
13 least possible that she came up from below 127; right?
14 A. Yes.
15 THE CHAIRMAN: That's the first point. The second point is,
16 even if you set aside that point, doctor, if other
17 children have made their way back from 127 and have been
18 restored to health, doesn't that really raise your
19 curiosity about why Lucy didn't?
20 A. Yes, but the follow-on from that is I would logically
21 seek other causes for her decompensation because at that
22 level I was seeing a number of children who had been
23 very well and --
24 THE CHAIRMAN: Isn't the problem about that that this
25 sequencing doesn't fill in the gap?

1 A. No. No, it doesn't.
2 MS ANYADIKE-DANES: Just on that point, when I was looking
3 through your CV it struck me that you were somebody who
4 might have some familiarity with children who had
5 suffered gastroenteritis.
6 A. Yes, working as a general paediatrician we see children
7 with gastroenteritis.
8 Q. How many children that you had cared for who'd had
9 gastroenteritis then went on to die with gastroenteritis
10 being, as they call it here, the starting point of that
11 sequence? How they describe it is that until you reach
12 the one that initiated the fatal sequence, so
13 gastroenteritis, in the way that this is formulated, is
14 actually the start of all of this and all of this flows
15 from gastroenteritis. How often had you come across
16 that?
17 A. I have seen children die with gastroenteritis with
18 rotavirus infection that has subsequently caused
19 cerebral oedema as a result of encephalitis, so I have
20 seen that.
21 Q. Did you know that Lucy at that time, when you were
22 filling this in -- had you looked at her lab results and
23 known that rotavirus was involved?
24 A. No, but it is the most common bug causing diarrhoea
25 illnesses.

1 Q. And how many children were you aware of had actually
2 died having started with gastroenteritis, if I can put
3 it that way, as at April 2000?
4 A. Very few. I'm unsure of the number, but certainly very
5 few.
6 Q. So that in and of itself would be a rare event; isn't
7 that right?
8 A. Yes.
9 Q. In fact, the inquiry's expert provided us with some
10 guidance to show just how rare an event that would be,
11 and I think we were down to about four in the year, in
12 the whole of England and Wales, in the year when Lucy
13 died. Just so that I'm putting it to you properly, one
14 can see it at 250-004-032.
15 The first four codes are to do with gastroenteritis,
16 as you see them there. The second one, which is 558,
17 that's other and unspecified non-infectious
18 gastroenteritis and colitis. If you take the four
19 there, Lucy's age range is above 12 months, she was
20 about 17 months at the time. So that would mean in her
21 year of death there had been none at all in the whole of
22 England and Wales. And in fact, you have to go back to
23 1998 to find a child who died of that.
24 If you look at the 558 category, in her year that is
25 1 to 4 years old, none recorded up until, in this

1 sequence we're looking at here, 1999 when there were
2 two, and then in the year 2000 there were four. So
3 given the population of England and Wales, that's
4 a pretty rare event, wouldn't you agree?
5 A. Yes.
6 Q. So did that also pique your interest as to how such a
7 thing, which you said you're not even sure that you had
8 come across, a child dying like that as at April 2000,
9 to actually ask, "What on earth happened to Lucy?" I'm
10 simply speaking now from a professional interest point
11 of view. Did that not prompt you to do that?
12 A. Yes.
13 Q. What was the answer you got?
14 A. It was unclear to me, looking through the notes, and the
15 post-mortem summary, as I've said, and even considering
16 the electrolyte profile of 127 -- sorry, sodium of 127.
17 So I was certainly unclear as to the cause of death.
18 Q. In fact, could you understand from that why anybody
19 would want a hospital post-mortem in those circumstances
20 to try and assist?
21 A. Yes, because we would just want to make a decision with
22 access to as much information as possible to inform the
23 decision to get a balanced decision.
24 Q. Exactly. And now if you hadn't had access to
25 Dr Hanrahan, say you were having to formulate this

1 yourself as the registrar, would you have felt confident
2 that you could actually have formulated a cause of death
3 from the information that was available to you in her
4 notes?
5 A. I would have always asked the consultant.
6 Q. I appreciate that, but in terms of from a clinical point
7 of view do you think that the information in her notes
8 was sufficiently clear for you to identify what the
9 cause of her death was?
10 A. It was unclear.
11 Q. Thank you.
12 THE CHAIRMAN: Is that why you rang Dr Hanrahan? When this
13 query came in from Fermanagh and you got your hands on
14 the notes, if the cause of Lucy's death was clear, would
15 you have completed the form and then run it past
16 Dr Hanrahan?
17 A. Certainly not. No way, no. Even if it was abundantly
18 clear, such as a child with meningococcal septicaemia,
19 we would always check with the consultant.
20 THE CHAIRMAN: You believed that Dr Hanrahan dictated that
21 death certificate to you over the phone.
22 A. Yes.
23 THE CHAIRMAN: I'm just querying with you, if there was an
24 absolutely clear cause of death, would you have
25 completed the death certificate and then rung

1 Dr Hanrahan to say, "This is what I'm putting in, is
2 that okay?"
3 A. No. I would still have gone through him.
4 MS ANYADIKE-DANES: I had asked Dr McKaigue yesterday, I'm
5 not sure if you were here yesterday.
6 A. No.
7 Q. I had asked Dr McKaigue about this certificate, just
8 these series of questions in terms of the sequencing and
9 so on, and he struggled, I think that would be a fair
10 enough way of putting it, a little bit with that. One
11 of his concerns is that if you had wanted to put all the
12 things that you might legitimately put to help you with
13 the sequencing, you might end up requiring more lines or
14 an additional line, I think, than is there on the
15 medical certificate of death. Now, was the possible
16 requirement of an extra line anything that troubled you?
17 A. No, not at that time, that I can recall. I cannot
18 recall that troubling me at that time.
19 Q. Mr Chairman, just for clarity, I wonder if I could pull
20 up 032 in this sequence, so that would be 315-008-032.
21 Still in the same guide, Dr O'Donoghue, which
22 actually deals with that very question that didn't, as
23 you say, seem to trouble you at that time. It says:
24 "The MCCD has three lines in part 1 for the sequence
25 leading directly to death. If you want to include more

1 than three steps in the sequence, you can do so by
2 writing more than one condition on a line, indicating
3 clearly that one is due to the next."
4 So you can effectively get another line in by
5 linking a number of things on one line.
6 THE CHAIRMAN: Thank you.
7 A. Yes.
8 MS ANYADIKE-DANES: Two further things to ask you. The
9 medical certificate of cause of death has a place where
10 you can indicate whether you're prepared to provide
11 further information. Further information offered. Then
12 you can indicate. You have indicated yes. If we go
13 back to that again.
14 THE CHAIRMAN: 013-008-022.
15 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
16 I think it's actually on the back of this.
17 THE CHAIRMAN: Can you give us 023, please?
18 MS ANYADIKE-DANES: No? Well, in any event, you did
19 indicate yes to that question. We have made some
20 enquiries to see whether there was any further
21 information offered. Mr Butler, who's the Assistant
22 Registrar General of the Northern Ireland Statistics and
23 Research Agency, has confirmed that there was no further
24 information received. The reference for that is
25 324-001a-001. Perhaps we ought to pull that up because

1 I haven't been able to show you the back part of that.
2 My learned junior feels he might have found the back
3 part of the death certificate, which could be at
4 319-055-002. Yes, there we are. So this is on the back
5 part. It says:
6 "Further information offered."
7 The answer is yes. That's your signature on the
8 other side?
9 A. Yes.
10 Q. So this is the counterfoil that gets retained and this
11 is the part that goes off. Then we asked the question
12 as to whether there was any further information. Then
13 if we pull up the previous reference, 324-001a-001. If
14 we can get alongside it 324-001c-001. Then it refers to
15 the position in 2000:
16 "Where a certifying doctor indicated that further
17 information could be provided, the onus was on them to
18 do so. Such information was used solely to facilitate
19 the statistical coding of the cause of death."
20 Why did you tick or circle yes in relation to the
21 death certificate?
22 A. I always complete the death certificates with yes to try
23 to assist in any subsequent -- if there are any
24 subsequent queries. What I felt that meant was being
25 available to answer any questions at a later date.

1 THE CHAIRMAN: So you don't interpret it the same way? They
2 interpret that as you're saying to them, "I will provide
3 more information".
4 A. Yes.
5 THE CHAIRMAN: Whereas you interpret it as saying, "If you
6 want more information, come and ask me"?
7 A. That is the way I interpreted it, yes.
8 MS ANYADIKE-DANES: Had you received any guidance on how to
9 interpret that?
10 A. No.
11 Q. The last thing I think -- it's not the last thing, you
12 did this before you filled in the medical cause of
13 death, it's the inpatient/outpatient advice note.
14 061-012-036. You fill that in on -- at least you date
15 it 17 April, so that's just the day after Lucy dies.
16 Who directed you about filling this in?
17 A. That's part of the coding for the chart, so I cannot
18 recall anybody specifically directing me to do -- to
19 fill that in, but we would always have filled that
20 inpatient/outpatient advice note in for any child who
21 was admitted and subsequently discharged from intensive
22 care. It's just to close the paperwork and to optimise
23 the coding information.
24 Q. Who asked you to do it as opposed to anybody else?
25 A. It's likely one of the administrative staff or nursing

1 staff in intensive care.
2 Q. You have put in there that the consultant is Dr Crean;
3 is that right? It's very difficult to see but it looks
4 like Dr Crean.
5 A. Yes. What I likely would have looked at when completing
6 that form is the yellow advice -- sorry, the yellow
7 admission sheet that comes with all admissions to the
8 Children's Hospital where a consultant is specified
9 about halfway down the page, and it may be that
10 I referred to that yellow admission sheet when
11 completing the inpatient/outpatient advice note to have
12 some continuity.
13 Q. Yes. Then you've put the primary diagnosis. Write
14 major symptoms if diagnosis is not known. And you have
15 put that as cerebral oedema?
16 A. Yes.
17 Q. Then it says:
18 "Underlying conditions and co-morbidities."
19 What do you understand that to mean?
20 A. Other medical problems.
21 Q. And you have put "viral gastroenteritis". As at
22 17 April, had not other medical problems been identified
23 other than the viral gastroenteritis?
24 A. Yes.
25 Q. Why didn't you put those?

1 A. I'm not sure why I did not record those at that time.
2 Q. This is actually being directed to the patient's GP.
3 A. Yes.
4 Q. To allow the GP to know what has happened to their
5 patient.
6 A. That's correct, but the main information source for the
7 GP is usually by telephone contact immediately following
8 a death to ensure that no appointments, for instance,
9 are being sent out, and then that's followed up by
10 a comprehensive dictated letter to the GP. So those are
11 the two main sources of information that the GP
12 receives.
13 Q. And when does that typically go out to the GP, the
14 letter?
15 A. There's often a delay in that occurring. The rate(?)
16 limiting steps are the clinician dictating the letter
17 and, secondly, the secretary typing it, and then the
18 clinician signing the letter and then sending the letter
19 by post at that time and still at this time actually.
20 Q. In your experience is that something that gets sent off,
21 bearing in mind there's a bit of administration that has
22 to go with it, relatively quickly?
23 A. No, not always. But the communication with the GP would
24 be almost -- that would be straightaway in most cases
25 just to try and ensure all the medical records are

1 complete. Also, the GP is often very interested
2 because, in many cases, the GP will have referred a
3 child to the hospital, it would have gone to intensive
4 care, and they'd be very keen to know about the
5 follow-up and subsequent medical progress.
6 THE CHAIRMAN: Thank you.
7 MS ANYADIKE-DANES: In this case, when you were looking at
8 the notes to complete that medical certificate, did you
9 look to see if there was a letter like that, which might
10 have assisted you?
11 A. A dictated letter to the GP?
12 Q. Yes.
13 A. In that time frame, it would definitely not have been --
14 Q. It wouldn't have happened in that time frame?
15 A. No.
16 Q. Okay. Then if we go down -- well, sorry, did you say
17 that there could have been more that could have been
18 added than the viral gastroenteritis?
19 A. Yes.
20 Q. Forgive me if you have answered it, but you can't quite
21 recall why you didn't put more?
22 A. Yes. On reflection, whenever I completed the death
23 certificate with the three diagnoses, then I should have
24 completed or had records of those three diagnoses on the
25 inpatient/outpatient advice note.

1 Q. Is there not also a discharge summary for a child who
2 dies?
3 A. The discharge summary is usually dictated and there's
4 a dictated letter that I've mentioned already, and it's
5 sent to the GP and other healthcare professionals who
6 might be involved in the patient's care.
7 Q. There is a pro forma discharge summary one, isn't there?
8 I mean, apart from just a handwritten letter or a typed
9 letter? I can show you one, 061-004-011, which was
10 actually on Lucy's file. It's not completed at all, but
11 that was on her file.
12 A. Yes. In my experience and my recollection of working in
13 intensive care, I did not see many of those forms
14 completed. Most of the communication is as I've said,
15 by telephone, by the inpatient/outpatient note, and also
16 by a dictated letter and to the GP.
17 Q. And then one final thing, because we've asked just about
18 everybody about it. Were you aware of any change in use
19 of Solution No. 18 while you were in the Children's
20 Hospital?
21 A. No.
22 Q. Any discussion about that?
23 A. No.
24 THE CHAIRMAN: Thank you.
25 MS ANYADIKE-DANES: And after Lucy had died, were you ever

1 invited or heard about any meetings, professional
2 meetings I mean amongst clinicians, to try and address
3 why she had died, why she had come to the Children's
4 Hospital in the condition that she had?
5 A. No. I subsequently learnt, I think it was whenever
6 I was completing the first statement for Lucy, that
7 there had been discussions, but I had not been party to
8 them or even aware of them. I think that was in 2004,
9 2003. I hadn't been aware. In 2004 I left to do
10 research, so I wasn't doing any clinical work and
11 I didn't have any contact with the clinical -- any other
12 clinicians, I was in the university, just working with
13 cells and didn't have any clinical responsibilities at
14 that stage.
15 Q. Given that Lucy had come in a moribund state and there
16 seemed to be, I think you have recognised it fairly,
17 a degree of lack of clarity as to exactly how she
18 managed to be in the state that she was, if I can put it
19 that way, and therefore exactly what the cause of her
20 death was, did you expect that there would be some
21 meeting amongst the clinicians to review what had
22 happened?
23 A. Well, if I could maybe answer that question by looking
24 at the present practice where, if a child dies in
25 intensive care, they automatically are reviewed in

1 monthly morbidity mortality meetings, so yes, I would
2 have expected that type of review to have taken place.
3 Q. In fact, there was one. There's a list of those who
4 attended morbidity meeting audit on 10 August, I believe
5 it was, in 2000. Dr McKaigue was there, Dr Taylor was
6 there, those two who have been involved in some shape or
7 form with Lucy. Dr Taylor, I think, had been, like you,
8 signing off on the IV fluids at some point. If there
9 was a meeting like that, is that a meeting that comes to
10 the attention of an SHO?
11 A. Not necessarily. It does now because the information is
12 disseminated over by e-mail. At that stage e-mail
13 wasn't so prevalent and may not have been brought to
14 everyone's attention. However, people would try and
15 attend audit meetings, of which the morbidity mortality
16 meeting would be part, just for ongoing, continuing
17 professional education, if possible. Obviously, with
18 clinical commitments not everyone is able to attend.
19 Q. Of course. When I looked at the list, which we had up
20 yesterday and we don't need to pull up now, but there
21 are SHOs and registrars who attended that particular
22 mortality meeting. What I wanted to ask you, and it's
23 really my final question to you, is: how do you get to
24 know that a meeting like that is going to be held?
25 A. At the moment? Present practice is that this is

1 disseminated by the audit coordinator, who e-mails all
2 the clinicians and nursing staff in the Children's
3 Hospital to inform them of the audit meeting and to give
4 an agenda for an audit meeting.
5 Q. Literally all of them?
6 A. I can't say everybody, but I see -- I can see the
7 numbers of names to which the e-mails are copied and it
8 looks like 50 or 100 people.
9 Q. What would have happened in 2000?
10 A. There would have been -- it's likely that a notice would
11 have been put up on a notice board in the Children's
12 Hospital, informing people of a forthcoming audit
13 meeting and part of that would be the morbidity and
14 mortality meeting as well.
15 Q. And does that notice indicate the children whose deaths
16 are being considered?
17 A. No, because that is confidential information and the
18 thoroughfare that it would have been put on would have
19 been used by parents and other cleaning staff and
20 ancillary staff. That would be confidential information
21 so that would not have been up on a poster.
22 Q. So how would you know it was one of the children that
23 you might have been involved in, albeit as a registrar
24 or SHO, that you might like to follow up? How would you
25 know that?

1 A. You might have been approached by the administrative
2 staff from intensive care to inform you of a patient
3 that was going to be discussed. That's certainly what
4 happens at the moment. If I have a patient who passes
5 away in intensive care, I get asked to present that
6 patient at the meeting, so it's attended by a lot of
7 other people, but the main person who will present that
8 would be myself, if I was the consultant in charge of
9 that patient.
10 MS ANYADIKE-DANES: Thank you very much indeed.
11 MR UBEROI: Sir, may I add for clarity, I think my learned
12 friend, just in asking one of her questions a few
13 moments ago, suggested Dr Taylor may have been involved
14 in the IV fluids of Lucy, and I think that's an error.
15 He obviously chaired the mortality meeting. But unless
16 I've misunderstood the question, I just wanted to raise
17 that for clarification.
18 THE CHAIRMAN: I think she said he was at the August
19 meeting.
20 MS ANYADIKE-DANES: No, I didn't, actually, Mr Chairman.
21 Sorry, I did say he was at the August meeting, but also
22 if one pulls up 061-039-125, what I said was, "Involved
23 as he was in the IV fluids". There you see on 13 April,
24 the reverse of fluid balance sheet indicates that fluids
25 were prescribed by -- and there's a list of four names,

1 one of them I take to be Dr Taylor.
2 MR UBEROI: Yes. Thank you for the reference. Maybe we can
3 explore that with Dr Taylor. It may need to be
4 explored.
5 MS ANYADIKE-DANES: Of course.
6 THE CHAIRMAN: Thank you.
7 Mr Quinn, any questions? Any questions from the
8 floor?
9 Doctor, thank you very much for coming and giving
10 your evidence today. Unless there's anything further
11 you want to say, you're now free to leave.
12 I was hoping to get Dr Auterson started before
13 lunch, but not at 12.55. We'll start at 2 o'clock.
14 (12.55 pm)
15 (The Short Adjournment)
16 (2.00 pm)
17 THE CHAIRMAN: Mr Wolfe?
18 MR WOLFE: Good afternoon, chairman. The next witness is
19 Dr Thomas Auterson.
20 DR THOMAS AUTERSON (called)
21 Questions from MR WOLFE
22 MR WOLFE: Dr Auterson, good afternoon. I'm going to ask
23 you whether you wish to adopt a number of statements
24 that you've made, going all the way back to 2000, as
25 part of your evidence today, and subject to anything you

1 say orally. Working your way back to April 2000, you
2 provided a statement or a report to the Sperrin Lakeland
3 Trust as part of its internal review of Lucy's case, and
4 you'll remember that?
5 A. Yes.
6 Q. You have it in front of you.
7 A. Mm-hm.
8 Q. For reference purposes, that can be found at
9 033-102-316. Moving along the line then
10 chronologically, you gave evidence before the coroner
11 in relation to Lucy's inquest, which took place
12 in February 2004. In advance of that and as well as the
13 oral evidence that you prepared deposition, isn't that
14 right?
15 A. Yes.
16 Q. That can be found at 013-025-091. Thereafter, you were
17 interviewed by the Police Service of Northern Ireland as
18 part of its investigations into Lucy's case, and you
19 provided two statements to that organisation on or about
20 3 and 4 February 2005. Those statements can be found at
21 115-018-001. The second reference is 115-017-001.
22 THE CHAIRMAN: Sorry, doctor, do you have a query about
23 that?
24 A. I don't have copies of those statements to the best of
25 my knowledge.

1 THE CHAIRMAN: Okay. If you are going to be referred to any
2 part of those statements, I'll ensure they're brought up
3 on the screen in front of you.
4 A. Okay, right.
5 MR WOLFE: You do remember making such statements to the
6 police?
7 A. I think I do.
8 Q. Yes, okay. I can assure you that you did.
9 A. It was a long time ago.
10 Q. I will show you the documents in due course?
11 THE CHAIRMAN: You won't be questioned on those statements
12 without having a chance to look at them.
13 MR WOLFE: Finally, moving along this chronology, and most
14 recently, you provided two witness statements to this
15 inquiry. One dated 6 November 2012, which can be found
16 by reference to WS274/1, and then on 22 January this
17 year, 274/2.
18 A. Yes.
19 Q. And you have those?
20 A. Yes.
21 Q. As I prefaced that sequence, do you wish to adopt those
22 statements and subject to the police service statements
23 which we will turn to as part of your evidence?
24 A. Yes.
25 Q. Now, you are a consultant anaesthetist, doctor, is that

1 correct?
2 A. That's correct, yes.
3 Q. And you're currently employed in the South West Hospital
4 in Enniskillen?
5 A. Yes.
6 Q. And your CV, I'm not sure if you have it in front of
7 you, but I don't intend to dwell on it too long. It can
8 be found for reference purposes at 315-007-001. You
9 qualified as a medical doctor in 1977; is that correct?
10 A. That's correct, yes.
11 Q. And thereafter, you became a fellow of the Faculty of
12 Anaesthetists and College of Surgeons of Ireland in
13 1987?
14 A. Yes, that's true.
15 Q. You commenced employment at consultant level at the
16 Erne Hospital on 1 July 1992?
17 A. Correct.
18 Q. So by the date at which you treated Lucy in 2000, you
19 had been a consultant for approximately eight years?
20 A. That's true.
21 Q. And as we all know, the Erne Hospital no longer exists
22 and you took up your duties in the South West Hospital
23 when it opened this time last year?
24 A. Yes.
25 Q. Now, as a consultant anaesthetist, the whole area of

1 fluid management would be part and parcel of your stock
2 in trade; is that fair?
3 A. It's an everyday thing. Something we do every day.
4 Q. And when the inquiry asked you in your witness statement
5 request to explain your experience and knowledge of
6 fluid management, you told us that it was part of your
7 general training?
8 A. Yes.
9 Q. And it was part of ad hoc education which you would have
10 received from senior anaesthetists as part and parcel of
11 your training as a junior doctor?
12 A. That's correct.
13 Q. Over time, it's self-evident that you would have built
14 up experience in that whole area so that you would,
15 almost as a matter of first nature, could I suggest, be
16 aware of the appropriate fluids for given situations?
17 A. Yes.
18 Q. The document which is known as the advanced paediatric
19 life support manual, is that something that's familiar
20 to you?
21 A. I'm aware of it, yes.
22 Q. Is it something you would have been aware of at the time
23 of Lucy's death in 2000?
24 A. I can't remember.
25 Q. You can't say?

1 A. I can't remember.
2 Q. Can I ask you about fluids and fluid management in 2000?
3 Can I ask you this: in terms of maintenance fluids for
4 children, it was the fashion of the time to use
5 Solution No. 18 in the management of maintenance for
6 children who required intravenous fluids; is that fair?
7 A. Yes.
8 Q. Now, if a child required resuscitation, if they were
9 perhaps on the verge of circulatory collapse or if they
10 had suffered such a collapse, what would be the
11 appropriate fluid in that situation at that time?
12 A. Well, if you're envisaging having to transfuse
13 considerable amounts of fluid, you would consider
14 something like normal saline or something like
15 Hartmann's solution. If the situation is serious
16 enough, you might consider other fluids such as plasma,
17 something like that. Human plasma.
18 Q. Albumin?
19 A. Something like that, yes.
20 Q. In a situation where you had moderate to severe
21 dehydration, what fluids would you be considering for
22 that kind of situation in a child?
23 A. I think you'd consider, as I said, saline or Hartmann's
24 until you had corrected any deficit. Once that had been
25 corrected, you might consider continuing with

1 maintenance fluids such as Solution No. 18.
2 THE CHAIRMAN: This might show my ignorance. If you correct
3 a deficit so that the child is no longer dehydrated,
4 do you need to continue with anything?
5 A. If the child's ill, the child may not be able to take
6 oral fluids and you have to continue intravenous
7 hydration until feeding or drinking is re-established.
8 THE CHAIRMAN: Thank you. So you have taken care of the
9 dehydration and the continuing intravenous fluids are to
10 help the child cope with whatever else the ailment is?
11 A. An alternative would be to use two intravenous lines and
12 use one for replacing the deficit with something like
13 saline and use the other one for ongoing maintenance
14 fluids.
15 THE CHAIRMAN: Thank you.
16 MR WOLFE: Indeed, doctor, the APLS guidelines, and we
17 needn't necessarily put them up on the screen, but if
18 you feel the need for them we'll do so, the APLS
19 guidelines describe fluid balance as not necessarily an
20 exact science, and in circumstances where you need, say,
21 replacement fluids for a dehydration situation, you need
22 to marry those with ongoing maintenance fluids.
23 A. Yes.
24 Q. And a convenient choice of fluid in that situation might
25 be 0.45 per cent saline with some dextrose rather than

1 two separate fluids going in?
2 A. That's possible, but then 0.45 per cent saline is also
3 hypotonic and you may also run the risk of causing
4 hyponatraemia if you transfuse too much.
5 Q. Yes.
6 A. So the fluid replacement is dependent on serial
7 measurement of urea and electrolytes and your ongoing
8 fluid replacement is based on that in the ill child.
9 THE CHAIRMAN: That seems to be the -- at least one lesson
10 from the earlier deaths, particularly Claire's death,
11 that you do monitor the electrolytes and if you don't
12 monitor them, then there's a risk that things will --
13 A. You're in the dark really.
14 MR WOLFE: Does it follow then from what you have said that
15 where you have a need to infuse a bolus to take care of
16 circulatory shock or anticipated circulatory shock, you
17 wouldn't use Solution No. 18, in other words you
18 wouldn't use a fluid low in saline?
19 A. No, you would tend to use saline or ...
20 Q. Moreover, it would be wrong to use Solution No. 18, by
21 the standards of the time we're talking about, 2000,
22 it would be wrong to use Solution No. 18 where you need
23 to replace losses such as in a case where there is
24 dehydration?
25 A. It would not be advisable.

1 Q. Now, at or about 2000, if we can try to think back to
2 that time, you had been a consultant about eight years.
3 A. Yes.
4 Q. The whole territory of hyponatraemia, is that something
5 you appreciated at the time,
6 appreciated the circumstances in which hyponatraemia
7 could occur?
8 A. Yes. I mean, as one of a body of anaesthetists we were
9 aware of what can happen if a person becomes
10 hyponatraemic, either chronically or acutely. For
11 instance, when working in intensive care you would often
12 see elderly patients who had come in with a sodium of
13 120, but they didn't get cerebral oedema because this is
14 something that arose over months. It was a chronic
15 condition. Therefore, the cerebral circulation,
16 et cetera, slowly adapted.
17 THE CHAIRMAN: Am I right in understanding that it's more
18 common in elderly people than it is in children?
19 A. Because there are larger numbers of -- in elderly,
20 you have dietary reasons, some people drink lots of
21 water for whatever reason. There are lots of drugs used
22 in elderly people, which --
23 THE CHAIRMAN: I thought we were supposed to be encouraged
24 to drink water, doctor!
25 A. Moderation in all things.

1 THE CHAIRMAN: I see.
2 A. And several drugs as well cause increased sodium
3 excretion through the kidneys, which can lead to
4 a chronic state. The risky thing is if someone develops
5 hyponatraemia and you try to correct it quickly. It's
6 not the absolute value of the sodium or the low sodium,
7 it's the rate at which it falls is a big factor in the
8 development of cerebral oedema.
9 THE CHAIRMAN: So the rate at which it falls is significant,
10 but then also there's a risk that you try to
11 overcompensate too quickly by bringing it up again?
12 A. Yes.
13 THE CHAIRMAN: Thank you.
14 MR WOLFE: And just to spell it out for us, doctor, what are
15 those risks if you try to overcorrect or try to correct
16 too quickly?
17 A. Well, one is cerebral oedema. If you transfuse large
18 amounts of fluid into someone who has a history of
19 cardiac disease, you may precipitate something like
20 acute heart failure, something like that. So the actual
21 concentration of the correcting solution and the rate at
22 which it goes in are important.
23 Q. What you've just discussed with us, was that your
24 learning at the time, was that your state of knowledge
25 at the time in 2000?

1 A. And long before that. This is something we -- as junior
2 anaesthetists we just know, we pick it up. Formal
3 lectures, physiology lectures, teaching in theatre.
4 It's almost second nature.
5 Q. I was going to ask you whether you were at that time
6 a member of the Western Anaesthetic Society.
7 A. I was a member of the Northern Ireland Society of
8 Anaesthetists.
9 Q. There was a society which Dr Chisakuta spoke about on
10 Wednesday of this week when he gave evidence and he
11 talked about giving an inaugural lecture to that body,
12 at which there was discussion about the appropriate
13 post-operative fluids to give a child in order to avoid
14 the risks of hyponatraemic encephalopathy. But it seems
15 from what you're saying that you wouldn't have needed to
16 go to such a meeting if you understand those risks.
17 Is that fair?
18 A. Partly. The other reason was those meetings were always
19 held in Derry. At that stage, we were few on the ground
20 in Enniskillen on a very onerous rota and to give up
21 a whole evening off to go to Derry was -- you had to
22 have a good reason for doing it.
23 Q. Yes, it'd be difficult. Well, let me then attempt to
24 orientate you with your involvement in Lucy's case. Can
25 we set the scene perhaps by working through a chronology

1 so that I can ask you various things. In the early
2 morning of 13 April 2000, you were an anaesthetist
3 working in the hospital and you were called by
4 switchboard to attend Lucy urgently; isn't that correct?
5 A. I was at home.
6 Q. You were at home?
7 A. Mm-hm. When on call, we were not resident.
8 Q. So you made it into the hospital promptly and you have
9 said in various documents that you were there by about
10 3.50 in the morning?
11 A. Possibly a little earlier. I think I was called at
12 about 3.35, 3.40. It takes about 10 minutes to get in.
13 Q. And upon attendance, if I can summarise the position,
14 you noted that Lucy's pupils were fixed, dilated and
15 unresponsive; isn't that correct?
16 A. Yes.
17 Q. And you took responsibility then for intubating her?
18 A. Yes. By the time I arrived, she had been given oxygen
19 by face mask. I think Dr O'Donohoe had tried to
20 intubate himself possibly twice, unsuccessfully. I took
21 over from him, ventilated her lungs manually but with
22 a bag and mask, and was then able to intubate Lucy
23 without the use of any anaesthetic drugs. In other
24 words, there were no reflexes. Normally, when you --
25 this would not really be possible in a 17-month old

1 child who was fully conscious. In fact, Lucy had a, as
2 far as I remember, had a coma score of 3 at that stage
3 when the maximum coma score is 15.
4 Q. We don't need to deal in any great detail with clinical
5 aspects of Lucy's case for obvious reasons, but I just
6 want to run through this chronology with you and at
7 a later stage we'll look at what you were able to pick
8 up and interpret from your engagement at that time
9 in the morning and whatever conversations you might have
10 had. You became aware that Lucy was in receipt of
11 intravenous fluids, that was obvious to you when you
12 arrived?
13 A. Yes, there was an IV running.
14 Q. And were you aware that that was normal saline being run
15 in?
16 A. According to all the records, I think it was normal
17 saline that was running, which had been erected roughly
18 at the time Lucy had the fit.
19 Q. And we'll come back again to some of those finer details
20 presently. You also became aware that blood had been
21 taken for serum electrolytes; isn't that right?
22 A. Yes.
23 Q. And indeed, while you were resuscitating Lucy, you were
24 notified of the electrolyte results; isn't that correct?
25 A. Yes.

1 Q. And those electrolyte results showed that her
2 electrolytes were deranged, there had been a drop from
3 137 to 127 in sodium?
4 A. Yes.
5 Q. And that potassium was low at 2.5?
6 A. Yes. That's correct.
7 Q. A decision was also taken at or about that time to
8 conduct X-ray examination of her chest and lung fields?
9 A. I think as far as I remember, chest X-ray had been
10 ordered before I arrived and was done in the side room,
11 a portable machine was brought and a chest X-ray was
12 done. Well, in fact, in someone of that size a chest
13 X-ray would also take in the abdomen. I think only one
14 picture was taken.
15 Q. A decision was made that the child needed a CT scan of
16 the brain?
17 A. Yes.
18 Q. And would need to be referred to paediatric intensive
19 care?
20 A. Yes.
21 Q. Can you recall who made that decision?
22 A. I think it was -- well, she needed paediatric intensive
23 care and then a CT scan.
24 Q. Yes.
25 A. Well, I think Dr O'Donohoe and I both came to the

1 conclusion that we couldn't provide paediatric intensive
2 care in the Erne and I'm trying to remember was our
3 CT scanner up and running at that stage. I can't
4 remember. But urgent transfer to Belfast was really the
5 main concern.
6 Q. There's an issue that has emerged in a number of the
7 cases that this inquiry has been looking at and I'll
8 maybe delve into it a little bit here and go off my
9 track a little. It'll be convenient to deal with it
10 now. The argument goes like this, doctor. Lucy's
11 pupils were fixed and dilated. She was effectively in
12 a moribund state.
13 A. Mm-hm.
14 Q. Was there any likelihood of her being retrieved from
15 that situation and, if not, what was the point of
16 transferring her to Belfast?
17 A. The chances are that she was beyond retrieval, but any
18 chance that she might have had would only have been
19 increased by transfer to the tertiary centre.
20 THE CHAIRMAN: So even if it's the remotest of chances, you
21 take it?
22 A. Yes. Plus when we transferred her to intensive care and
23 I put her on a ventilator, which was totally unsuitable
24 for her because we didn't have any paediatric
25 ventilators, we couldn't have properly dealt with her,

1 and she had to go to Belfast.
2 THE CHAIRMAN: Thank you.
3 MR WOLFE: Now, a decision was taken then to bring her to
4 the intensive care unit within the Erne Hospital to
5 stabilise her for transfer.
6 A. Yes.
7 Q. And you participated in that?
8 A. Yes.
9 Q. Mannitol was given to her?
10 A. Yes. I can't remember the exact dose.
11 Q. I think the notes say --
12 A. She was given mannitol, either 10 or 20 per cent,
13 I can't remember. And I can't remember the --
14 Q. I think it was 25 ml --
15 A. That would have been appropriate, and she had an
16 antibiotic as well.
17 Q. Could you help us in terms of why she was given
18 mannitol, what was the suspicion and why was mannitol
19 appropriate?
20 A. Mannitol is used in the treatment of cerebral oedema.
21 It basically acts as what's called an osmotic diuretic.
22 It is not metabolised in the body and passes through the
23 kidneys, drawing water with it, and promotes excretion
24 of larger amounts of urine.
25 Q. Now, we'll go back and talk in some more detail about

1 the fluids that she'd had up to that stage and your view
2 on what caused her deterioration. You spoke to
3 Dr O'Donohoe about the fluids that were appropriate for
4 the journey, the transfer.
5 A. Yes.
6 Q. And a decision was made to continue on normal saline?
7 A. Yes.
8 Q. At a rate of 30 ml per hour.
9 A. Considering her weight, which was 9.1 ...
10 Q. 9.14 kilograms.
11 A. Say for ease of calculation you could round it up to 10,
12 and the -- you know, the maintenance fluids for
13 a 10-kilogram child are 4 ml per kilo per hour equals
14 40 ml. 36 ml for 9 kilograms. Dr O'Donohoe suggested
15 30. I had no difficulty with that. And I can't
16 actually remember at what rate they were running when
17 she left, but it was either 30 or 40.
18 Q. Yes. At or about that time, certainly prior to
19 transfer, you had an opportunity to speak to Lucy's
20 parents?
21 A. Very briefly. There was no formal meeting.
22 Q. We'll come back to that point in a moment and just look
23 at what was discussed, if anything. The ambulance
24 arrived at shortly after 6 o'clock.
25 A. Yes.

1 Q. And brought Lucy to Belfast. And it appears from the
2 records that an anaesthetist phoned PICU, an
3 anaesthetist from the Erne phoned PICU to deliver over
4 the telephone the repeat electrolyte results?
5 A. Yes.
6 Q. And that's what the record shows. I understand you
7 accept that you did make contact with the Royal?
8 A. Once Lucy had left, I went home, showered and had
9 breakfast, came back into the hospital after 8 o'clock.
10 I rang children's intensive care at about 8.30, just to
11 enquire had she arrived safely, what was her condition.
12 I think a Dr McLoughlin mentioned in her deposition that
13 an anaesthetist had contacted the children's ICU at
14 about 9 o'clock to convey the repeat U&E results. It
15 could only have been me because I was the only
16 anaesthetist in the hospital at 8.30, and I am 99
17 per cent sure I only made one phone call. So I assume
18 it was me.
19 Q. I want to look at that scenario in a little more depth
20 presently, but thank you for that. Then I think
21 you have told us, just charting our way along this
22 chronology again, in the 24 to 48 hours after this
23 serious incident which you attended, you would have
24 discussed your attendance on Lucy and some issues
25 associated with your attendance on Lucy informally with

1 a number of colleagues.
2 A. Yes.
3 Q. And you can remember, I think, speaking to Dr O'Donohoe?
4 A. I wouldn't have spoken to him until the next day or
5 possibly the day after.
6 Q. I think you refer in your statement to within a period
7 of 24 to 48 hours, so within that time frame
8 Dr O'Donohoe, Dr Cody, one of your anaesthetic
9 colleagues?
10 A. Yes.
11 Q. Dr Holmes, an anaesthetist?
12 A. Yes.
13 Q. And also Dr Anderson?
14 A. Yes.
15 Q. And you have also told us that either Dr Kelly or Dr Fee
16 asked you to provide a report or a statement, and you
17 express it in those terms. Can you help us in terms of
18 being any clearer about who asked you to provide
19 a statement?
20 A. I can't remember who it was. It was one of -- it was
21 probably either Dr Kelly or Mr Fee. I honestly can't
22 remember. I was asked about -- I made my statement on
23 the 20th, which was a week after Lucy's transfer. It
24 might have been the day before I was asked, but I made
25 the statement and dated it 20th April.

1 Q. Okay. As we indicated in the preface to your evidence,
2 you provided various accounts over the years, as Lucy's
3 unfortunate case has moved through various procedures.
4 I want to start with the most recent account, that's the
5 accounts you have provided --
6 MR GREEN: Mr Chairman, it may assist if we flush out what
7 it is that the doctor says he said to Dr Anderson in the
8 24 to 48 hours after Lucy's death before we move on to
9 the specific written accounts.
10 THE CHAIRMAN: Okay.
11 MR GREEN: If my learned friend would be good enough to do
12 that, it would perhaps assist.
13 THE CHAIRMAN: If we can do that now?
14 MR WOLFE: It's something I was intending to get to, but if
15 my friend has a particular concern.
16 THE CHAIRMAN: It will be reached, Mr Green. I think
17 Mr Wolfe is about to highlight what the doctor has said
18 to the inquiry and then to compare that to what he said
19 in earlier occasions.
20 MR GREEN: That's right, but it may assist to identify what
21 it is now that the doctor says he said to Dr Anderson
22 before we move through what may or may not turn out to
23 appear to be morphing accounts in various accounts down
24 the years. I'm happy for my learned friend to take his
25 own course, but --

1 THE CHAIRMAN: I'll let him take his course, but I'll bear
2 your point in mind and if at a later point this
3 afternoon you want to come back to it, that's fine.
4 MR GREEN: Thank you very much.
5 MR WOLFE: I think I'll take the course I'd planned.
6 Now, doctor, what I want to focus upon at this
7 stage, just to be absolutely clear about it, is what you
8 told the inquiry in your two witness statements about
9 your view of the treatment afforded to Lucy Crawford
10 in the Erne Hospital and the impact of that treatment on
11 her deterioration. Is that clear?
12 A. Mm-hm.
13 Q. Now, you've told us -- perhaps if we could put your
14 witness statement up to the screen, it might assist you.
15 WS274/1, page 4, please. You have your own copy with
16 you, doctor?
17 A. Yes.
18 Q. You are asked at question 8 to detail all steps which
19 were taken by you after Lucy's death to inform yourself
20 of the causes or the potential causes of her
21 deterioration and death. You said that you reviewed the
22 fluid balance chart and lab results and they led you to
23 believe that hyponatraemia played a significant part in
24 Lucy's deterioration and death.
25 A. Yes.

1 Q. Could I ask you to be as specific as you can on this?
2 At what point in time did you review the fluid balance
3 chart and the lab results?
4 A. Well, I had the lab results at the time of
5 resuscitation. I had a brief glimpse of her fluid
6 balance chart at resuscitation, but it was extremely
7 difficult to interpret. In fact, the figures that had
8 been entered seemed to be -- I couldn't interpret them
9 at all.
10 Q. So you couldn't interpret them?
11 A. I mean, I knew that she had received Solution No. 18 and
12 I think I was told it was at 100 ml an hour. But that
13 didn't correspond with the fluid balance chart. But
14 I was fairly sure that if she'd had too much fluids,
15 then her clinical condition and her sodium and potassium
16 results, when all put together, would have led to me
17 being reasonably sure that it was a dilutional
18 hyponatraemia.
19 THE CHAIRMAN: I understand that. Can I get you to focus --
20 this is the point which may be controversial and what
21 Mr Wolfe is asking you is, by reference to your answer
22 to question 8, at what point in time did your review of
23 the chart and the results lead you to that view? Was it
24 that morning in the Erne or was it the following week
25 when you were preparing your statement, or was it long

1 after the event?
2 A. It was long after the event because when I made the
3 report, I didn't have access to Lucy's chart.
4 THE CHAIRMAN: When you made your report for the internal
5 trust review?
6 A. On 20 April. It was all from memory.
7 THE CHAIRMAN: Okay. Then let's pin down the time. When
8 you say long after the event, can you help us on that?
9 A. I can't remember when I definitely came to that
10 conclusion. I'm sorry, I can't give you a date.
11 THE CHAIRMAN: There's at least -- if I try crudely to
12 define the different periods, you didn't do it for your
13 report or statement for the internal trust review on
14 20 April.
15 A. Mm-hm.
16 THE CHAIRMAN: There's then some continuing trust
17 investigation over the weeks which follow.
18 A. Yes.
19 THE CHAIRMAN: Did you do it at that stage?
20 A. No, because I wasn't involved in that whole ... And
21 really, the whole thing became clear at Lucy's inquest,
22 which was in 2004.
23 THE CHAIRMAN: Yes.
24 A. Because then, I didn't receive all the documentation
25 regarding the Trust investigation until I was informed

1 that there was going to be an inquest in February 2004.
2 I can't remember, but some time before that obviously
3 I got copies of the relevant documents. On reading all
4 that, it basically confirmed my suspicions.
5 MR WOLFE: Let me start with your suspicions, doctor. You
6 arrived at the hospital some minutes before 4 o'clock
7 in the morning.
8 A. Mm-hm.
9 Q. And within a short period of time of being there, you
10 realised that Lucy's neurological status was such that
11 her pupils were fixed and dilated; isn't that right?
12 A. Yes. And she had stopped breathing.
13 Q. Yes. The second thing you became aware of, quite
14 quickly, was the repeat electrolyte results; isn't that
15 correct?
16 A. Yes.
17 Q. And can I ask you whether you engaged in a comparative
18 exercise to test those repeat electrolyte results and
19 compare them with the earlier results?
20 A. It wasn't until sometime later that morning that I was
21 aware of her previous -- her admission U&E when her
22 sodium was 137.
23 Q. So within a period of a few hours, you recognised that
24 there had been a drop from 137 to 127?
25 A. Yes.

1 Q. And during that period of time, which led to the fluids
2 or the electrolytes dropping in that way, she had
3 Solution No. 18; isn't that correct?
4 A. Correct.
5 Q. And you were able to identify from the fluid balance
6 chart the nature of the fluid, the type of fluid that
7 she had received?
8 A. Um ... I think the only fluid written on the back of
9 the fluid balance chart was, to the best of my
10 knowledge, actually 500 ml of normal saline.
11 Q. You were telling us earlier about Solution No. 18, yes?
12 A. But that was recorded on the front of the chart where
13 the nurses had written in the fluids that she was
14 getting since 11 o'clock, and there were figures as to
15 the rate and cumulative total of fluids received.
16 Q. Yes. Well, if we go to the --
17 A. There was no actual formal prescription of
18 Solution No. 18.
19 Q. Did you look at the fluid balance chart in the early
20 hours of the morning?
21 A. Yes.
22 Q. And what did you see?
23 A. On the front of the fluid balance chart, it mentioned --
24 there were figures pertaining to the rate of infusion.
25 Q. Yes.

1 A. There was --
2 Q. Let's have it up on the screen in front of you at
3 027-019-062.
4 A. It looks like there's not.
5 Q. Sorry? You can observe from --
6 A. Yes, there's -- at 11 pm in the fourth column, it
7 mentions No. 18.
8 THE CHAIRMAN: Yes.
9 A. And it says 100/100. For midnight, it says 100/200.
10 MR WOLFE: Yes.
11 A. So you can take from that in the first hour, between 11
12 and 12, she had 100 ml of No. 18 Solution and, at the
13 end of that hour, her total was 100.
14 Q. What are you telling us, doctor? What we're interested
15 in hearing from you now is in the early hours of the --
16 THE CHAIRMAN: Sorry. What that means is that in the first
17 hour from 11 to 12 she received 100 ml of
18 Solution No. 18; right?
19 A. Yes.
20 THE CHAIRMAN: This is your reading of it. In the second
21 hour, from 11 to midnight, she received another 100 ml,
22 which brought the total she had received to 200.
23 A. Yes.
24 THE CHAIRMAN: How do I interpret midnight to 1 am?
25 A. You can see it's written, she got another 100 ml in the

1 next hour, but the running total still remains at 200.
2 THE CHAIRMAN: Right. Is it the same confusion from 1 am?
3 A. It's the same at 2 am.
4 THE CHAIRMAN: Well, do you read that as meaning that she
5 got 400 ml? It's not perfectly clear, but do you read
6 that as meaning she got 400 ml?
7 A. Yes.
8 THE CHAIRMAN: Between 11 pm and 3 am?
9 A. 3 am.
10 THE CHAIRMAN: Then how do you read the 3 am entry?
11 A. That was roughly the time she had the fit.
12 THE CHAIRMAN: Yes. In terms of the fluid, how do you
13 interpret 500 normal saline?
14 A. That was put up by someone on the ward before I arrived.
15 THE CHAIRMAN: If you had to look at that chart on its own,
16 doctor, how would you read from that how much normal
17 saline she received from 3 am?
18 A. You can't from that. But I think when I arrived, most
19 of it had gone in. I think, if I can remember rightly.
20 THE CHAIRMAN: Right. So working from this chart, and from
21 what you saw on your arrival, which was a bit before 4
22 am, you would look at that and say she has received 400
23 ml of Solution No. 18 over a four-hour period.
24 A. Yes.
25 THE CHAIRMAN: And from 3 am she's on normal saline and

1 I can look and see what she's received is something
2 coming up to 500 ml?
3 A. Yes.
4 THE CHAIRMAN: Thank you.
5 MR WOLFE: So can we say, doctor, that from your
6 consideration of this document on the morning of
7 13 April 2000, you were able to work out for yourself
8 that she had received 400 ml of Solution No. 18?
9 A. Yes.
10 Q. And did you reach a conclusion as to the appropriateness
11 of that fluid for that child?
12 A. The conclusion I reached was that in view of her
13 neurological collapse, it was probably due to
14 hyponatraemia-induced cerebral oedema. That was my
15 working diagnosis.
16 Q. In terms of the cause or the trigger for that
17 hyponatraemia, is it fair to say that you reached
18 a conclusion that the child had received the wrong type
19 of fluid at the wrong rate?
20 A. More of a suspicion than a conclusion. You know,
21 I was ... It seemed to me the most likely cause for the
22 hyponatraemia.
23 Q. Well, you have said in your witness statement, if we
24 could bring it up just to assist others, WS274/1,
25 page 5, and if we could highlight (g), please, and

1 you are asked:
2 "When did you reach the view that Lucy was given too
3 much of the wrong fluid?"
4 Do you see that?
5 A. Yes.
6 Q. And your answer is:
7 "At the time of resuscitation, it could be the most
8 likely cause of hyponatraemia."
9 A. Yes.
10 Q. So if I can interpret that, and correct me if I'm wrong,
11 based on her neurological status, based upon the
12 electrolyte results and taking into account the
13 information you gleaned from the fluid balance chart,
14 you recognised that fluids had caused the hyponatraemia
15 and the hyponatraemia had caused the cerebral oedema?
16 A. Yes.
17 Q. That was your working diagnosis?
18 A. Yes.
19 Q. And just to be clear with regard to your view that the
20 wrong type of fluid had been given, was it your view
21 that Lucy should not have received Solution No. 18 and
22 that she should instead have received a fluid with
23 a higher rate or a higher percentage of saline?
24 A. Possibly. But I think the more important factor was the
25 rate of the fluids.

1 Q. Looking at the answer that you have given, and it's an
2 answer that you have given the inquiry and you were to
3 give the coroner --
4 A. Whilst the Solution No. 18 -- it was a combination of
5 the fluid and too much of that fluid.
6 Q. In terms of the -- let's start with the type of fluid.
7 Did you reach a view in terms of what type of fluid she
8 should have been given?
9 A. Um ...
10 Q. To put it another way, why was the fluid that she
11 received the wrong fluid?
12 A. It was the wrong fluid when too much had been given.
13 THE CHAIRMAN: Can I ask it more directly? If she was in
14 because she was dehydrated as a result of
15 gastroenteritis, was Solution No. 18 the right fluid in
16 the first place or should she not have been on
17 a replacement fluid rather than a maintenance fluid?
18 A. Probably not, probably not.
19 THE CHAIRMAN: Thank you.
20 MR WOLFE: So as well as it being the wrong rate of fluid,
21 it was the wrong type for her condition; isn't that
22 right?
23 A. Basically, yes.
24 THE CHAIRMAN: What about, just in case we don't come back
25 to this later, what about giving her 500 ml of normal

1 saline from 3 o'clock? If 400 ml over four hours is an
2 excessive rate, what do you think of 500 ml?
3 A. It certainly didn't help the situation. I don't know at
4 what time the repeat U&E was done, but if it was done
5 after she had had some of that 500 ml of normal saline,
6 then it is possible that her sodium level, at the end of
7 having had the 400 ml of Solution No. 18, might have
8 been lower than 127.
9 THE CHAIRMAN: So depending on that timing issue, the 127
10 might not be the true low point in her reading?
11 A. Yes, and I can't speculate as to what it might have
12 been, but --
13 THE CHAIRMAN: If you wanted to correct what had gone wrong
14 before, part of doing that would be to give her normal
15 saline?
16 A. Yes.
17 THE CHAIRMAN: But it would not help -- you would impede the
18 beneficial effect of the normal saline by giving it to
19 her at an excessive rate?
20 A. Yes.
21 THE CHAIRMAN: And 500 ml in approximately an hour --
22 A. For a 9-kilogram child is a lot.
23 THE CHAIRMAN: Yes. Thank you.
24 MR WOLFE: Now, we got into that sequence of questions,
25 doctor, because I think you were telling us that it

1 wasn't until some later point that you accessed the
2 notes and were able to reach firm conclusions
3 in relation to all of this.
4 A. Mm-hm.
5 Q. Is it not the tenor of the evidence that you've given in
6 your witness statements that you were able to work this
7 out at the time? In other words, at the time or shortly
8 after the point when you were resuscitating the child?
9 A. Yes.
10 Q. And if that's right, at a future date when you got hold
11 of the charts, the notes and records and the fluid
12 balance, what did that do, did that simply reinforce
13 your earlier conclusions?
14 A. Yes, but I didn't get all those documents until prior to
15 the inquest.
16 Q. Well, as you sat down to have your breakfast that
17 morning, and just before you phoned the Royal Belfast
18 Hospital for Sick Children, what view were you sitting
19 with in terms of the cause of this child's deterioration
20 and collapse?
21 A. It was my suspicion that it was all due to dilutional
22 hyponatraemia.
23 Q. And taking a step back from that, all due to the fluids
24 that she had received?
25 A. Yes.

1 THE CHAIRMAN: Can I take it from that that it was a strong
2 suspicion?
3 A. Yes.
4 MR WOLFE: In fact, the notes relating to Lucy remained
5 in the Erne Hospital; isn't that correct?
6 A. I don't know where they were.
7 Q. Well --
8 A. I assumed that they had gone to Belfast with the child.
9 Q. But they didn't go to Belfast with the child.
10 A. I wasn't aware of that.
11 Q. Were you not aware that for the purposes of completing
12 your report for the internal review that Lucy's notes
13 were available to clinicians who wished to consult them?
14 Was that ever said to you?
15 A. No.
16 THE CHAIRMAN: Did you ever ask?
17 A. No.
18 THE CHAIRMAN: If you were going to give a helpful report
19 for an internal review, wouldn't it have been relevant
20 to say, "Can I see the notes if they're still
21 available"?
22 A. Because it was only a week after the event and things
23 were pretty fresh in my mind then.
24 THE CHAIRMAN: Okay. So in other words, you were confident
25 that you could help the internal review from your memory

1 of that morning's events without recourse to the
2 contemporaneous records?
3 A. Yes.
4 THE CHAIRMAN: Right, thank you.
5 MR WOLFE: Can I just ask you about that before we leave
6 this topic altogether. If we look at the report that
7 you provided -- and we'll come back later to deal with
8 the report in some detail. Just looking at the report
9 briefly at this stage, it can be found at 033-102-317.
10 THE CHAIRMAN: Do you have that in front of you?
11 A. That's the handwritten version of that.
12 THE CHAIRMAN: Okay, thank you.
13 MR WOLFE: Can I suggest to you, doctor, that when one looks
14 at your report for the review, which was, as you see in
15 front of you, dated 20 April 2000, that it is so full of
16 detail in terms of facts and figures that you either
17 have a very good memory or you must have had the notes
18 in front of you.
19 A. When something like that happens, you have a very good
20 memory.
21 Q. If we scroll through it, if we go to the next page,
22 please, you could remember the blood pressure?
23 A. Yes.
24 Q. You could remember the degree of oxygen?
25 A. Yes.

1 Q. You could remember the urea and electrolytes?
2 A. Yes.
3 Q. Going down the page, what are the figures in relation to
4 the ventilator? Second last line.
5 A. The Puritan Bennett refers to the type of ventilator
6 that was in ICU. It was an adult ventilator. The VT
7 stands for tidal volume, which is the volume of each
8 breath that the machine delivers to the patient. F is
9 the frequency of ventilation, the number of breaths her
10 minute. FIO2 stands for inspired concentration of
11 oxygen, or inspired proportion of oxygen. 1.0 means 100
12 per cent oxygen. The VT would have been the lowest
13 setting on the ventilator that I could get. She
14 obviously was on 100 per cent oxygen because of what had
15 happened. And a frequency of 20 would have been
16 appropriate, in my opinion, for a child of that size.
17 Q. And over the page, if we would, 318. You set out the
18 other features of her case, the administration of the
19 mannitol.
20 A. Yes.
21 Q. The antibiotic?
22 A. Yes.
23 Q. When was it that you did have the notes available to
24 you? Was it only at the time of the inquest?
25 A. Yes. I do not remember seeing them in the weeks or

1 months following the event.
2 Q. Now, as you have said already, your strong suspicion on
3 the morning of Lucy's transfer to the Royal was that
4 hyponatraemia had caused the cerebral oedema.
5 A. Yes.
6 Q. And you had an opportunity to speak to Lucy's parents
7 at the point of transfer; isn't that right?
8 A. When we transferred Lucy to ICU, I was busy for some
9 time putting her on the ventilator and sorting a few
10 things out. At some point, Lucy's parents were shown
11 into the nursing station area of the intensive care
12 unit, which sort of overlooked the bed that Lucy was in.
13 So they were fairly close to the bed and to Lucy.
14 Q. Now, at this point you were suspicious about the fluid
15 management of Lucy?
16 A. Yes.
17 Q. Was this an opportune time to tell the parents that
18 there had been this difficulty?
19 A. I thought it inappropriate to discuss possible reasons
20 until my suspicions had been confirmed because they were
21 already in a fairly distressed state.
22 Q. So that wasn't the moment?
23 A. And really, I was only -- I mean, I basically had spoken
24 to them for a minute in the middle of being very busy
25 and I just said, "Lucy's very ill, we can't deal with

1 her here, she has to go to Belfast".
2 THE CHAIRMAN: Do parents have a right or an expectation
3 that if there has been an inadequate treatment of their
4 child, that they will be told that?
5 A. They should be, but that would not have been the ...
6 THE CHAIRMAN: I understand the reason that you've given,
7 that this situation is disastrous enough for Mr and
8 Mrs Crawford, but there's still perhaps a remote chance
9 that something might be done to save Lucy, so as she's
10 being transferred to the Children's Hospital you may not
11 start to discuss with Mr and Mrs Crawford what has gone
12 wrong, I understand that. But do you accept the point
13 that if things went wrong with Lucy because of the
14 treatment she received, that Mr and Mrs Crawford could
15 reasonably be expected to be told that?
16 A. Yes, I would agree with that, but --
17 THE CHAIRMAN: And I accept your point that this may not
18 have been the appropriate time to tell them. You say,
19 "I thought it was inappropriate to discuss my suspicions
20 until they were confirmed". When were your suspicions
21 confirmed?
22 A. Sometime later. I can't remember exactly when.
23 THE CHAIRMAN: Well, in the days after Lucy's death?
24 A. Yes.
25 THE CHAIRMAN: And if the parents could reasonably expect to

1 be told once your suspicions were confirmed, what did
2 you do to relay that news to them?
3 A. I considered it was not my responsibility to mention
4 that thing or that possibility to the parents. It was
5 the responsibility of the paediatricians under whose
6 care she was.
7 THE CHAIRMAN: That would mean that the paediatrician --
8 what, the paediatrician who was more directly involved
9 or who had responsibility for Lucy's care should tell Mr
10 and --
11 A. Yes, who had been involved with her care since
12 admission.
13 THE CHAIRMAN: Did you speak to the paediatrician to tell
14 him your view was that Mr and Mrs Crawford should be
15 told that Lucy's death resulted or may have resulted
16 from her fluid management in the Erne?
17 A. I didn't discuss that with him.
18 THE CHAIRMAN: Why not?
19 A. I can't remember.
20 THE CHAIRMAN: I am sorry, doctor, I have to say, with
21 respect, "I can't remember "is not a good enough answer.
22 A. I didn't think it was appropriate at the time. If I had
23 told him that Lucy was seriously ill because of X --
24 THE CHAIRMAN: I'm not talking about the time as in the
25 morning she was transferred to the Royal. I'm talking

1 about the following days when you knew or you had had
2 your suspicions confirmed that her death, her dilutional
3 hyponatraemia, which led to the cerebral oedema, was
4 because of fluid mismanagement.
5 A. Yes.
6 THE CHAIRMAN: Now, you say it wasn't for you to tell the
7 parents because you were not the person who was
8 responsible for Lucy.
9 A. Yes.
10 THE CHAIRMAN: But Lucy's parents should have been told,
11 shouldn't they?
12 A. Yes.
13 THE CHAIRMAN: And since you recognised what the problem was
14 or what you believe the problem to have been, why did
15 you not say to Dr O'Donohoe, "I'm afraid, doctor, that
16 you should speak to Mr and Mrs Crawford and tell them
17 that Lucy probably died because of fluid mismanagement"?
18 A. I have no answer to that, I'm sorry.
19 THE CHAIRMAN: Well, if you didn't go to Dr O'Donohoe to
20 speak to him on that basis, did you speak to anybody
21 else in the Trust?
22 A. No.
23 THE CHAIRMAN: Why not?
24 A. I submitted my report to the review.
25 THE CHAIRMAN: Your report doesn't deal with this. As

1 I understand it from the sequence of evidence you've
2 given this afternoon, your suspicions were confirmed
3 in the days following Lucy's death.
4 A. Mm-hm.
5 THE CHAIRMAN: And that's despite the fact that you had no
6 access to her medical records; is that right?
7 A. Yes.
8 THE CHAIRMAN: Was it on the basis of anything that you were
9 told from a doctor in the Royal?
10 A. No.
11 THE CHAIRMAN: Did you discuss what had happened to Lucy
12 with any doctor in the Royal?
13 A. No.
14 THE CHAIRMAN: So your confirmed view that Lucy died because
15 of fluid management in the Erne was reached on the basis
16 of what you had recognised when you were called into
17 hospital on the morning of Thursday 13 April?
18 A. Yes.
19 THE CHAIRMAN: And on the basis of no further information?
20 A. Yes.
21 THE CHAIRMAN: Well then, why did you not include it in the
22 statement which you made on 20 April when the Trust was
23 doing an internal review about what had happened to
24 Lucy?
25 A. Because other people were aware of this as well.

1 THE CHAIRMAN: Mr Wolfe will turn in a few moments to what
2 other people were or were not aware of, but Mr and
3 Mrs Crawford were not told. You identified what had
4 gone wrong.
5 A. I was suspicious of what had gone wrong.
6 THE CHAIRMAN: Well, you said -- I'm sorry, doctor, it's
7 more than that because you told me you had a strong
8 suspicion and that your suspicions were confirmed in the
9 following days. But they weren't confirmed by any new
10 information which came to hand, they were confirmed
11 apparently by you reflecting on what had happened.
12 Right?
13 A. Yes.
14 THE CHAIRMAN: And in that scenario, and recognising that
15 Mr and Mrs Crawford have a right to be told what has
16 happened to their daughter and why it happened, you say,
17 "It's not my responsibility to tell them, it's
18 Dr O'Donohoe's", you didn't speak to Dr O'Donohoe and
19 you didn't speak to anyone in the Trust to ensure the
20 Crawfords were told.
21 A. I discussed the possible reason for the thing only with
22 Dr O'Donohoe at the time, the resuscitation, and he was
23 aware of the electrolyte results and I assumed,
24 obviously wrongly, that he would mention this at the
25 review.

1 THE CHAIRMAN: When you're giving your statement for the
2 review, one interpretation that I can place on your
3 statement is that you deliberately left out of your
4 statement your full knowledge.
5 A. I did not deliberately leave anything out. Certainly
6 not deliberately.
7 THE CHAIRMAN: So is it your evidence that you believe that
8 Dr O'Donohoe recognised at the time when Lucy was being
9 resuscitated what had gone wrong?
10 A. Yes.
11 THE CHAIRMAN: So you assumed then that he would face up to
12 this?
13 A. Yes.
14 THE CHAIRMAN: And talk to the Crawfords about it?
15 A. Yes.
16 THE CHAIRMAN: And facing up to it would also of necessity
17 involve advising hospital management, wouldn't it?
18 A. Yes.
19 THE CHAIRMAN: Did you confirm with anybody that he had
20 taken either of those steps?
21 A. No.
22 THE CHAIRMAN: Which meant at the very least that you
23 continued to work in the coming months and years with
24 a colleague, not knowing if he had acknowledged his
25 responsibility or his contribution to a child's death.

1 A. Yes. This was not a deliberate act on my part.
2 THE CHAIRMAN: Doctor, the only reason anybody knows about
3 this is because of Stanley Millar. Stanley Millar is
4 the single person in the Health Service who can take
5 credit for the fact that Mr and Mrs Crawford know why
6 their daughter died.
7 A. When I completed my report for the hospital review,
8 I submitted my report to the best of my knowledge. The
9 report contains the repeat U&E, which, by definition, is
10 severe hyponatraemia. Why was this not picked up on by
11 anyone else? I was never asked by the review -- I can't
12 even remember who was leading the review. I was never
13 asked to make any other comments or observations. The
14 patient went to the Royal. They were informed of the
15 hyponatraemia. When I reviewed the notes that were made
16 in the Children's Hospital, in the Royal, the only
17 reference that I could find -- and I stand corrected --
18 was a note written by Dr McLoughlin that she had
19 received a report from the Erne Hospital about the
20 repeat U&E. Nothing seems to have followed from that.
21 THE CHAIRMAN: You're absolutely right, nothing did follow
22 from it. The Royal doesn't come out, on the evidence
23 that I have heard to date, with any credit. But what
24 I'm looking for is to see what happened in the Erne.
25 And your evidence couldn't be clearer. Your evidence is

1 you and Dr O'Donohoe discussed this while Lucy was
2 being resuscitated. So at 4 o'clock in the morning you
3 and Dr O'Donohoe were discussing this.
4 A. It wasn't so much a discussion. I said, "Look, there's
5 the U&E result, it shows hyponatraemia, maybe she got
6 too much fluid, blah, blah". So --
7 THE CHAIRMAN: Sorry, bring that out. Don't say, "Maybe she
8 got too much fluid, blah, blah". Unless I misheard you,
9 I think you were going to say "blah blah", as if to say
10 "et cetera, et cetera". What is the "et cetera, et
11 cetera"?
12 A. I'm not with you.
13 THE CHAIRMAN: You said a few moments ago that it wasn't so
14 much a discussion, "I said, 'Look, there's U&E result,
15 it shows hyponatraemia. Maybe she got too much fluid'."
16 And what --
17 A. This was in the midst of an extremely chaotic
18 resuscitation scenario. This was not a head to head
19 over a table discussion. Things were extremely
20 difficult that morning.
21 THE CHAIRMAN: When did the head to head over the table
22 discussion take place?
23 A. It didn't.
24 THE CHAIRMAN: Okay. Mr Wolfe?
25 MR WOLFE: Can I start where you were with an answer just

1 a moment or two ago. You pointed out the fact that
2 while the anaesthetist, who we take to be you, reported
3 the repeat electrolytes to Dr McLoughlin in the Royal,
4 the Royal didn't appear to follow up on this. Now, by
5 that time, in the morning, doctor, you had worked out
6 that there were too much of the wrong type of fluid, you
7 had worked out the sequence of events. Now, as well as
8 telling the Royal to repeat electrolytes, why didn't
9 you give them that extra bit of information that the
10 wrong fluid regime had been applied?
11 A. Because I assumed, obviously wrongly in retrospect, that
12 that information would have been transmitted by the
13 transferring doctor, in this case Dr O'Donohoe.
14 Q. And he didn't do it so far as we --
15 A. And I believe there was a problem that, with no notes
16 going with the patient, et cetera, so really, I mean, my
17 job that night was to resuscitate Lucy, stabilise her
18 and get her transferred to Belfast.
19 THE CHAIRMAN: That's absolutely right and I don't have any
20 criticism of what you did that night. I just want to
21 make that clear, doctor, so there's no misunderstanding.
22 I'm not here to investigate how Lucy was resuscitated,
23 whether it might have been done differently, or with
24 a different result. That's not the point of this
25 segment of the inquiry. The point of this segment of

1 the inquiry is to find out what happened as Lucy was
2 dying and after she died because Mr and Mrs Ferguson in
3 Derry have a concern that if what had happened to Lucy
4 had been faced up to, it might have raised issues about
5 the use of Solution No. 18, about avoiding
6 hyponatraemia, and whether that might in turn have led
7 to Raychel being treated rather differently in June 2001
8 in Altnagelvin. It doesn't seem to me to be some huge
9 leap for them to make to say things might have been
10 different had Lucy been faced up to. And to be fair to
11 the doctors in the Erne, this might go back to Claire
12 and it might go back to Adam. Okay? So I'm not
13 singling out the Erne.
14 A. When this happened in 2000, I was not aware of the two
15 previous cases and any ...
16 THE CHAIRMAN: And the inquiry is looking at that and why
17 that didn't happen and whether more should have been
18 told, whether more should have been disclosed. That's
19 really what brings together the different deaths with
20 which the inquiry is concerned. It's a general Health
21 Service issue about learning lessons if mistakes are
22 made. Okay? I just want you to be quite clear about
23 potentially what it is that you're facing here. It's
24 not a criticism of the work that you did as an
25 anaesthetist being called in to try to save Lucy. It's

1 what followed after that or perhaps, more accurately,
2 what didn't follow after that. Let's take a break for
3 ten minutes and we'll come back.
4 (3.30 pm)
5 (A short break)
6 (3.40 pm)
7 MR WOLFE: Doctor, in terms of your decision to call the
8 Royal Belfast Hospital for Sick Children, it appears,
9 although you don't appear to remember that you gave the
10 hospital the electrolyte results, those results were
11 delivered to you by a nurse orally at the time you were
12 resuscitating Lucy.
13 A. Yes.
14 Q. And at that time you told us in your witness statement,
15 Dr O'Donohoe was present?
16 A. Yes.
17 Q. So is it fair to say he left the Erne to transfer Lucy,
18 knowing what the repeat electrolyte results were?
19 A. Yes.
20 Q. Can you help us then with this: why did you see the
21 need, do you think, to provide the electrolyte results
22 to the Royal if Dr O'Donohoe was going there?
23 A. Because I wasn't sure they would have had it, had the
24 results.
25 Q. You would agree with me that that was a key piece in the

1 jigsaw puzzle for the Royal to be told?
2 A. The reason might have been because when I rang, I think
3 they still weren't in receipt of any charts from the
4 Erne. And I may have said that just to clarify things,
5 but I mean I can't remember exactly why I gave them the
6 repeat results.
7 Q. Before Dr O'Donohoe left for the Royal, did you have any
8 discussion with him about what he was going to tell the
9 Royal in order to explain Lucy's condition?
10 A. No.
11 Q. Were you at all concerned that he wasn't going to pass
12 on the electrolyte information to the Royal?
13 A. I had no concerns on that front. I assumed that he
14 would.
15 Q. You assumed that he would?
16 A. I assumed that he would.
17 Q. If you made that assumption, then can you help us at all
18 in terms of why you delivered the information?
19 A. I can't remember why.
20 Q. In your witness statement, you have outlined a number of
21 discussions that you had with colleagues over the 24 and
22 48 hours following this incident.
23 A. Yes.
24 Q. Could I start with Dr O'Donohoe. In answer to some
25 questions from the chairman, you have said that you

1 didn't subsequently speak to Dr O'Donohoe about the
2 cause of Lucy's deterioration.
3 A. No.
4 Q. Is that correct?
5 A. Sorry, could you repeat the question?
6 Q. Let me put it in this way. You told the chairman that
7 as you were resuscitating Lucy, it was quite chaotic,
8 but you did have a discussion along the following lines.
9 You said to Dr O'Donohoe: look at her electrolyte
10 results, it appears that she may have had too much
11 fluid, and then you said what the chairman interpreted
12 as "et cetera, et cetera". Self-evidently that was
13 quite a chaotic time in the morning. You would have had
14 another opportunity to speak to Dr O'Donohoe when he
15 returned from the Royal Hospital, isn't that correct?
16 A. I didn't see him until -- I don't think I saw him until
17 the day after.
18 Q. Right. So I'll come to that in a moment. You're back
19 in the hospital after your breakfast. Did you give any
20 consideration to reporting what you'd just witnessed in
21 terms of Lucy and her deterioration and your concerns
22 about that? Did you give any consideration to reporting
23 all of that to the medical director?
24 A. Not at that stage.
25 Q. Why not?

1 A. Because she was still a patient in the Royal.
2 Q. Sorry, the child had left the Erne in a moribund state.
3 You thought her chances of recovery were bleak. And
4 your explanation for not informing the medical director
5 was that she was a patient in the Royal?
6 A. I mean, she was still being treated.
7 Q. Right.
8 A. No, I didn't speak with him.
9 Q. Did you make any attempts subsequently to contact the
10 medical director who, at that time, was Dr Kelly?
11 A. I don't recall doing so.
12 Q. So even after she ceased to be a patient in the Royal,
13 ceased being treated, you didn't think it appropriate to
14 contact Dr Kelly?
15 A. I didn't contact him.
16 Q. And your explanation for that?
17 A. I don't have one, really. Well, apart from the fact
18 that I would have expected that the review that was
19 instigated shortly after Lucy's death would have got to
20 the bottom of the problem.
21 Q. Dr O'Donohoe then. You saw him the next day?
22 A. The day after, yes. Sorry, it would have been the
23 Friday, the 14th.
24 Q. The day of Lucy's death?
25 A. Yes.

1 Q. And here was an opportunity to further discuss what had
2 gone wrong with Lucy the morning before; isn't that
3 right?
4 A. As far as I remember, it was purely a brief meeting
5 in the corridor. I don't think at that time actually
6 that Lucy had been declared dead. I can't be exactly
7 sure of the time that I spoke to him.
8 THE CHAIRMAN: Why does that matter? Let's suppose Lucy had
9 survived but was brain damaged or let's suppose she had
10 made a miraculous recovery. Why does that matter in
11 terms of discussing and reporting the treatment she had
12 received in the Erne?
13 A. It doesn't.
14 MR WOLFE: Could I have up on the screen, please, witness
15 statement 274/2 at page 2? You can see, doctor, at
16 question 2 that the preface to the question alludes to
17 an answer you've given in your previous witness
18 statement, where you call to mind certain informal
19 discussions with various people. In other words,
20 Dr O'Donohoe, Dr Anderson, as well as your anaesthetic
21 colleagues. Let me work through these various
22 questions. You identify for us the anaesthetic
23 colleagues, Doctors Cody and Holmes.
24 You're asked:
25 "State precisely what you discussed with

1 Dr O'Donohoe about Lucy's case in the day or two after
2 her treatment in the Erne Hospital."
3 And you say you discussed with Dr O'Donohoe the
4 transfer to the Royal and her condition on arrival
5 there. Do you see that?
6 A. Yes, that would have been what -- the sort of thing
7 I would have discussed with him, yes.
8 Q. So you discussed with him the fact that she had
9 travelled to the Royal, which was a given.
10 A. Yes.
11 Q. And her condition on arrival, which you knew from your
12 previous discussion with the Royal the morning before
13 was unchanged?
14 A. Mm-hm.
15 Q. Why did you not discuss with him the chaos of the night
16 before?
17 A. What do you mean by chaos?
18 Q. Well, doctor, I'll translate that for you. A child had
19 come into the hospital with gastroenteritis and was now
20 dead or close to being dead because, in your view, she
21 had received the wrong fluids. Now, why did you not
22 discuss that chaos with Dr O'Donohoe at that point and
23 try to get an explanation for it?
24 A. I don't know.
25 Q. Did you seek any reassurance from him that he was going

1 to address the issue with the medical director?
2 A. I don't recall that, no.
3 THE CHAIRMAN: Did you encourage him to?
4 A. I don't think so.
5 THE CHAIRMAN: Did you tell him that really he had no option
6 but to do that?
7 A. I don't remember, no. I don't think so.
8 THE CHAIRMAN: Do you believe that he had any option but to
9 do that?
10 A. With the benefit of hindsight, he should have done it,
11 yes.
12 THE CHAIRMAN: But even at the time.
13 A. Yes.
14 THE CHAIRMAN: And I know that there was an issue which
15 we are not investigating about what went wrong as
16 between -- or did something go wrong between
17 Dr O'Donohoe and the nurses about the fluid that Lucy
18 received? But however exactly it happened, he was the
19 paediatrician responsible for her care, wasn't he?
20 A. Yes.
21 THE CHAIRMAN: Which is why you thought it was not up to you
22 to speak to Mr and Mrs Crawford?
23 A. Yes.
24 THE CHAIRMAN: So a child under his care had been treated
25 with the result that she was now hyponatraemic and had

1 developed cerebral oedema.
2 A. Yes.
3 MR WOLFE: The next person in the list of persons you spoke
4 to is Dr Anderson.
5 A. Yes.
6 Q. And can you recall whether you sought Dr Anderson out?
7 A. We met in the corridor outside theatre in the Erne and
8 really in passing, and there was a problem, and, yes, he
9 said he was aware of it and --
10 Q. Sorry, I can't hear you.
11 A. I mentioned in passing. I mean, this was a brief
12 meeting in the corridor and, had you heard about what
13 happened, and that sort of thing. At the time he was
14 director of maternity and child health. Therefore,
15 I would have thought, well, he'll probably be setting up
16 some sort of inquiry or some sort of review and,
17 subsequently, I got the request to make a statement.
18 Q. Had he heard of the untoward event?
19 A. Yes.
20 Q. He was aware of it?
21 A. Yes.
22 Q. Did you bring the issue up with him then in passing?
23 A. No, he was aware of it.
24 Q. But who introduced the subject matter of Lucy's case
25 into the conversation?

1 A. I can't remember.
2 Q. And you have said here at answer (c) that you discussed
3 with him the sequence of events during resuscitation?
4 A. Yes.
5 Q. And transfer.
6 A. Yes.
7 Q. You weren't on the transfer.
8 A. Well, that's true.
9 Q. Yes.
10 A. Maybe that's badly written.
11 Q. Okay. Well, focusing on the sequence of events during
12 resuscitation, can you recall what you told him about
13 that?
14 A. Not exactly. I may have mentioned the sudden collapse,
15 the hyponatraemia and subsequent admission to ICU and
16 subsequent transfer to Belfast.
17 Q. Just to be fair to Dr Anderson, he has said in a witness
18 statement to the inquiry that the subject matter of
19 hyponatraemia had never been introduced into the whole
20 debate over the period of the review, so just to be --
21 A. Well, I can't understand that.
22 Q. Why do you not understand that?
23 A. Because hyponatraemia was mentioned in my report.
24 Q. The 127, the reference to 127?
25 A. Yes.

1 Q. Well, in terms -- just focusing on the answer you've
2 given here, when you talked to Dr Anderson about the
3 sequence of events around the time of resuscitation,
4 do you think you could have spoken to him about what it
5 was that caused a need for there to be resuscitation?
6 In other words, that the fluids had been mismanaged?
7 A. I can't remember exactly what I said.
8 Q. Well, is that not one of the more important things to
9 say?
10 A. This was a very brief, 30 second meeting in the
11 corridor.
12 Q. You then say that you had a discussion with anaesthetic
13 colleagues, Dr Cody and Dr Holmes.
14 THE CHAIRMAN: Just before we go to that, you say you can't
15 understand how Dr Anderson can say there was no
16 reference to hyponatraemia because the 127 is mentioned
17 in your statement.
18 A. Yes.
19 THE CHAIRMAN: Right. Now, I think you were here earlier on
20 today.
21 A. Yes.
22 THE CHAIRMAN: And you'll have heard evidence which the
23 inquiry has heard before from different people to say
24 that a reading of 127 means that a person is
25 hyponatraemic, but that is usually recoverable, and that

1 a doctor who was giving evidence this morning,
2 Dr O'Donoghue, says that he has treated children who
3 have a reading of 127 and they recover fine from it.
4 Okay?
5 A. Yes.
6 THE CHAIRMAN: And you have indicated earlier in your
7 evidence that you've treated other people, including
8 adults, with far lower readings than 127 and they also
9 recovered from it. It's a complication, but how you
10 manage it is the crucial thing.
11 A. Yes.
12 THE CHAIRMAN: So does that not mean that the reading of 127
13 in itself doesn't really tell the story about what went
14 wrong with Lucy? Because if often there are patients,
15 children or adults, who have readings of 127 and who
16 recover with appropriate medical treatment. Simply
17 putting a reference to 127 in the report will not truly
18 disclose what went wrong in Lucy's case; isn't that
19 right?
20 A. A sodium of 127 -- and it may have been lower than that
21 at the time of her seizure or whatever it was -- in
22 combination with a review of her fluid balance chart
23 would strongly suggest that the hyponatraemia was due to
24 too much fluids. I can't believe that those two -- the
25 fluid balance chart and the repeat electrolytes weren't,

1 how shall I say, seized upon during the review.
2 I cannot believe that I was the only person to have
3 strong suspicions.
4 THE CHAIRMAN: Again, let me reassure you, doctor, that
5 we will be probing more witnesses from the Erne to see
6 if what you've said is exactly right. But you are the
7 witness from the Erne who says in terms, "I knew pretty
8 much straightaway what had happened to Lucy".
9 A. Yes. I mean, I was not 100 per cent definite, but I had
10 strong suspicions that that was the sequence of events.
11 THE CHAIRMAN: Thank you.
12 A. And it should have been picked up by ... Without
13 seeming flippant, it's the elephant in the room. Why
14 did nobody else come to this conclusion?
15 THE CHAIRMAN: And you would say --
16 A. Why did the people in the Royal not come to this
17 conclusion? And whilst I can be severely criticised for
18 not informing the medical director and various other --
19 speaking to Lucy's parents, I feel that (a) as regards
20 speaking to Lucy's parents and discussing what
21 eventually turned out to be the cause of death, that
22 I felt it wasn't my responsibility and other people
23 should have been doing that. There was no deliberate
24 attempt on my part to conceal any facts. The fact that
25 I did not mention fluid balance and possible errors on

1 that in my report, I can't explain it, it's a bad
2 reflection on me. But as to pursue the whole thing with
3 the medical director, I feel I was -- I only dealt with
4 Lucy for three hours that morning, she was admitted
5 under another consultant, it should have been his
6 responsibility to make sure that all avenues of
7 investigation were done. And, with the benefit of
8 hindsight, I was somewhat surprised that I wasn't asked
9 to make further comments or submissions to the review
10 in the Erne.
11 THE CHAIRMAN: Thank you.
12 MR WOLFE: Just to put this in context because this started
13 out as a response to what I had said Dr Anderson had
14 reflected upon, just for your reference, sir, it's
15 WS291/1, page 19, and what Dr Auterson appears to be
16 expressing incredulity at is what I said Dr Anderson has
17 said, and that is:
18 "At the time of our review the word 'hyponatraemia'
19 had not yet been mentioned, nor was Solution No. 18
20 recognised as being a causative factor."
21 MR GREEN: Mr Chairman, forgive me for interrupting, before
22 we move away from this issue, a moment ago the doctor
23 said this:
24 "But as to pursue the whole thing with the medical
25 director, I feel I was -- I only dealt with Lucy for

1 three hours that morning, she was admitted under another
2 consultant, it should have been his responsibility to
3 make sure that all avenues of investigation were done,
4 and with the benefit of hindsight ..."
5 And so on. The position is that a few minutes ago
6 the doctor gave evidence to the effect that he thought
7 that the review was going to get to the bottom of the
8 problem as I think he put it.
9 THE CHAIRMAN: Yes.
10 MR GREEN: The review, of course, that was instituted was
11 self-evidently going to be based on evidence.
12 Dr Auterson must have known that and had relevant
13 evidence to give and, on his own version today, simply
14 did not give it. And I wonder if that could just be
15 explored with him a little more. If you think it has
16 already been sufficiently explored I'm content for my
17 learned friend to move on, but it's important, given
18 that Dr Auterson has passed the buck, as it were, back
19 to the medical director that he be tested a little
20 further, in my submission, on this point.
21 MR WOLFE: Sir, if I can say so, we're going to move to
22 Dr Auterson's submission to the review just now, just
23 after the next question.
24 MR GREEN: Thank you very much.
25 MR WOLFE: Just to finish this sequence of conversations,

1 Cody and Holmes, doctor. According to your answer in
2 your witness statement, if we go back to that, you say
3 you discussed with doctors Cody and Holmes the sequence
4 of events and possible causes of Lucy's condition. So
5 these two doctors are fellow consultant anaesthetists;
6 isn't that right?
7 A. Yes.
8 Q. And what did you discuss with them, if you can recall,
9 in terms of the sequence of events and possible causes?
10 A. I met Dr Cody shortly after 9 o'clock on the Wednesday
11 morning and, as we usually do if anything significant
12 happens during the on-call period at night, we would
13 talk amongst each other and discuss things in general.
14 Q. Was she the director of that department?
15 A. Sorry?
16 Q. Was she the director of that department, anaesthesia?
17 A. No. It's a he, actually. Dr Matt Cody. He was
18 a fellow -- he's a fellow anaesthetist, as is William
19 Holmes. So I just went through the 17-month old child
20 in, collapse, blah, called in, transferred,
21 resuscitated, she had a very low sodium, blah blah. And
22 he agreed with my suspicions that probably it was
23 a fluid-related problem.
24 Q. This was Dr Cody?
25 A. Cody.

1 Q. And Dr Holmes?
2 A. I spoke to him later.
3 THE CHAIRMAN: Sorry, can I just pause you for one moment?
4 You said that this was done on -- you met Dr Cody
5 shortly after 9 o'clock on the Wednesday morning. You
6 had been called in to see Lucy on the Thursday morning,
7 so is it the following Wednesday?
8 A. Sorry, I beg your pardon. I was called in on the
9 Wednesday night/Thursday morning. It was shortly after
10 I'd made contact with the Royal, when he came in to
11 start his day's work.
12 THE CHAIRMAN: Don't worry.
13 A. I met Dr Holmes, I can't remember whether it was later
14 that day or the following day, and as usual we discussed
15 various things, you know, and he seemed -- he did not
16 disagree with my presumptive diagnosis.
17 MR WOLFE: Did they make any suggestion to you in terms of
18 whether you should report it?
19 A. No.
20 Q. Did they suggest any form of action to you?
21 A. Not really, no, not that I can remember.
22 Q. Now, you are asked to submit a report for the purposes
23 of the review; isn't that right?
24 A. Yes.
25 Q. And you believe that you were asked to do that by either

1 Dr Kelly or Mr Fee?
2 A. Yes. I can't honestly remember which of them got in
3 contact with me.
4 Q. You say got in contact with you. Does that suggest that
5 they made verbal contact with you as opposed to sending
6 you a letter?
7 A. I think it was probably done over the phone.
8 Q. Because one of the concerns which the inquiry's expert
9 has about the process of the review is that while nurses
10 were written to and asked to focus on particular issues,
11 clinicians such as yourself don't appear to have been in
12 receipt of specific correspondence. It's your memory --
13 A. I don't recall any written correspondence. As far as
14 I can remember, it was a verbal request.
15 Q. And you have told us in your witness statement for the
16 inquiry that you were to provide a statement setting out
17 the facts surrounding your part in the incident.
18 A. Yes.
19 Q. And you provided the report that we saw up on the
20 screen, dated 20 April?
21 A. Yes.
22 Q. In making that report, you knew it was for the purposes
23 of an internal review?
24 A. Yes.
25 Q. And were you aware that the Trust had appointed

1 a Dr Murray Quinn, a consultant paediatrician in the
2 Altnagelvin Hospital, to provide advice with regards to
3 the notes associated with Lucy's care? Were you
4 informed of that?
5 A. I became -- I can't remember how I got informed, but
6 I became aware of it. This was probably weeks later.
7 Q. When you sat down to write your report and you touched
8 on this earlier in terms of not having the notes in
9 front of you, but when you sat down to write it, did you
10 see it as your obligation to provide as much information
11 as possible to the review in order to inform about the
12 cause of the deterioration of Lucy Crawford?
13 A. I was asked to provide a factual report of the events as
14 I recall them on that night.
15 Q. Yes.
16 A. And I believe I did that with the unfortunate omission
17 of the fluid question.
18 Q. Well, as you correctly described earlier, the elephant
19 in the room was the fluids; isn't that right?
20 A. Yes.
21 Q. And you left the elephant out of your report.
22 A. Yes.
23 Q. We don't need to go through the report line by line. If
24 we could perhaps have it up on the screen, please, by
25 reference to its first page. It's 033-102-316. It is

1 fair to say, doctor, that when you came to compiling
2 this report you were aware of the fluids that Lucy had
3 received pre-seizure and the fluids that she had
4 received post-seizure?
5 A. Yes.
6 Q. And they're not mentioned in your report?
7 A. No. I only mentioned intravenous fluids were being
8 administered.
9 Q. You would also have been aware of, albeit we add the
10 caveat that the notes are difficult to interpret, but
11 you had a knowledge of the volume that had been infused?
12 A. Yes.
13 THE CHAIRMAN: I think you had your interpretation of that?
14 A. It looked excessive.
15 THE CHAIRMAN: Yes.
16 MR WOLFE: On the second page of the report, if we go over
17 to 317, you outline the results of the repeat
18 electrolytes.
19 A. Mm-hm.
20 Q. And beside that you pose the question or the query:
21 "When sample taken?"
22 A. Yes.
23 Q. Can I ask you a few questions around that.
24 THE CHAIRMAN: First of all, is that your writing, "When
25 sample taken?"

1 A. On this?
2 THE CHAIRMAN: Yes.
3 A. Yes. That's my writing.
4 THE CHAIRMAN: And that was written in at the time of your
5 statement?
6 A. Yes, it was all contemporaneous, yes.
7 MR WOLFE: What is the significance of that query, why were
8 you raising it?
9 A. Because for further management, I would have needed to
10 have known her U&E result as close to the event as
11 possible. And as it turned out, I later discovered that
12 the sample had been taken, I think by Dr O'Donohoe, or
13 his SHO, shortly after the time of the fit, which would
14 have been about half an hour before I arrived on the
15 scene.
16 Q. And after a quantity of normal saline had been run in?
17 A. Yes. As regards the normal saline, I cannot be sure
18 about this, but I don't think the normal saline was on
19 the fluid balance chart when I arrived.
20 THE CHAIRMAN: So although we have a fluid balance chart in
21 which it is entered, you're not sure if that was on --
22 that had been written on yet?
23 A. Because the fact that she'd had an extra half litre of
24 saline only became -- well, I only picked this up a very
25 short time ago when I was going through the documents.

1 THE CHAIRMAN: So does that mean that when you identified
2 what was wrong with the fluids, you believed that
3 what was wrong was the 400 ml of Solution No. 18?
4 A. Yes.
5 THE CHAIRMAN: And only recently, going through the --
6 A. It may have been there, but I ... Was that fact written
7 contemporaneously?
8 THE CHAIRMAN: Right.
9 MR WOLFE: I think you have told us earlier this afternoon
10 that when you arrived, you observed that most of the
11 normal saline had been run in.
12 A. Yes. I don't think it was written in the fluid balance
13 chart.
14 Q. No, no, that's not my point.
15 A. There was saline running, yes.
16 Q. You would have acknowledged from your observation,
17 however brief, of the fluid balance chart that
18 Solution No. 18 was the initial fluid and then when you
19 arrived, you obviously saw the bag of normal saline
20 erected.
21 A. Mm-hm.
22 Q. And mostly run in. Taking up the point that Mr Green
23 has intervened with, this was a process of investigation
24 or review of Lucy's care and, on behalf of Dr Kelly,
25 Mr Green makes the point that you know that this was an

1 investigation but you're passing the buck to Dr Kelly to
2 try and get to the bottom of this without actually
3 giving him all of the relevant information that you were
4 aware of that could have assisted with that process of
5 review?
6 A. I don't like the term "passing the buck".
7 THE CHAIRMAN: If I understand your evidence correctly,
8 you have effectively accepted that the failure of your
9 statement to refer to the fluid regime is something for
10 which you can be legitimately criticised.
11 A. Yes.
12 THE CHAIRMAN: If that is unfair, please tell me. I think
13 you said that a few minutes ago. You said, "The fact
14 that I didn't mention the fluid balance and possible
15 errors in my report, I can't explain. That's a bad
16 reflection on me ".
17 A. Mm-hm.
18 THE CHAIRMAN: Right. And I've taken that as a concession
19 which I have to say strikes me as being entirely
20 appropriate, doctor, that while you were being asked for
21 a report on your involvement, if you were alert to
22 a problem which you were having to deal with, that
23 that is a problem which should have been included in
24 your report.
25 A. Yes.

1 THE CHAIRMAN: Is that fair?
2 A. Mm.
3 THE CHAIRMAN: Thank you.
4 MR WOLFE: Just to be clear, doctor, then what you're saying
5 is that you should have fully exposed the elephant
6 in the room by commenting upon the inappropriateness of
7 the fluid regime when describing its effect in causative
8 terms on the cerebral oedema?
9 A. Yes.
10 Q. And you've said in explanation for the failure to do
11 that in your witness statement to us, you have said:
12 "I did not mention this [that is the fact that wrong
13 fluids had gone in] as I regarded it as an obvious
14 conclusion."
15 So while you're saying that you can be properly
16 criticised for not spelling it out in your report, you
17 think it was sufficiently obvious that others should
18 have picked up on it?
19 A. Yes.
20 Q. And when you're asked in your witness statement about
21 the people this should have been obvious to, and the
22 reference is 274/2, page 3, that's the witness statement
23 reference, you say:
24 "It should have been obvious to Dr Malik and
25 Dr O'Donohoe."

1 That is at page 3 of your second witness statement,
2 doctor, in answer to question 3.
3 A. Yes.
4 Q. Who else do you think this should have been obvious to,
5 if anybody?
6 A. Anyone else performing the review.
7 THE CHAIRMAN: Can I just make it clear? Do I take it from
8 what you have said that Dr O'Donohoe did actually
9 recognise the problem? Because you had spoken to him
10 about it during resuscitation.
11 A. It almost certainly was discussed. Whether he said,
12 "Yes", I can't remember. But I'm nearly sure he was
13 aware of my suspicions.
14 THE CHAIRMAN: And in fact, you can go further, that you'd
15 be worried if he didn't spot the problem? You'd be
16 worried if a consultant paediatrician didn't spot
17 what was likely to have gone wrong?
18 A. Yes.
19 MR WOLFE: You have read the report of Dr MacFaul?
20 Dr MacFaul is the expert retained by the inquiry to look
21 at the clinical governance aspects of this case. If
22 I could have up on the screen 250-003-045. If you could
23 highlight the top paragraph, I'd be grateful. It goes
24 over two pages, but the relevant part I wish to address
25 is on this page, doctor.

1 In his report, Dr MacFaul analyses your input into
2 the review and he says:
3 "In my opinion, Dr Auterson should have reported his
4 concerns about the fluid regime to Dr Kelly at the time
5 and arguably to the review."
6 That's a criticism I think you now accept?
7 A. Yes. I have never seen this document before.
8 Q. Okay. Well, this is the expert report -- report of the
9 expert retained by the inquiry to examine all of the
10 steps that were taken in the context of the
11 investigation of Lucy's care. So it may well be that if
12 we could have up on the screen for the doctor side by
13 side with this page the preceding page, please. Over
14 the course of --
15 THE CHAIRMAN: I'm not sure in light of what Dr Auterson has
16 said whether this criticism is now controversial,
17 Mr Simpson.
18 MR SIMPSON: Not in the light of what he's said.
19 A. I have had dozens of e-mails containing dozens of
20 documents and I have done my best to read them all.
21 I have never seen this.
22 MR SIMPSON: Effectively, what Dr Auterson has said is
23 what's stated there.
24 THE CHAIRMAN: The point I'm making is if he was resisting
25 the criticism that Dr MacFaul had made, I'd have to give

1 him a few moments to read the document, but I don't
2 think, as his evidence has emerged this afternoon, that
3 he is resisting the criticism.
4 MR SIMPSON: I don't see that to be the case.
5 THE CHAIRMAN: Doctor, this is a very, very long report by
6 an inquiry expert called MacFaul. In this segment of
7 it, which is -- there's a reference to you, which is why
8 Mr Wolfe is taking you to it. I'm sorry that
9 you haven't seen this document before, but in light of
10 the concessions which you have made this afternoon
11 I don't think I need to stop to allow you time to
12 consider it because in effect you have conceded the
13 point which Dr MacFaul has made against you. On the
14 screen at the moment, on the right-hand side, in the
15 second line:
16 "In my opinion Dr Auterson should have reported his
17 concerns about the fluid regime to Dr Kelly at the time
18 and arguably to the review."
19 And before the break, we went through that sequence
20 and I think you made concessions which go to the heart
21 of that criticism. So rather than delay the completion
22 of your evidence this afternoon, what I would intend to
23 do is to allow your oral evidence to finish and, if
24 you have anything contrary to what Dr MacFaul has said
25 that you want to put before the inquiry, I will allow

1 you to do it in writing, or if needs be, orally at
2 a later point. Is that okay?
3 A. The paragraph at the top of the right-hand page possibly
4 summarises what I've already said.
5 THE CHAIRMAN: It does.
6 A. I can't contest that.
7 THE CHAIRMAN: Thank you very much. In fact, in fairness to
8 you, he goes on at line 4 in terms to say you wouldn't
9 have been on your own because he says:
10 "The extent to which colleagues reported what they
11 judged to be substandard care provided by colleagues
12 at the time was variable."
13 So it's that embarrassment of reporting somebody who
14 you work with even though there's an obligation to do
15 it. It should be done but it's easier to do in the
16 abstract than it is in reality.
17 MR WOLFE: If there's another layer of fairness to be drawn
18 attention to, it's the comment on that paragraph,
19 doctor. If you can see it, it's the last three lines.
20 It's a criticism of the review process, which of course
21 will be explored with the coordinators of the review
22 when they give evidence. What is said is:
23 "If the review process had taken the step of
24 reconciling the deficiencies of information provided
25 and, in particular, had interviewed Dr Auterson or

1 requested specific responses, the issue would have come
2 to light much earlier."
3 I think that's a point you have already made in your
4 evidence.
5 A. Once I submitted my written report, I heard nothing.
6 THE CHAIRMAN: You didn't think that would be the end of it
7 if I understand you correctly?
8 A. Well, I thought they would have come to the obvious
9 conclusion that I -- the strong suspicion that I had.
10 THE CHAIRMAN: Thank you.
11 MR WOLFE: You can see in that paragraph, doctor, that
12 Dr MacFaul has referred to the Good Medical Practice,
13 which was a guideline published by the GMC in 1998. He
14 draws attention to paragraphs 23 and 24 of that code and
15 I want to look at those in addition to some other
16 paragraphs in the code, just to have your comment in
17 fairness to you.
18 If we can go to 315-002-009 and just run through
19 these with you. At paragraph 18, it says, under the
20 general heading "If things go wrong":
21 "If a patient under 16 has died you must explain, to
22 the best of your knowledge, the reasons for, and the
23 circumstances of, the death to those with parental
24 responsibility."
25 I think in your earlier answers, when this has been

1 put, this point has been put to you, in broad terms you
2 say you don't feel that responsibility belonged to you.
3 A. No.
4 Q. Why didn't it belong to you?
5 A. Because Lucy wasn't my patient. She had been looked
6 after by Dr O'Donohoe and his staff from admission.
7 I was merely called in once the acute episode happened,
8 did what I had to do, arranged transfer, and as far as
9 I was concerned at the time she was his patient and
10 therefore it was up to him to speak with the parents and
11 explain any -- answer any queries they may have had.
12 Q. You didn't take any steps to ensure that that was done
13 by him?
14 A. Unfortunately not. How shall I say this? In my
15 defence, if that's the right word, this situation had
16 never occurred to me before. I had never been in this
17 position before. Therefore, had I had a similar problem
18 before, I might have learned something and dealt with
19 this case differently. But this was a, in my view,
20 a one-off event. I was unaware of the previous two
21 cases that had caused some difficulties. I did not
22 deliberately try to evade any -- anything. And that's
23 it.
24 Q. If we could skip over the page to the two paragraphs
25 that Dr MacFaul specifically cites, paragraph 23 and 24:

1 "You must protect patients when you believe that
2 a doctor's or other colleague's health, conduct or
3 performance is a threat to them."
4 Now, the chairman suggested to you earlier that you
5 were party to a situation whereby you knew that
6 a colleague and his application of his practice to Lucy
7 had caused a situation whereby Lucy's health was
8 endangered, in other words the fluid management of Lucy
9 had caused the cerebral oedema and you didn't expressly
10 reveal that to anyone at any time.
11 A. Dr O'Donohoe was not the only person involved in the
12 administration of fluids to Lucy.
13 Q. That's right. Dr Malik --
14 A. And the nursing staff, et cetera. I do not feel that it
15 was solely his conduct or performance.
16 Q. Whatever --
17 A. Caused, you know --
18 Q. Whatever doctor was implicated in performance issues
19 that were a threat to this particular patient, is it not
20 all the more reason that you should identify them all,
21 so far as you can, and bring it to, for example, the
22 medical director's attention, whether it's nursing or
23 medical staff?
24 A. I repeat again, I believed that was the duty of the
25 review to identify who was responsible or liable for the

1 maladministration of the fluids.
2 Q. Paragraph 24, which Dr MacFaul refers to:
3 "Before taking action, you should do your best to
4 find out the facts."
5 Of course, you were aware of the facts, and yet you
6 didn't take action.
7 A. I wasn't aware of all of the facts.
8 THE CHAIRMAN: Well, you were aware of sufficient facts to
9 have a strong suspicion, which turned into a confirmed
10 belief as the week went on without reference to any
11 additional material. And if you didn't have all the
12 facts, it was because you didn't make any enquiries to
13 find out any more facts because you didn't ask to see
14 the records. Isn't that right?
15 A. Yes.
16 THE CHAIRMAN: Okay.
17 MR WOLFE: Moving on, doctor, it is the case that you didn't
18 see the review report; isn't that right?
19 A. That's right.
20 Q. The review report, so far as this inquiry is aware,
21 wasn't shown to anybody who was involved in Lucy's care,
22 though it may have been discussed with Dr O'Donohoe.
23 Can I draw your attention and ask for your comments on
24 Dr Quinn's input to the review. If we could have up on
25 the screen, please, 033-102-271. At the bottom of the

1 page under the heading "Fluids", he reaches the
2 following conclusions:
3 "She was treated with Solution No. 18, which would
4 be appropriate."
5 A. Yes.
6 Q. Now, do you see that? If that report had been shown to
7 you, how would you have responded to that sentence?
8 A. I would have not agreed with it.
9 Q. Then he goes on to describe the fluids given over
10 a seven hour period. One of the issues the inquiry will
11 explore with him is the fact that the intravenous fluids
12 were expressed or infused over a four hour period before
13 the seizure.
14 A. Mm-hm.
15 Q. He goes on to say over the page:
16 "Calculating the amounts over that period of time,
17 this would be 80 ml per hour."
18 And he goes on to say:
19 "I have calculated the rates of fluid requirements.
20 If she was not dehydrated, she would have required 45 ml
21 per hour. If she was 5 per cent dehydrated, it would
22 have worked out at 60. 10 per cent, 80. I would
23 therefore be surprised if those volumes of fluids could
24 have produced gross cerebral oedema causing coning."
25 Then he goes on to note the absence of a written

1 prescription?
2 A. Mm-hm.
3 Q. So we're saying that the type of fluid, Solution No. 18,
4 was appropriate and the rate or the total volume
5 expressed over a period of seven hours would be
6 appropriate? If that report had been shown to you
7 at the time, how would you have commented?
8 A. As far as I can remember, the fluids were given over
9 five hours and I would not be in agreement with that
10 statement.
11 Q. And why would you not be in agreement?
12 A. Because those volumes of fluid did produce gross
13 cerebral oedema.
14 THE CHAIRMAN: Because once you get the number of hours over
15 which the fluids have been given wrong, then the maths
16 become unreliable.
17 A. Yes.
18 MR WOLFE: It transpired, doctor, that nobody associated
19 with Sperrin Lakeland Trust, nobody in the
20 Erne Hospital, reported this death to the coroner.
21 A. Yes.
22 Q. And the coroner has made observations in relation to
23 that in a police statement, which he made in 2005. If
24 I could have up on the screen, please, 115-034-003. If
25 we could highlight the top portion, please. He refers

1 to the fact that, in the left-hand side about seven
2 lines down:
3 "Dr Hanrahan did report the death promptly to my
4 office and did consult with the assistant state
5 pathologist."
6 He goes on to say, referring to the legislation,
7 section 7 of the Coroners Act:
8 "There is an onus on every medical practitioner to
9 make a report if they have reason to believe that the
10 patient died in one of the circumstances caught by the
11 act."
12 And what he says is that he takes the view that the
13 duty to report did not stop with Dr Hanrahan, it
14 extended also to the pathologist, Dr O'Hara, and also
15 applied to the doctors concerned with the care and
16 treatment of Lucy in the Erne.
17 Now, did you, doctor, give any consideration to
18 reporting Lucy's death when you heard about it to
19 the coroner?
20 A. No.
21 Q. Was there any conversation among colleagues in the Erne
22 about the need to report the death to the coroner?
23 A. Not that I can remember.
24 Q. Why didn't you think of reporting it?
25 A. Because I didn't think it was my responsibility.

1 THE CHAIRMAN: Can I ask you, do you agree -- sorry, what is
2 your view on whether Lucy's death should have been
3 reported to the coroner?
4 A. It should have been reported to the coroner.
5 THE CHAIRMAN: Okay.
6 A. I believe when she died in the Royal that the staff
7 there requested or queried a coroner's --
8 THE CHAIRMAN: When did you find that out?
9 A. Oh, much, much later.
10 THE CHAIRMAN: Okay. So in 2000, in April 2000, taking the
11 view that Lucy's death was reportable, why is her death
12 not reportable within the hospital where the inadequate
13 treatment was given to her? Or is it in fact reportable
14 from the Erne?
15 A. It's usually reported from the place where the patient
16 dies.
17 THE CHAIRMAN: If the patient dies in the Royal because of
18 inadequate medical treatment received in another
19 hospital, do you agree that there's an onus within the
20 initial hospital to report to the coroner?
21 A. Probably, yes.
22 THE CHAIRMAN: And applying that to Lucy's case, within the
23 Erne who is responsible for reporting?
24 A. The consultant in charge of the case.
25 THE CHAIRMAN: Okay. What about any other doctor, what

1 about a situation where that consultant doesn't report
2 the death but another doctor believes on reasonable
3 grounds that the death is attributable to fault within
4 the hospital?
5 A. I suppose ... Um ...
6 THE CHAIRMAN: What the legislation says is that every
7 medical practitioner who has reason to believe that
8 a person died as a result of negligence or misconduct or
9 malpractice on the part of others shall immediately
10 notify the coroner. And I think we can take it that the
11 legislation is in those terms in order to avoid
12 a situation where the negligent doctor doesn't report,
13 it imposes a duty on other doctors to report. It's
14 really unarguable, isn't it?
15 A. I mean, I didn't do it, I ...
16 THE CHAIRMAN: Thank you.
17 MR WOLFE: Doctor, you gave evidence to the coroner in 2004.
18 A. Yes.
19 Q. At the time of Lucy's inquest.
20 A. Yes.
21 Q. And let me just ask you some questions about that. Up
22 until that time you had not made any public expression
23 of your view that Lucy had received too much of the
24 wrong type of fluid.
25 A. Yes.

1 Q. Now, you knew that the Sperrin Lakeland Trust had
2 carried out a review in 2000.
3 A. Yes.
4 Q. And you had made an assumption that they would get to
5 the bottom of it?
6 A. Yes.
7 Q. And expose what you knew to be correct, that is that
8 Lucy had her fluids mismanaged. Now, when was the first
9 time that you realised that the Trust had not exposed
10 what you knew to be true, hadn't got to the bottom of
11 it?
12 A. I can't really remember. I suppose when I got all the
13 documents prior to my appearance at the inquest.
14 Q. So you received a package of documents to help you
15 prepare for the inquest?
16 A. Yes.
17 Q. Did that include the report of the review into Lucy's
18 case carried out by the Trust, which would have included
19 Dr Quinn's report?
20 A. I got a copy of Dr Quinn's report. I'm not sure whether
21 I got a copy of the review.
22 Q. I emphasise that I'm not asking you, doctor, about
23 conversations that you might have had with lawyers,
24 which would be privileged conversations.
25 A. Mm-hm.

1 Q. But in preparing for the review when you discovered that
2 the correct way of things had not been established in
3 2000, did you express your view to, for example, the
4 medical director?
5 A. No.
6 Q. Did you discuss your view with anybody in the Sperrin
7 Lakeland Trust?
8 A. Sorry, I -- there was a report.
9 Q. Can I help you with a document?
10 A. No, no, it's ...
11 Q. There was a report prepared by Dr Jenkins on behalf of
12 the Trust. Is that what you're looking for?
13 A. Yes. There is a list of appendices in here, one of
14 which has Dr Auterson's report, which presumably is the
15 one I gave on 20 April.
16 MR COUNSELL: 033-102-269, I think may be the list of
17 appendices.
18 THE CHAIRMAN: Is that it?
19 A. Yes.
20 THE CHAIRMAN: Thank you, Mr Counsell.
21 MR WOLFE: Can I help you with what you might be searching
22 for, doctor? This is what you received; is that what
23 you're telling us?
24 A. Yes. I'm not so sure about Dr Jenkins.
25 Q. But you received these documents?

1 A. Yes.
2 Q. And from those documents, you're able to see that
3 Dr Quinn was saying that there was an appropriate fluid
4 regime and that he would be surprised if it had caused
5 the cerebral oedema?
6 A. Yes.
7 Q. And you clearly had not been shaken from your view that
8 the fluid regime and fluid mismanagement had caused the
9 cerebral oedema?
10 A. No.
11 Q. And in that jarring of positions, did you speak to
12 anybody in authority at the Sperrin Lakeland about your
13 contrary view?
14 A. Not that I can remember.
15 Q. Could I put one final point to you, doctor, and it's
16 this, and it's a view expressed by Mr Green. He wishes
17 this position to be put on behalf of Dr Kelly. Your
18 position on the issue of fluid management has evolved,
19 Dr Kelly would suggest. In other words, going back to
20 the very beginning in 2000, you submitted a report that
21 didn't draw any attention, he would say, to the fluid
22 mismanagement, and you've now reached a position with
23 the inquiry of being express and specific that the fluid
24 regime caused this deterioration and death. How can you
25 account for that? Well, first of all, is the premise

1 correct?
2 THE CHAIRMAN: Sorry, to be fair to Dr Auterson, that
3 position was reached before this inquiry, I think. That
4 position is expressed in his evidence to the coroner, is
5 it not?
6 A. Yes.
7 MR WOLFE: Your evidence to the coroner, if we can briefly
8 look at it, if we call up the helpfully typed version,
9 013-025-094. Hopefully you can take my word for it,
10 doctor, that initially you prepare a deposition for
11 the coroner, which, in this instance, was simply
12 a repetition of the report that you had submitted to the
13 review. Do you remember that?
14 A. Yes. They're exactly the same.
15 Q. It's practically word for word the same. In that
16 deposition you didn't draw attention to, flexion, the
17 assertion that you made when giving evidence that there
18 was too much of the wrong type of fluid. So as we can
19 see, it's only when you gave evidence before the coroner
20 in this typed up sequence of responses to either
21 the coroner's questions or counsel's questions that you
22 draw attention to your view that the wrong fluid was
23 given. Do you see there alongside Mr Fee's name:
24 "The wrong fluid was given, too much of it was
25 given, and the rate of infusion should have been

1 regulated. Lucy's care was not up to standard."
2 So the point that is being made on behalf of
3 Dr Kelly, if I could ask you to address it, doctor, is
4 this: it is only when it comes to the coroner's inquest
5 that you say something like that and in fact you don't
6 even go on there to say, "And it caused the
7 hyponatraemia that caused the cerebral oedema". Can you
8 comment on that? Has your evidence evolved over the
9 years?
10 A. Sorry, what are you referring to in that last sentence?
11 THE CHAIRMAN: You see beside the name of Mr Fee, the notes
12 beside Mr Fee's name, that is Mr Fee, a barrister.
13 A. Yes, I remember.
14 THE CHAIRMAN: The notes beside his name are the answers you
15 gave to his questions. What you're noted by the coroner
16 as having said is that the wrong fluid was given, too
17 much was given, and the rate of infusion should have
18 been regulated. On behalf of Dr Kelly of the trust two
19 points are made. The first point is that that is the
20 first occasion on which you express those views. The
21 second point which I think is being made is even at that
22 point you did not attribute Lucy's cerebral oedema to
23 this fluid regime.
24 MR SIMPSON: I wonder if I could interrupt your question,
25 sir? You will know, as we all do, that this is arising

1 out of a series of questions. For example, immediately
2 above that is the questions to the coroner where in the
3 last sentence of the bit above Mr Fee's name it says:
4 "I agree that in Lucy's case too much of the wrong
5 fluid was given."
6 That's clearly an answer to the coroner saying,
7 "Do you agree that?" and the answer, "I do, yes", and
8 then Mr Fee cross-examines. With respect, he's
9 answering questions at that stage. Those questions
10 didn't go on, clearly, to say anything about the
11 cerebral oedema. It would be wrong, in my respectful
12 submission, to criticise him for not volunteering that
13 information when he's answering questions.
14 THE CHAIRMAN: Thank you. Let's stick to the first point
15 that's being made then. Dr Kelly, I think, is going to
16 give evidence and he will say you didn't tell anyone
17 within the Erne before you came to give evidence at the
18 inquest that you believed that Lucy got too much of the
19 wrong fluid at a rate which was excessive. Now, is that
20 factually right, that you had not expressed that view to
21 anybody in the Erne?
22 A. I can't remember.
23 THE CHAIRMAN: We know that you hadn't given that as part of
24 your written report and you've already conceded that
25 that's an omission, a failing on your part not to have

1 done so. And as I understand it, you're not suggesting
2 that apart from the written report you had said to
3 anybody, any of your colleagues or any of the trust
4 management that the problem here was that Lucy got too
5 much of the wrong fluid at an excessive rate. Is that
6 fair?
7 A. I mean, these answers were in response to questions
8 about the cerebral oedema.
9 THE CHAIRMAN: Yes, let me put it more bluntly. In essence,
10 some of your colleagues, past or present, in the Sperrin
11 Lakeland Trust are going to say it's all very well and
12 good for you to go and say that to the inquest. Why
13 didn't you tell us in 2000?
14 A. Because, rightly or wrongly, I assumed that other people
15 would have come to the same conclusion as I did.
16 THE CHAIRMAN: Is that your point, Mr Counsell? Sorry,
17 Mr Green's point. He's gone.
18 A. As I said before, I find it very hard to believe that
19 I was the only person to have come to the same
20 conclusion based on the evidence that I had.
21 THE CHAIRMAN: Well, if it's of any consolation to you,
22 having heard Dr Chisakuta and Dr Stewart, they say there
23 was a consensus, a fairly early consensus in the Royal
24 that this is what had gone wrong too. We will certainly
25 explore in the coming days, doctor, the proposition that

1 what was apparent to you was not apparent to others.
2 MR WOLFE: Just finally, doctor, you have provided us with
3 an explanation along the lines that this was so obvious
4 that others should have recognised it and you've
5 identified those others for us. But was there an
6 element of professional embarrassment on your part?
7 A. Embarrassment?
8 Q. In the sense that you could have blown the whistle and
9 spoken directly to, for example, the medical director
10 and told him exactly what the score was here, to use
11 a euphemism? You could have spelt this out? Did you
12 fail to do because you didn't want to blow the whistle
13 on a colleague?
14 A. No, that didn't come into it at all.
15 Q. Is that not part of it?
16 A. No.
17 Q. Is the explanation less benign then? Is the explanation
18 that you didn't want to see this information see the
19 light of day?
20 A. Absolutely not.
21 Q. It would have been --
22 A. Why would I want to conceal it?
23 Q. It would have been very easy to reveal it.
24 A. And that is a failing on my part that I can't defend.
25 MR WOLFE: Very well.

1 THE CHAIRMAN: Mr Quinn, anything for the doctor? Anything
2 for the doctor? Mr Simpson?
3 Doctor, thank you very much. I hope that you
4 understand that the concessions that you have made are
5 welcome and to a degree they chime with some of the
6 earlier evidence I heard this week. And we'll be
7 picking up the issues which you have emphasised this
8 afternoon with witnesses who are still to come. Unless
9 there's anything you want to say, you're now free to
10 leave the inquiry.
11 A. As I've already said, I was only partly involved with
12 the treatment of Lucy. I had no previous experience of
13 such an event and, had I had, I may have approached
14 things differently with regard to the review and
15 reporting matters. I cannot offer any defence as to why
16 I didn't. There was no deliberate omission on my part.
17 But again, Lucy was not my patient. I did what I could
18 for her. Unfortunately, she died, but the subsequent
19 management of conveying information to her parents
20 I believe was the sole responsibility of the
21 paediatrician in charge of her case. It was tragic. In
22 fact, it was the second time I saw Lucy. The first time
23 I saw Lucy was on the day she was born because
24 I anaesthetised her mother for a Caesarean section and
25 it's particularly tragic that I should see her again on

1 the day that she basically died. I did my best for her.
2 The subsequent events, I can only apologise for.
3 I think that's all I can say at the moment.
4 THE CHAIRMAN: My concern, doctor, if it's of any
5 reassurance is I entirely accept that you did all that
6 you could for Lucy. I'm afraid it's the aftermath and
7 whether more could have been done for her parents and
8 for parents of other children. That's the real problem.
9 A. In my defence of that, I'll say there were many other
10 people who should have picked up on things.
11 THE CHAIRMAN: It may very well be that you're right and
12 that's the evidence I'm hearing at the moment.
13 Thank you very much for your time. Ladies and
14 gentlemen, 10 o'clock on Tuesday morning.
15 (5.07 pm)
16 (The hearing adjourned until 10.00 am on Tuesday 4 June)
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