Thursday, 30 May 2013

(10.00 am)

THE CHAIRMAN: Before we start, ladies and gentlemen, I see Dr McKaigue here and he was due to be followed today by Dr Gannon's evidence. Dr Gannon's evidence has to be postponed. We received a further witness statement from Dr Gannon after 5 o'clock last night, in which she takes serious issue with Mr Lucas of the inquiry. We haven't had an opportunity to speak to Professor Lucas, and what we've arranged, this morning, Mr McAlinden, is that Dr Gannon and Professor Lucas give evidence together on Monday 1 July.

MR McALINDEN: Yes.

THE CHAIRMAN: That gets us around that hiccup. I don't think Professor Lucas will have taken a full day and it seems to make sense for him and Dr Gannon to give evidence together. That means that today, in a few moments, we'll hear from Dr McKaigue, but before we do that, I want to say something.

I heard evidence yesterday, quite specific evidence yesterday, that it was recognised in the Children's Hospital on Thursday 13 April 2000 that there were identified issues about the treatment which Lucy was given in the Erne on Wednesday 12th and Thursday 13th April. That evidence came from Dr Chisakuta, who



was one of a number of paediatric anaesthetists involved in Lucy's care, and from Dr Caroline Stewart, who was working as a registrar to Dr Hanrahan.

Despite what they identified as recognition in the Royal of problems which had been caused in the Erne, the Crawford family appears not to have been told of those problems and there appears, on the evidence as it stands after yesterday, to have been no learning at all in the Royal. Even less is there any evidence of an exchange between the Royal and the Erne which would have helped the Erne learn from what had happened. I don't want to go further into the evidence than that, but I also have to say that yesterday's evidence is capable of a much harsher analysis than what I have just said.

I recognise that the evidence may change and that the picture which was painted yesterday may alter, but I encourage the Belfast Trust, the Western Trust and the individuals who have still to give evidence to consider and, if necessary, reconsider their evidence. We already know from previous sessions in this inquiry that people and organisations paint themselves into corners on occasions. For instance, Dr Taylor did that in Adam's case, and I believe from having heard his evidence that he regrets that almost as much as Adam's mother regrets it.



It is worthwhile for the trusts and the individuals who are to give evidence to consider if they need to reassess their positions and if they do so then it would be helpful to me and to the inquiry generally if they said so at the start of their evidence. In other words, if they identify at the start of their evidence any departure which they intend to make from their written statements.

Yesterday, Mr McAlinden, I have to say was not a good day for the Trust.

MR McALINDEN: I take on board the comments, Mr Chairman.

THE CHAIRMAN: So I'm ready to hear Dr McKaigue now.

Let me emphasise, doctor, what I have just said is not in any way aimed at you as opposed to any of the other individuals who are about to give evidence, but I can't let yesterday's evidence pass without remarking on the evidence, the very stark and clear evidence, which was given by the two doctors yesterday.

Are you content for me to move straight into Dr McKaigue's evidence?

MR McALINDEN: Yes, thank you.

THE CHAIRMAN: Doctor, would you come forward, please?

DR JAMES MCKAIGUE (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, doctor. Do you have there



by you your CV?

A. Yes.

Q. Thank you very much. Doctor, you've made a number of statements, not just in relation to this part of the inquiry to Lucy's case, but also in relation to the previous cases of Adam and Claire. You've given evidence in Claire's case; I don't believe you gave evidence in Adam's case.

A. No.

Q. But in any event, I'm going to ask you if, when I recite what those statements are, if you wish to adopt them as your evidence, subject to anything that you may say now when you give your oral evidence.

So if I tell you what they are. You had a PSNI statement dated 16 March 2005. That was in relation to this case, Lucy's case, and the reference for that is 115-027-001. Then you had your witness statement in the Adam case, that's witness statement 129/1. You had a statement in the Claire governance part, and we don't need to go into that because you gave your evidence and you adopted that statement in the course of that.

But in the Lucy section that we're going to deal with now, you've provided three statements. Each has a series of 302: the first is dated 21 November 2012, then 23 January 2013, and then 26 April 2013; do you

adopt all those as your evidence?
A. I do.
Q. Thank you. If I confine it in relation to the Lucy aspect of it, have you discussed with your colleagues or anyone else for that matter, apart from your legal representatives, the evidence that is in those witness statements in relation to Lucy?
A. I have discussed it with my wife.
Q. I understand. I meant more in trying to sort of recollect and formulate your thoughts on some of the questions that we asked you.
A. No, if you're saying, "Have I discussed it with my colleagues?", no.
Q. Yes. I put the same question to Dr Chisakuta. Is that a policy that's been adopted or that's just how it happened when you made your statements?
A. Well, it's the realisation that this is evidence. It's my evidence.
Q. I'm very grateful, thank you.
Then if we go briefly to your CV, the reference for it is 306-086, but perhaps if we go to two pages and pull them side by side, 306-086-003 and 004. Then if we look down at the bottom of the left-hand side under your employment, you became a consultant paediatric anaesthetist at the Children's Hospital on



1 August 1995, which means you were newly made a consultant by Adam's case.
A. Yes.
Q. And you've remained in employment there since?
A. Yes.
Q. Then if we look to the right-hand side, we see under "Management and committees" that you were lead clinician, paediatric anaesthesia, from July 1997 to July 1999. First, can I ask you, who was your predecessor, do you remember?
A. This was a new title, a new role which had just been created. I was the first person to --
Q. You were the first?
A. -- to occupy that.
Q. What led to the creation of that role?
A. To be honest, I can't answer it. My understanding is that it was to try and, within the department, maybe give people more responsibilities. It's a complex organisational thing and it was Dr Crean who asked me if I would take up that role.
Q. What did the role involve?
A. From what I remember principally, I was, as you can see there, the anaesthetic rota organiser, so there was a significant practical management role in optimising theatre resources. In other words, ensuring that the



anaesthetic cover was matched to surgical cover and vice versa, and then, within that lead clinician paediatric anaesthesia role, I remember having one or two meetings about the transfer of paediatric neurosurgery, which was performed in the adult Royal, over to Children's. So there were discussions about how many anaesthetic sessions might be required and ICU beds and so on and so on. I did not see myself as having a significant major planning or strategic role from that point of view.
Q. Maybe we'll come on to that later on and see what that kind of position could have assisted with. But then if we look down under "Audit", we see:
"Convenor for the paediatric anaesthesia audit group."
That is 2000 to 2004. What did that involve?
A. That arose out of a realisation that the audit session per month was multi-professional and there was then a move to make it multidisciplinary. So there were lots of different interest groups attending the audit meeting and we felt that, apart from the mortality presentations on a number of audit meetings per year, we would take ourselves -- remove ourselves from the other part of the audit meeting and look at issues which we felt were important for us.



Q. For example?
A. For example, we would meet with the paediatric surgeons about management of babies with congenital diaphragmatic hernia, we would meet with plastic surgeons to agree guidelines for managing children with burns.
Q. So these were clinical meetings when you discussed clinical issues?
A. Essentially that, yes, how we could improve our service within the Children's Hospital, but because we don't work in isolation, we sort of like had our topics which we felt perhaps, if we could sit down with the surgeons, we might be able to talk out a few things. So that was the rationale behind that. We also -- now that I remember, we did -- we audited how anaesthetic charts were filled out and we did look at critical incidents as well, which happened, say, in anaesthesia and theatres.
Q. And who was a member of that group? Were you automatically a member if you were an anaesthetist?
A. Yes, all the paediatric anaesthetists were automatically members.
Q. And you may have said -- and if you did, forgive me -- but how often did you meet like that?
A. I would say possibly maybe six times a year.
Q. Were the anaesthetists expected to go?
A. Yes, because it was part of the audit session.

Q. Thank you. Then under "Teaching", we see:

"Trainee anaesthetists on the topic of IV fluids, blood and blood products."

If we just stick with the issue of IV fluids, when would you have been doing that teaching?

A. That would principally have been in theatres, informal teaching during a case. There would have been some sort of set-piece lectures to maybe a wider group of anaesthetists in the Trust.

Q. Sorry?

A. A wider group of trainee anaesthetists; this is trainee anaesthetists.

Q. When you said "than the Trust", do you mean those who were anaesthetists, but not within the Trust, could also come to these lectures?

A. At any one time there might be three, four, five trainee anaesthetists in the Children's Hospital. So while they were there for their three-month attachment I would have taught fluid management then, on the job so to speak, and then there were --

Q. This is part of a series of talks that would be available for --

A. Yes, I would have given some talks.

Q. Can you remember if you always gave talks on IV fluids or, if not, when you started?



A. I recall I started before 2000, and I carried on after that for a number of years. It's some years since I've actually given the talks. It's not in my CV there, but I think I also gave maybe one or two talks to medical students as well. But the predominant audience was trainee anaesthetists. Certainly after 2000, 2001 possibly.

Q. Well, before 2000, when you think you might have given some talks before then, did you give any talks on hyponatraemia?

A. Um ...

Q. At least if I put it a different way, the use of low-sodium fluids?

A. Yes. I may have, I cannot recall the individual talks, but I almost certainly would have talked about hyponatraemia, I'm sure.

THE CHAIRMAN: As an aspect of a talk on IV fluids?

A. Yes, the IV fluids, including, you know, the administration of blood and blood products.

MS ANYADIKE-DANES: I'll come back to some of that when I deal with some substantive issues as we go through some of the issues that arise out of that, but thank you.

Then you treated Adam when he was in PICU, post-surgery; is that correct?



A. No.

Q. Okay. You weren't in PICU when Adam was admitted?

A. Not that I can recall, no.

Q. Did you sign off on a statement -- let me pull it up for you, 011-014-107A. Have you seen that before?

A. Yes.

Q. In relation to that, did you sign-off on that?

A. There were a number of versions of that statement.

Q. There were.

A. And I redressed this in some of my witness statements because I remember there were a number of versions going around. So I signed-off on one version.

Q. Yes. But any of those versions referred to the need to be carefully monitoring post-operative children who might have a potential for electrolyte imbalance. That's a common theme in all of them. So you were endorsing that, I take it. And:

"The now known complications of hyponatraemia will be assessed."

That was a common theme in them. And if you go down to:

"All anaesthetic staff will be made aware of these particular phenomena and advised to act appropriately."

Were you aware that that was an element of what the coroner was going to be told?



A. I believe so. Unless the statement I've signed -- unless what I've said in my previous witness statement differs significantly from that one.

Q. Well, how was that going to happen?

A. How was it going to happen?

Q. Yes. How were all anaesthetic staff going to be made aware of these particular phenomena and advised to act appropriately?

A. For trainees that would have been an intrinsic part of on-the-job anaesthetic training. It would have been second nature to -- if you were an anaesthetist, using this sort of apprenticeship model of training where there's no absolutely defined curriculum, as and when teaching opportunities arose, you would highlight them and make points which were learning points.

Q. Did you when you were engaged in your teaching?

A. Yes.

Q. You referred to Adam's case?

A. I may have, I cannot remember. I cannot honestly remember, but I may have.

Q. And when you were lead clinician, which was a couple of years after, in fact the following year -- the inquest for which this statement was produced was in the summer of 1996, you became lead clinician, paediatric anaesthesia, in July 1997, so about a year after this.

At that stage, were you thinking about how you might incorporate the learning from Adam's case into something more systematic, if I can put it that way, for trainee anaesthetists?

A. I wasn't thinking of something formalised or systematic, no.

Q. Were you thinking at all about how you might communicate this?

A. Rather than specifically communicate the Adam Strain case, the importance and the concept of hyponatraemia and dilutional hyponatraemia with No. 18 Solution.

Q. So if you're the lead clinician, you'd be wanting to make good on that statement, that there was training going out to the trainee anaesthetists in relation to what is described there as "the particular phenomena"; would that be right?

A. Yes.

Q. So that means that the trainee anaesthetists coming through your hands, if I can put it that way, should be aware of these issues?

A. And my colleagues' hands too.

Q. Yes, and your colleagues also.

A. Yes.

Q. So as from at least when you took over in the summer of 1997, they should have been aware -- and probably before



then -- if that statement is going to be made good?

A. Yes.

Q. And then when we come to the case of Claire Roberts. Were you aware of that case?

A. Yes.

Q. In your witness statement, we don't need to pull it up, but it's 302/1, page 6, you say:

"In the case of Claire Roberts, hyponatraemia was a contributory factor to the development of fatal cerebral oedema."

So that was recognised by you in that case?

A. Yes.

Q. Did you think that, well, that's another case of hyponatraemia we've got, maybe we should perhaps redouble our efforts to ensure that people are aware of the implications of the use of low-sodium fluids?

A. I personally was aware and I believe I would have communicated, in a general manner, the care that had to be taken with No. 18 Solution.

Q. But how is that going to be done in a way that you can be satisfied, as the lead clinician, that these matters are being taken on board? This statement comes in the summer of 1996, Claire's death happens towards the end of that same year and then, in the summer of the following, year you have taken on responsibility with



this new role. How are you going to make sure that this lesson in terms of the potential dangers or risks involved in the use of low-sodium fluids is being understood, accepted and properly addressed?

A. Well, I have to say that I didn't consider that, so I didn't personally take any steps to ensure that under my role as lead clinician in paediatric anaesthesia.

Q. Is there any particular reason why not because you personally would know of two cases within a year that had happened?

A. I can't explain why.

THE CHAIRMAN: Did the doctor know in 1996 that hyponatraemia was a contributory cause of Claire's death?

A. Did I know? Yes, I did.

MS ANYADIKE-DANES: Yes, that was in his witness statement, Mr Chairman.

And you signed-off on this, so although you hadn't treated Adam, you were aware of the issues because there was communication back and forth that led to this statement --

A. Yes.

Q. -- which was going to be provided to the coroner? So you were aware of two instances within a year of each other.



A. Yes.

Q. So then what I was asking you was: well, why didn't you?

A. In my job we had lots of demands on our time and I never got the time, really, to reflect on that. That's the only explanation I can offer.

Q. What about when you become convenor? You become convenor in February 2000, things have moved on. That is convenor for the paediatric anaesthesia audit group, February 2000 to May 2004, so things have moved on a bit. That is just before Lucy gets admitted.

A. Yes.

Q. At that time, of course, there are perhaps more publications in relation to the potential risks of low-sodium fluids. Did you think with that, in that forum, it might be something that could be discussed?

A. I personally don't recall making that thought.

Q. Let me just read you out what you said about how that group operated. It's at 302/1, page 2:

"It focused on issues important to us as paediatric anaesthetists, e.g. drawing up guidelines with multidisciplinary input, if appropriate, collating anaesthetic critical incidents and then reviewing them for learning points. A report was produced for each meeting, which was circulated within the group, the Trust audit department and our clinical director, with

the intention of sharing information and learning opportunities among other anaesthetists."

That would be a good forum for doing that.

A. Yes.

Q. I mean, did you know that Dr Chisakuta, for example, in 1998 thought to include in a talk he was giving at an inaugural lecture for the Western Anaesthetic Society -- that he would pick up on the newly-published article by Professor Arieff on the risks of low sodium and he did that in 1998? Were you aware of that?

A. I was aware of that paper, yes.

Q. The paper. Were you aware that he was going out to Derry to give a talk in relation to that?

A. No.

Q. When that paper came out, did it not strike you that what was being said there was perhaps something that was worthy of greater dissemination amongst your colleagues and trainees?

A. I suppose the issue of hyponatraemia was one -- a very important part of my professional job, to avoid hyponatraemia --

Q. Yes.

A. -- but there was just so many other things going on that it's not that I positively decided to not do anything about hyponatraemia. On top of my busy clinical job,



I must have been distracted by a multitude of other things, so it wasn't a conscious decision to exclude that; it was just the way life was.

Q. I understand. In your witness statement at 302/1, page 11 -- and maybe this is worth picking up -- you talk about your practice changing. The question that you're being asked is in relation to Adam and Claire, who you both knew about:

"How did the knowledge about them affect your work?"

And the answer to that is:

"My practice did change in that at some point I no longer used Solution No. 18 as a maintenance fluid and this became Trust policy."

Can we just pause there? Am I correct from the way you framed that that you would always have considered it inappropriate to use it as a replacement fluid?

A. I believe that I didn't -- I would not have used it as a replacement fluid. I would have been very comfortable with using Hartmann's or saline. So that would have been, from memory, my intuitive practice.

Q. So what you're talking about here is a change in your practice when at one stage you would have used it as a maintenance fluid and what you're telling the inquiry here is that your practice changed in relation to that?

A. Yes.



Q. And you simply stopped using it as a maintenance fluid; can you remember when did you that?

A. No, I'm aware that that's a question the inquiry have been asking for some time now and of many different people. I cannot -- there is no particular date or even period in my mind.

Q. Maybe I can help you this way: do you know why your practice changed?

A. It changed because of the issue of ADH.

Q. When did that become something that you recognised and were taking cognisance of?

A. Well, I -- after, I suppose, the Adam Strain case, I would have been aware of the issues of ADH.

Q. Does that mean after his case, you -- maybe not immediately, but gradually -- changed your use of Solution No. 18? Would that be a fair way of putting it?

A. As a maintenance fluid?

Q. Yes, as a maintenance fluid.

A. I think that would be a fair point to make.

Q. When you were doing that, did you discuss that, because that's a change in practice and it's a practice that many others carried on adhering to? Did you discuss that with any of your colleagues?

A. I can't remember individual discussions, but it would



have been a topic, yes. It was a topic that we would have discussed.

Q. And do you think you were alone in that?

A. In discussing it with my colleagues?

Q. No, alone in responding in that way in changing your practice.

A. As a group or as an individual?

Q. Well, you said you thought you did it. Were you aware of any of your other colleagues doing it?

A. Yes, I -- and I suppose, just to go back, to be clear what you're asking me, is that as a maintenance fluid or as a resuscitation fluid?

Q. As a maintenance fluid.

A. I'm honestly not sure what my colleagues -- I mean, I would -- in the absence of having factual sight of a lot of anaesthetic records, I'd be loath to speculate on what they were actually doing.

Q. Do you think you would have taught your trainees that?

A. At some stage I did, but I can't remember when.

Q. Would you not have taught them when you started yourself to change your practice?

A. Yes.

Q. And explained the reason for it?

A. Yes, very much so.

Q. I know I've asked you this question, but I'm not sure

why, if you're actually changing your practice, why that's not something that would get discussed in one or other of these fora that you were telling us before.

A. You see, I'm not exactly sure when, you know, from what date or even what year that was happening, so it's hard to -- if I'm not quite sure when it happened, it's hard to know when it didn't appear in one of the meetings.

Q. Yes, but what you did say is you thought you might have done it in response to your learning about ADH in relation to Adam Strain.

A. Yes.

Q. Well, that case happened in -- you may not have really learnt much about it until 1996, but that's quite a while ago.

You've mentioned that --

THE CHAIRMAN: Sorry, let me just ask one more point on that.

You were considering the continued use of Solution No. 18 as a maintenance fluid. You had used it previously as a maintenance fluid and then at some point you stopped doing that.

A. Yes.

THE CHAIRMAN: Can I take it that when you stopped using it as a maintenance fluid you stopped dead? Having sort of considered to and fro the arguments for and against, if



you stopped using it, say, hypothetically on a Monday or Tuesday, I presume that two weeks later you weren't using it again on an occasional basis as a maintenance fluid. When you stopped using it as a maintenance fluid, because you identified some risks involved in it and you were comfortable using Hartmann's or saline, from then on you would not have used Solution No. 18 at all as a maintenance fluid?

A. It would be very hard to me to say I never used it, but -- as a maintenance fluid. I'm ... I suppose this period we're talking about spans many, many years in the Children's Hospital where we have complicated patients with maybe electrolyte abnormalities, so it's very hard to say that at a certain date I never used it. But there was this very, very -- at some stage there was a very strong trend to dispense with No. 18 Solution.

THE CHAIRMAN: Can you remember, when you were in discussions with your colleagues, whether you were out on a limb or whether they were, at least some of them were with you, even if it wasn't universal?

A. No, it would have been as a group.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: You said earlier, when I started this line of questioning, that you were aware that the inquiry's been trying to put a date to it because



a number of your colleagues have been asked. What prompted some of that line of enquiry was that Dr Nesbitt initially wrote a letter to Dr Fulton. Do you know who Dr Nesbitt is?

A. Yes, I do.

Q. So he was the clinical director at that time at Altnagelvin. He also was a consultant anaesthetist who had seen first-hand Raychel before she collapsed in Altnagelvin and accompanied her to the Children's Hospital. He writes a letter to his medical director having made some investigations in relation to the use of Solution No. 18. If I just take you to that, the letter is to be found at 026-005-006.

You can see he says that he has contacted -- have you seen this letter before, by the way?

A. I don't think so.

Q. Right. You see the date, 14 June. Very proximate to Raychel's death:

"I have contacted several hospitals, including the Children's Hospital."

And he has made enquiries. He is trying to find out what everybody else does about their perioperative fluid management. He says:

"The Children's Hospital anaesthetists have recently changed [recently to June 2001] their practice and have



moved away from No. 18 Solution to Hartmann's solution. This change occurred six months ago and followed several deaths involving No. 18."

Then he goes on to say that:

"The anaesthetists in Craigavon have been trying to change the fluid also to Hartmann's, but they've met resistance in the paediatric wards where the paediatricians wished to follow a medical paediatric protocol."

Can you help us with what might have happened? Firstly, was there a change like that so far as you're aware?

A. In the Children's Hospital?

Q. Yes.

A. There definitely was a change, but I'm not sure of the time frame, when it started.

Q. But there was a change?

A. Yes, because now we no longer use --

Q. I know you don't now.

A. Now it's very clearly we don't use it, but I'm not sure when that started.

Q. He attributes a reason for that shift six months ago, he said:

"Following several deaths involving No. 18 Solution."

Do you recollect that?
A. The deaths?
Q. Yes.
A. Well, Adam Strain, Claire Roberts, and this is in June 2001, and Lucy Crawford.
Q. So are you saying that the Children's Hospital was recognising in June 2001 that the use of Solution No. 18 was implicated in Claire Roberts' death?
A. I would imagine that he -- he mentioned three cases.
Q. "Several."
A. Seven?
Q. "Several."
A. Several cases. Um ... Well, I don't know where he got that information from.
Q. No, but what I'm asking you is: when you mentioned Adam and Claire, were you saying that because it was recognised in the Children's Hospital in 2001 that Solution No. 18 had been implicated in Claire's death?
A. I recognised that it was implicated. I'm not sure, you know, what the ... um, the hospital itself, the corporate hospital, had recognised.
Q. Did you make that known to the hospital that you thought the use of a low-sodium fluid, Solution No. 18, was implicated in her death?
A. No, I didn't.



Q. Can I ask you why?
A. I remember that in Claire's case it was it was a contributory cause to her death.
Q. Yes, I said "implicated".
A. Implicated, yes.
Q. So why didn't you communicate to the hospital that in your view Solution No. 18 was implicated in her death?
A. At the same time as I felt that, the No. 18 Solution was being given at normal maintenance rates as per -- as what would have been standard paediatric --
Q. What caused you to think its use was implicated in her death?
A. Because it was contributory to her death.
THE CHAIRMAN: It makes it even worse. If you thought that Claire didn't receive an excessive rate of Solution No. 18, but Solution No. 18 contributed to her death, that raises even more issues about Solution No. 18, doesn't it? So it's not: here's a young girl who got too much of Solution No. 18; here is a girl who got, you suggest, roughly the right amount of Solution No. 18, but that nevertheless contributed to her death. Would that not make you stop and say, "Look, this is really something we have to look at?"
A. No. 18 Solution -- Claire had hyponatraemia, which was one of the contributory factors to her cerebral oedema.



I would just need to refresh myself in my own mind. She had SIADH, so she developed hyponatraemia on the basis of SIADH, and the No. 18 Solution, being a low-salt solution, would not have been helpful.
MS ANYADIKE-DANES: That's exactly the point, Dr McKaigue, because you realised, after Adam died, the risks if a child developed ADH, I don't mean a normal response but an over-response, so we're retaining fluids, which is what happened to Adam. You had realised that if that happened and you were providing low-sodium maintenance fluids, then there was a risk, and that is why, I think you were telling the chairman just a little while ago, that is part of what led you to change your practice in relation to its use as a maintenance fluid.
So now Claire comes along and that confirms it. Adam had all his renal problems and received an excessive dose of fluids. Here is Claire not apparently having any renal problems, not receiving, in your view, an excessive amount of fluid, and she develops a response, an SIADH response, and she's on low-sodium fluids and that is implicated in the development of her fatal cerebral oedema. That particular circumstance, is that not just the kind of risk that ought to be published because it's something that people might not be aware of?



A. It's just something you said at the start about immediately following Adam, I changed from No. 18 Solution as a maintenance fluid.
Q. I don't think I said immediately. If I said immediately, I certainly didn't intend to.
A. Well, between Adam and Claire I changed.
Q. You did change?
A. No, no, I thought that's what you said.
Q. No, I thought your evidence to the chairman had been that one of the reasons you changed is that you appreciated the dangers of ADH in combination with low-sodium fluid, and where you got that information from was Adam's case.
A. I'd have to go back and just see what I was saying in the context I was saying.
Q. But in any event, leaving aside Adam, in relation to Claire your evidence was that you had formed a view that the use of low-sodium fluids was implicated in her death. Despite the fact that she didn't receive an excessive amount of low-sodium fluids, nonetheless it was implicated. My question to you is: if you thought that could happen, which is something that anaesthetists and other clinicians may not appreciate, why didn't you take that information to the Trust?
A. In Claire's case, the No. 18 Solution was being given at

normal maintenance rates, which was standard practice in paediatrics.

Q. Exactly, so something that was standard practice could, in certain instances, end up being implicated in a child's death. That's exactly the point.

A. As an anaesthetist, I felt that all the time in Claire's case I was, if you like, looking at what paediatricians were doing. Where I came from with Adam was -- Adam had received a large volume of No. 18 Solution, a large volume, whereas Claire hadn't, and there were other -- there was SIADH, which was contributing to the hyponatraemia.

Q. Yes.

A. So Claire's case and Adam's case were entirely different.

Q. But if you just stay with Claire's case, you have said Solution No. 18 was implicated. So it wasn't a neutral issue; it played a role. Implicated. That's why I'm asking you. Once you form that view, even if you formed it just as an anaesthetist and wondered whether the paediatricians had an answer to it, once you'd formed that view, why didn't you take that to the Trust or at least raise it in one of the fora that were available to you to do so because, if you were right, it might have significant implications?



A. Well, my answer to that is I didn't do it and I have no explanation for that.

THE CHAIRMAN: Let's go back. The note that was prepared for the coroner talked about managing electrolyte imbalances after major surgery, right?

A. Yes.

THE CHAIRMAN: So we've already had a debate about "major surgery", but let's move on to Claire's case. Claire didn't have major surgery. In fact, Claire didn't have any surgery, right? And Solution No. 18, the use of Solution No. 18 and monitoring electrolytes, has been identified at least to the coroner as a point that he's reassured the Children's Hospital will be alert to in future when monitoring children who have had serious surgery or major surgery.

A. Yes.

THE CHAIRMAN: A few months later, Claire comes in, she's had no surgery at all, she dies in a very short time, and you take a lesson from that that even though she didn't have an excessive rate of Solution No. 18, you regard hyponatraemia and Solution No. 18 as a contributory cause to her death. That's what you identify as a paediatric anaesthetist. So did you speak to any of your paediatric colleagues to say, "Look, this actually could be something that we should be worried



about"?

A. No, I didn't.

THE CHAIRMAN: Well, can you explain why? Sorry, was it something to be worried about that a child who didn't have any surgery, who got a normal rate of fluid, but the fluid she received was Solution No. 18, then died? Was that aspect of her death something to worry about?

A. Whenever I was thinking about Claire, what was very much in my mind were the other disease processes which were causing cerebral oedema, and among them was SIADH. So there were no particular warnings about SIADH and No. 18 Solution.

THE CHAIRMAN: But surely that's the point. The fact that a girl who had something else wrong with her or may have had something else wrong with her dies with hyponatraemia as a contributory cause. That must lead to you questioning the continued use of Solution No. 18 in a non-surgery case.

A. I can only say that SIADH was relatively common, No. 18 Solution was very common, and this would not have been the first instance that -- well, I'm speculating. But it would have been quite a common combination. Sick children would have had SIADH and would have received No. 18 Solution. It still seemed to be normal practice. That was my ...



THE CHAIRMAN: But it's going to stay normal practice until someone says it shouldn't be normal practice. The reason we got on to this is because this letter written in June 2001 talks about:

"... several deaths as a result of which the Royal stopped using Solution No. 18."

I think Ms Anyadike-Danes was saying to you that, in Adam's death, Solution No. 18 was implicated in that, particularly with the excessive volume which Adam received, and when she asked you whose the deaths were, you suggested Adam, Claire and Lucy; okay? So you have just told us about Claire.

In June 2001, was Lucy's death identified in the Children's Hospital as related to Solution No. 18?

A. With respect to Lucy, I didn't know that. My answer to that question was sort of partly informed with the knowledge I have now. But at the time I didn't know that fluids played a role in Lucy's death.

MS ANYADIKE-DANES: Sorry, just before we exactly get on to that, that statement which had been up just a little while ago that you approved in 1996, C5 as it's called, shown to the coroner, that refers to an article by Professor Arieff and his colleagues, in particular Ayus, who was working on this area of hyponatraemia, and you must have known that because it's actually referred to

in all the versions of the statements.

A. Yes.

Q. And that is 1992. The title of that article is:

"Hyponatraemia and death or permanent brain damage in healthy children."

That is what that article is about; it's not necessarily about children post-operatively. It's about the risks of the use of low-sodium fluids, and the problem is you can't actually tell which child is going to respond in a particular way, and you have just highlighted that yourself. A number of children may develop a syndrome of inappropriate antidiuretic hormone, SIADH, they may also be given low-sodium fluids --

A. Yes.

Q. -- but they don't necessarily go on to develop a fatal cerebral oedema. But some do, and you'd recognised that Claire was one of those. For some reason -- maybe in response to some of the underlying factors that you were thinking about -- she developed SIADH, which means that she was going to inappropriately retain water. She was also being given low-sodium fluids, and because she was inappropriately retaining it and -- one presumes she carried on retaining the water, coupled with the fact that she was being given low-sodium fluids, admittedly



at a normal maintenance rate or close to normal maintenance rate. The combination of those factors for matter, you have just recognised, was fatal because you have -- sorry, if I may just finish? Maybe I can correct myself.

What you recognised is that the low sodium was implicated in her death in some way; that is what you said, yes?

A. Yes.

MR McALINDEN: Just before the witness answers this question, I have refrained from interrupting at this stage until now, but I think the line of questioning that this witness is now facing is really going back into a previous case. The line of questioning which he expected to face in relation to the line of questions that were submitted this morning, very early this morning, and indeed the details contained in his Salmon letter, do not deal with this aspect of the case.

If he's going to be asked in detail about the cases of Claire Roberts and Adam Strain, it's my submission that he should have time to refresh himself in relation to the contents of his detailed witness statements that were made in relation to Adam Strain and in relation to Claire Roberts because the questioning that he is now being subjected to really has been dealt with by him in



those earlier statements in quite significant detail.

In relation to his knowledge of Claire Roberts and in relation to his consideration of the factors that play in Claire Roberts, in witness statement WS156/1 at page 31 -- it's question 33, sub-paragraph (c) -- he deals --

THE CHAIRMAN: Sorry, page what?

MR McALINDEN: 156/1, page 31, question 33(c). He deals with it in detail with the various factors that were in play in Claire's case and his attribution of -- well, his opinion in relation to the causal significance of those factors. So if this line of questioning is going to go over this whole issue in relation to his state of knowledge in relation to Solution No. 18 at the time of Claire's death and thereafter, it would be my submission that, at this stage, he should be given some time to consider the contents of his earlier statements, which obviously would not have been at the forefront of his mind coming into the witness box to answer questions in relation to Lucy Crawford.

MS ANYADIKE-DANES: I understand that, Mr Chairman, but in fairness the second line of the line says:

"Knowledge of hyponatraemia and use of Solution No. 18."

But it may well be that he wasn't expecting that



I would ask him that in relation to going back to 1996.

MR McALINDEN: When a witness receives a Salmon letter, it's a very serious matter and I'm sure that when the witness received the Salmon letter, his concentration would have been primarily aimed at the issues that have been contained in that letter. And certainly the issues that have been raised this morning for the last hour appear nowhere in the Salmon letter that he received.

THE CHAIRMAN: Let me say this. There's a difference, Mr McAlinden, as you must very well know. I don't think there's a single witness in this inquiry to date who has been questioned only about the points in their Salmon letter. So to suggest that questioning should be restricted to points in a Salmon letter is entirely without foundation.

MR McALINDEN: I'm not suggesting that.

THE CHAIRMAN: So far as this evidence is concerned, this segment of the inquiry has been opened and yesterday's witnesses were questioned on the basis of Dr Nesbitt's letter. Dr Nesbitt's letter says that the Royal's position was that there had been several deaths as a result of Solution No. 18. And Dr McKaigue has identified three deaths which are in some way connected to the use of Solution No. 18. So he was being asked about Claire and he has said that he recognised that

Solution No. 18 was implicated in the sense that Solution No. 18 was a contributory element, perhaps not the primary element. And I understand that and I'm content now to move on to his position or his knowledge about Lucy. If he needs to go back to his earlier statements, that can easily be arranged. They're to hand. Okay?

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

A. If I could just make one point about the Arieff paper --

Q. Of course.

A. -- the 1992 Arieff paper? It never mentioned SIADH in that paper.

Q. No, I wasn't going to claim that it did do that. The chairman was talking about healthy children who can nonetheless succumb and die, partly as a result of the low-sodium solution that's administered to them.

If I then move on, and I'm dealing really with what could have given rise to the statement that Dr Nesbitt feels was made to him by the Trust, and his statement, at least in that letter -- we'll come on to what he says when he makes his statement to the police -- but in that letter he says that he's being told that, six months before Raychel's admission and death, the Children's Hospital had changed their practice and what had prompted them to do that was that there had been several



deaths in relation to the use of Solution No. 18. That's where we were, and I was asking you whether you knew about that. Although you didn't know what the source of his knowledge was, helping us with which deaths that they might be, you had identified Adam, Claire, and I think you said Lucy, but I'm not sure whether you did say Lucy.

A. I did say Lucy, but this is obviously important to my evidence today.

Q. Yes.

A. In answering that question, I'm drawing on knowledge which is in the public domain now but not what -- I think I qualified it finally by saying I personally did not know --

Q. You did do that.

A. I didn't answer your question correctly, and then again I suppose I wasn't really in a position to speak for the Royal. I could only speak for myself.

Q. Can you help me with this though? Even though you wouldn't be in a position to know that Lucy would be in that list, you knew about Adam and you knew about Claire, but you wouldn't know about Lucy. But so far as you're aware, did the Royal know that Lucy had died with Solution No. 18 being implicated in her death, if I can put it that way?



A. I don't know.

THE CHAIRMAN: What concerns me is that -- I don't know if you've had a chance to see or hear what Dr Chisakuta said yesterday. Dr Nesbitt's recollection is that -- in fact, it was Dr Nesbitt who wrote this letter fairly contemporaneously. He said: it was Dr Chisakuta who told me there had been several deaths. Dr Chisakuta said yesterday he didn't know about Adam's case and he didn't know about Claire's case. So if he was talking about "several deaths", who was he talking about?

A. I don't know.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Well, who could he have been trying to speak to? He's going round phoning hospitals to try and find an answer to the question. He's not actually trying to find out how many deaths happened in the Children's Hospital; he's trying to find out what is the Children's Hospital's practice in relation to perioperative fluid management. That is what he's actually trying to find out, in common with that same question he's putting to other hospitals. He's trying to see whether they were out of sync with people or not and then what they're going to do about it, whatever might be the answer to that. As it happens, the information he gets from the Children's Hospital is the



very one I have put to you. So if he was trying to find out that question, who's the appropriate person to have contacted in the Children's Hospital?

A. I suppose from a generic point of view, you might go to maybe the senior person. On the other hand, you might go to a colleague maybe who you've a good, say, friendship with, or on a personal level you might ring up somebody. It's really impossible for me to answer that.

Q. Let's leave the person you might know personally. If you were trying to make contact with the person who has the position that's likely to be able to help me with what is the Children's Hospital's perioperative fluid management regime or practice, what's the title of the person you're going to ask that of in your view?

A. Knowing the way anaesthetics works, titles may not necessarily mean an awful lot. It's more the individuals.

Q. So you wouldn't be going to whoever was the lead clinician in paediatric anaesthesia?

A. No. In my opinion, no.

Q. The most senior consultant in paediatric anaesthesia?

A. The most senior consultant would be an obvious choice.

Q. And who was the most senior consultant in 2001?

A. Dr Crean.

Q. Dr Crean?
A. Dr Crean, Dr Kielty -- was he retired then? I'd have to sit down and work that out. Dr Crean and Dr Kielty were the two senior consultants then.
Q. Dr Chisakuta was the lead clinician of PICU.
A. Yes.
Q. Leaving aside what you have said about titles, is that an appropriate person to ask?
A. Yes, it could be, yes.
THE CHAIRMAN: The truth is, there's no inappropriate person to ask, is there? If you speak to a paediatric anaesthetist who has been there for a few years, that person should be able to tell you?
A. Yes.
MS ANYADIKE-DANES: Thank you. He then makes a statement, which, as the chairman has said, which is where he actually names Dr Chisakuta as the person. If we pull up 095-010-040. This is a statement that Dr Nesbitt made to the PSNI. It's a little bit after these events, he made it in March 2006. If you go down to the bottom quarter, he's talking about his efforts. Right down at the bottom quarter:
"I spoke to Dr Chisakuta, a consultant in paediatric anaesthesia and intensive care in the Children's Hospital, about their use of No. 18 Solution in



post-operative surgical children and he informed me that they had been using precisely the same regime as Altnagelvin Hospital, but had changed from No. 18 Solution six months previously because of concerns about the possibility of low sodium levels."
So what he's saying there is, whether he's meaning to connect the deaths with the low sodium, but in any event on this statement, the concern that he hears from Dr Chisakuta is its role in low sodium. Well, it is a low-sodium fluid, so it's the consequence of using that.
In the six months previously, the end of 2000, beginning of 2001, is that something that you're aware of?
A. I was here for the hearing yesterday and I saw the pharmacy report.
Q. Then we can cut straight to that and see if you can help. 319-087c-003. So if you were here for that evidence, you would recall the tail-off that has been described. It really does seem to start at February-ish. But there is a very dramatic fall-off in the summer of 2001. Are you able to help with what was happening?
A. No.
Q. Do you remember that?



A. No, I don't.
Q. If you recall yourself changing your practice and, I think the way the chairman put it was you weren't out on a limb on that, and I think you described it as a group position, is this consistent with that?
A. Probably the vast amount of No. 18 Solution which would have been used in the Children's Hospital would have been on the wards, different clinical areas. So I wouldn't be -- I would suggest that, you know, the pharmacy could break that down to particular areas, then that might help you.
Q. Actually, no. What the question was was: what was the use of it post-operatively? That's where Dr Nesbitt was coming from because Raychel was a post-operative death.
A. Yes.
Q. So that's what he wanted to know and I presume that there are children on the normal wards who are post-operative children.
THE CHAIRMAN: I'm sorry, but the heading on the graph is "Inpatient areas", and I presume that "inpatient" covers both surgical and medical?
A. Yes.
THE CHAIRMAN: I know this is speculative and if you think this is pushing it too far, then tell me. What that would be consistent with would be some discussion having



taken place in light of Claire's death and a belated recognition that, in a non-surgical patient such as Claire, Solution No. 18 isn't the solution to use.
A. I think my comment to that would be across the board, throughout the hospital, there was a high-level decision made to stop using No. 18 Solution. That's all I could say.
THE CHAIRMAN: You'll understand our curiosity is who made that decision and at that point why was it made?
A. Yes, I don't know. I haven't heard anything. I cannot help you there.
THE CHAIRMAN: But it looks to you as if a high-level decision was made, which led to the purchases of Solution No. 18 falling off quite dramatically in those few months?
A. Yes.
MS ANYADIKE-DANES: Can I ask you this: if a decision like that was being made, where would it be made? Well, where and how would it be made? What's the place which makes a decision like that?
A. My own opinion would be that the paediatric directorate ran the Children's Hospital. They didn't run every particular corner of it, but they were the major stakeholders. So if that graph -- the way that graph suggests that, across the board, virtually within

six months, the prescribing practice for No. 18 Solution had changed in the Children's Hospital. Paediatric directorate or, you know, the bulk of the consultants in the Children's Hospital must have been aware of that in some way.

Q. If the paediatric directorate --

THE CHAIRMAN: Sorry. Mr McAlinden, could we check something? We're going on something of an assumption here. Could I ask that, at some point over the next few days, the figures for the following six months be provided? I just want to make sure that the purchase level stayed as low as this graph suggested it plummetted to.

MR McALINDEN: I have directed that enquiries be made not only in relation to that issue but also in relation to whether there is any increase in the use of alternative fluids. I have also directed that all correspondence to and from the company that was supplying all the fluids, which was Galen Pharmaceuticals be checked to ascertain whether there was any detailed correspondence during this period which may highlight the rationale behind the change in the supply of various types of fluid to the Children's Hospital.

THE CHAIRMAN: Thank you very much. I just want to make sure we're not working on an assumption which turns out



to be false. Thank you.

MS ANYADIKE-DANES: I think we had asked similar questions ourselves because we also wanted to see what happened in the preceding period to make sure we didn't have an aberrant year, for example.

It is an assumption, so it may well be one that gets corrected with more direct evidence. But from your point of view as a senior clinician in the Children's Hospital, if a decision was being made -- and you said you thought, to have this kind of effect, it would be one that would be made by the paediatric directorate -- what's the forum, what's the mechanism by which a decision like that would be made?

A. There was a directorate structure. I was not particularly familiar with it, but there would have been some sort of directorate structure that's headed up by a clinical director and then a business manager and senior nurses. So there was some sort of structure there. They would meet regularly and they would have lots of business to do. So I would imagine this would have to be signed-off by somebody or authorised by somebody because it's a major, major change in practice.

Q. So --

A. No. 18 Solution was deeply embedded in paediatric practice. For that to happen, there's enormous shift in



culture and attitudes.

Q. So if there was a decision like that or signed off, you'd expect there would be some sort of meeting, some sort of minute or something that recorded this change?

A. I would expect so.

Q. Thank you very much indeed. Then if we go on to things more directly concerning Lucy's time at the Children's Hospital. In your police statement of 16 March 2005 you say that you were the duty consultant.

A. Yes.

Q. Dr Chisakuta gave some evidence as to how the rotation works. Can you explain what that term "duty consultant" means and how the system of consultant cover works for PICU?

A. Yes. The paediatric intensive care unit has to be covered 24 hours a day, 365 days of the year. That is managed and planned with a rota. As you can see from my management responsibilities, I was the anaesthetic rota organiser for three years. I gave it up for an interval of a few years and two other colleagues took it on, and then I think, since 2006 up until now, I am the current rota organiser, so I have a lot of experience with rotas.

During the daytime, PICU would always have a consultant on. In other words, elective operating



lists would be cancelled to give PICU priority because of the emergency nature of the work. So it had the highest -- along with the emergency theatre, it had the highest priority in the hospital for anaesthetic cover. Night cover was from 6 o'clock in the evening until 9 o'clock the next day. There was a rota made out for that.

Q. The night cover, were you physically -- whoever was doing it, were they physically present in the hospital?

A. No, they weren't.

Q. So you were on call at home?

A. You were on call at home, yes.

Q. I understand.

A. So on the particular night that Lucy was transferred from Enniskillen, I was on call at home.

Q. And present in PICU at that time, so this would be the early hours of the morning, who would be actually present in PICU at that time?

A. There would always be a resident paediatrician.

Q. At what level in the early hours of the morning?

A. It would vary. It would be a very experienced SHO up to a very experienced senior registrar.

Q. Okay. So that's from the paediatric discipline?

A. Yes.

Q. Would there be an anaesthetist?

A. No, the anaesthetist -- the trainee anaesthetists did not have specific duties in ICU. The nursing staff and the resident paediatrician could call on them in an emergency or, if there was some particular anaesthetic advice or issue required, they might give the anaesthetist, the trainee anaesthetist, a call to troubleshoot some problem with equipment or ventilators or monitoring.

Q. What you go on to say is that -- this is in your statement. In fairness to you I will pull it up, 115-027-001. You say that you recall receiving a telephone call from the Erne Hospital about Lucy. The telephone call was from Dr O'Donohoe. You agreed to Lucy being transferred to the Children's Hospital. Is that the first contact that you had had about the prospect of Lucy being transferred?

A. The telephone call from Dr O'Donohoe?

Q. Yes.

A. I think it was. There are two ways -- there's two possible ways. The registrar may have rung me about the case and then said, "Dr O'Donohoe is going to ring you", or else Dr O'Donohoe may have been given my number by the registrar and he rang me directly.

Q. I don't know if you were here for Dr Stewart's evidence yesterday --



A. Yes.

Q. Dr Stewart -- it's not just in her evidence, it's in her PSNI statement. The reference for it is 115-022-001. She says that:

"[She] was on call in the early hours of that morning and that she accepted by telephone her transfer from the Erne Hospital around 6 o'clock in the morning."

In her evidence she said that what would happen is -- and what did happen is -- that she received a phone call and she contacted you. I believe that was her evidence, to tell you about that, and she gave you some brief details about it.

So if that's correct and you've said that sometimes it does happen like that, does that mean when Dr O'Donohoe called you, that wasn't the first you were hearing about Lucy and you were aware that there was a child in a very sick condition that you were going to hear about, if I can put it that way?

A. If that premise was the actual case, I personally don't remember the call from Dr Stewart. It's the call from Dr O'Donohoe is the call I remember, but I'm not disputing -- what she describes there is very standard routine practice.

Q. Yes. You say that you didn't make a note of the call and that you don't actually remember it with certainty,



but you think -- and this is in your second statement at 302/1, page 7:

"I believe it was a critically-ill child who had developed seizures, may have had fixed and dilated pupils, and an anaesthetist was planning to intubate the child or had already done so. I believed I would have advised the administration of mannitol if this had not already been given."

What would you have been wanting to know about the child before she came?

A. I got all the information I needed from that phone call because the scenario was an emergency one.

Q. Yes.

A. And it was happening in real time, so things had to be done quickly, and I prioritised the -- I had to satisfy myself that appropriate steps were being taken to prevent any further deterioration in the child. So that's what was the general discussion about her management.

Q. In fairness to you in your earlier -- I think you see it there in the PSNI statement, you say that:

"It was [your] recollection that there was a general discussion about treatment and the type of fluid she received, which [you] thought was a dextrose-based solution, but [you] don't remember whether he told [you]



about volumes."

The dextrose-based solution, what would that have connoted to you? If he had said that, would that have meant Solution No. 18 or something else?

A. It could have been dextrose 5 per cent, it could have been saline 0.45 per cent, dextrose 2.5 per cent.

Q. Why were you wanting to suggest that the child be given mannitol?

A. In the scenario that I believed I was dealing with, a child who had a seizure and now had fixed dilated pupils, in my experience that means that the brain is at risk from cerebral oedema and, as a generic response to treating brain oedema, I wanted to ensure that the child received mannitol promptly to reduce the swelling inside the brain.

Q. The information that the inquiry received about the use of mannitol is that it's an osmotic diuretic and it's a solution which is designed to provoke a rapid excretion of free water through the kidneys when given intravenously and it's part of the emergency treatment of cerebral oedema and raised intracranial pressure; would you agree with that?

A. Yes.

Q. So you were thinking we might be dealing with cerebral oedema here?

A. Yes.
Q. And there's a number of ways in which you could be dealing with cerebral oedema.
A. Yes.
Q. One of the ways in which you could be dealing with cerebral oedema is something to do with her fluids --
A. Yes.
Q. -- but you wouldn't necessarily know that at that stage.
A. Yes.
Q. When you went on to answer questions from us in relation to your second witness statement, you said:

"My priority during this telephone call [this is at 302/1, page 7] would have been to ensure that all available measures were being taken to treat a potential brain injury by protecting the brain if possible from any further insult. This approach applied to any scenario in which there was actual or potential brain injury."

If that's what you were trying to do, if she had a cerebral oedema and that is what was causing the raised intracranial pressure, that was what had caused the fit and what had led to her fixed and dilated pupils, if that's what you were dealing with --

A. Well --
Q. You might not have known her pupils were fixed and



dilated.
A. I think I recall they may have been fixed and dilated --
Q. Yes.
A. -- and the other sentinel event was the seizure. So something caused the seizure. That could have led to cerebral oedema in its own right.
Q. What I was asking you is: you've got cerebral oedema was a potential. You've got a phone call, you're trying to work out a number of different things that might be happening and give some guidance before the child is brought to the Children's Hospital to, so far as possible, protect the child's brain before you and your colleagues have an opportunity to see what's happening and see what can be done to reverse the situation, if that is possible.

So if that's where you're at and you've got cerebral oedema as a potential issue for you, do you not want to know, just as part of the routine things you might want to know, "What is she on in terms of her fluids?" You know she's on some fluids and if those fluids were low-sodium fluids and you were thinking along the lines of a potential cerebral oedema, that would not be helpful or might not be helpful.

A. I suppose -- going back to the seizure, I was concerned about the child -- something precipitated the seizure,



I don't quite know what it was. I was concentrating on ensuring that the child was going to be intubated, ventilated and on mannitol. I didn't see it as an important role at that stage to discuss down the phone with Dr O'Donohoe what fluids she had had.
Q. Well, are you not seeing yourself in the role of providing some guidance at that stage? Because you've provided some by talking about mannitol.
A. Yes.
Q. So you are seeking to provide some guidance?
A. Yes.
Q. And they have contacted the regional centre, the specialist centre, that they want to send her to?
A. Yes.
Q. And do you not have an interest in making sure that all that can be done is done to preserve her in the best possible state, if I can say, until you can actually, you and your colleagues it actually treat her?
A. Yes.
Q. And she's away in Enniskillen where, even if they left then and there, they already had her stabilised, you're talking about a trip of one-and-a-half hours, maybe two, depending. So there's some period of time. So do you not have an interest in giving some guidance as to what should happen to ensure she's best protected over that



period of time?
A. That's what I think I did.
Q. Yes, but is not a very basic thing to ask: what are her fluids?
MR McALINDEN: Mr Chairman --
THE CHAIRMAN: We're outside the remit here, Ms Anyadike-Danes.
MR McALINDEN: I would submit it's clearly a clinical issue.
THE CHAIRMAN: It's a clinical issue. This isn't the aftermath of Lucy's death. You're asking the doctor about the treatment that he might have directed to give to Lucy before her death, and that's outside the remit.
MS ANYADIKE-DANES: Yes, it is put in that way. What I was actually trying to establish --
THE CHAIRMAN: I'm sorry. The questioning was significantly outside the remit, I'm afraid.
MS ANYADIKE-DANES: Yes, Mr Chairman, I understand that. If I may just explain what I was trying to establish.

If he knew what the fluids were, then that becomes an issue as to what the Royal might have known and when they received her notes and how they treated her, what the Royal might have been concluding about what was wrong with her. Because that's the aftermath.

THE CHAIRMAN: I'm afraid that is markedly different from the question you asked.

MS ANYADIKE-DANES: That's why I have apologised for the way I framed the question.

What I'm trying to find out, doctor, and one of the reasons for putting it that way is because you couldn't clearly remember, so I was approaching it, badly, from trying to see, even if you can't actually remember, what might you have wanted to do to try and get a handle on the likelihood of you knowing what her fluid regime was or any prospect of knowing that? So that is why I was phrasing it as to, "What would you have wanted to know?", and I apologise for doing it rather badly.

But in any event, can you help us with this: so far as you're concerned, is it possible that you were told what her fluid regime was?

A. It is possible, yes.

Q. Thank you. And if you had been told what her fluid regime was, is that part of what would start to work with you, and when you communicated it to your colleagues, as to what the problem might be?

A. Yes.

Q. Thank you. You knew that Lucy, at that time, was being treated or being assisted by an anaesthetist --

A. Yes.

Q. -- and you were talking to her consultant paediatrician?

A. Yes.



Q. You're an anaesthetist. Did it ever occur to you or do you think it would have been a prudent step, even subsequently, for any of the anaesthetists who were treating her when she actually arrived to talk to that anaesthetist?

A. By telephone?

Q. Yes.

A. Not necessarily, no.

Q. Well, the reason I ask that is because some of the clinicians who saw Lucy have been unclear about elements of her treatment at the Erne and the significance of some of that treatment. And you have there an anaesthetist who, of the disciplines that were treating her, one of the disciplines that knows about fluids and fluid regime and their impact. And that is why I was asking you if there was any concern about what the fluid regime had been or any lack of clarity about it in relation to her notes, whether it wouldn't have been appropriate to have contacted the anaesthetists at the Erne.

A. It wouldn't have been inappropriate, if I can answer it that way.

Q. Would that not have been a simple thing to do?

A. Yes, it could have been considered.

Q. Did you know that the anaesthetists had actually



contacted the Children's Hospital?

A. Yes, I did, yes.

Q. So if he's doing that and, according to the note, and although he doesn't remember that part of it, he's not going to differ from Dr McLoughlin who records it, he contacted the Royal or the Children's Hospital to tell them the results of the second serum sodium test that had been done. So if he's being prepared to engage, if I can put it that way, with the Children's Hospital in relation to some element of what had happened to Lucy at the Erne, would that not have been appropriate to have taken that opportunity to have found out more about what happened there?

A. It was certainly an opportunity.

Q. Do you think it should have been taken?

A. It would depend what particular knowledge deficit you were trying to address. Yes, if there was a knowledge deficit, if there were questions to be asked and you come up against a brick wall, then yes, it would be entirely reasonable to contact the anaesthetist.

Q. Let me put it this way: you were there when Lucy arrived --

A. Yes.

Q. -- and you spoke to Dr O'Donohoe?

A. Yes.



Q. And he had with him her transfer letter?

A. Yes.

Q. And there was also a transfer form. Well, let me show it to you just in case. The transfer form can be found at 061-015-040 and if we pull up alongside it 061-016-041. That's a Western Health and Social Services Board standard patient transfer form and that's what was completed for Lucy. Do you recognise that?

A. I cannot ... I have possibly vague memories of seeing the list of blood pressure readings and heart rates and saturations at the time.

Q. Well, this is a form that goes to you, or does this go -- who else would it go to?

A. It would go to the clinical team, the clinical team.

Q. And you, at that stage, were the lead consultant in anaesthesia at PICU when she came in. In fact, you were the only consultant in anaesthesia in PICU when she came in.

A. Yes. So yes -- and as I say, I have a faint memory that I recall noting that the observations had been done in the ambulance. I think the patient had deteriorated, I think, and during the journey -- I recall that. When she arrived with me, I had concerns about her clinical condition. She was unstable.

Q. What do you mean by that, Dr McKaigue?

A. What do you mean, concerns about her --
Q. No, you said you regarded her as being unstable. What does that mean? Clinically I mean.
A. She -- her blood pressure and heart rate were giving me cause for concern. That's what I mean.
Q. When you saw her and had an opportunity to observe her, what was your view at that time as to the chances of being able to reverse her condition?
A. I felt they were very, very bleak.
Q. Did you think realistically there was any prospect of doing that?
A. Realistically, no.
Q. Thank you. So you got that, but maybe the document that you'd have paid even more attention to is the transfer letter. If we pull up the two pages of that, 061-014-038 and 039 next to it. What is the information that you would have wanted to have on the transfer letter?
THE CHAIRMAN: Instead of going through what's on the transfer letter, is there information which wasn't on the transfer letter that you would have expected to have seen?
A. I'm not even so sure I actually read that transfer letter at the time. I had a very --
THE CHAIRMAN: What, because you had Dr O'Donohoe with you?



I presume you did. I think you --
A. Dr O'Donohoe, yes, transferred the patient.
THE CHAIRMAN: Did you see him in the Children's Hospital when Lucy arrived?
A. Yes. He was ventilating Lucy.
MS ANYADIKE-DANES: I think you have said, as early as your PSNI statement:
"I recall speaking with Dr O'Donohoe when he brought Lucy to PICU."
THE CHAIRMAN: Well, is that why you think you may not even have seen this letter because you had Dr O'Donohoe there to speak to?
A. Whenever Dr O'Donohoe arrived, the patient's on a trolley, I recall him saying that she had been unstable during the journey. As the hands-on anaesthetist, my job was to transfer her, ensure that she was safely transferred from the trolley on to the bed and connected to the ventilator, ensuring monitoring is going on, and then looking at the patient, because her heart rate and blood pressure were giving me cause for concern. So I had other very pressing things on my mind, i.e. Lucy's condition was very much in extremis.
MS ANYADIKE-DANES: So you needed to stabilise her first?
A. Yes. I cannot recall seeing the letter because I would have been preoccupied with Lucy.



Q. As you're doing that, trying to get her on to the bed and stabilise her, are you also asking Dr O'Donohoe any questions about what's happened?
A. I may well have.
Q. You do say in your evidence to the inquiry that you don't think that you were there very long in treating her. In fact, we don't need to pull it up, but it's in your witness statement, 302/1, page 9, you say that you think you were with her for just approximately 15 to 30 minutes because then you urgently had to leave, you had another patient who was also presumably in an urgent situation, and you left her in the care of Dr Chisakuta, who had by that time come into PICU. So essentially, what you say you told him is:
"I would have told him about her low blood pressure, her slow heart rate and the need for a central line to continue the dopamine to support the circulation and I would have mentioned that she had fixed and dilated pupils. In effect, I had identified the need for urgent resuscitation and, if I had not been called away, I would have proceeded with these measures myself."
So do I understand you to say that before you could actually get started in what your plan for her would be, you were called elsewhere?
A. Yes.



Q. So you have a conversation with Dr Chisakuta?
A. Yes.
Q. Had it not been for that, would you have been, once you have stabilised her, formulating your plan, and in the course of that you would have been looking at the transfer letter and gathering together the information that you need?
A. Yes, I would have been reviewing the information which had been brought up.
Q. Yes. Your evidence is you might not actually have got to that stage at that time, but what would you have expected Lucy to be accompanied with in terms of her documents or records?
A. Well, I would have expected -- I would just need to read through this here to check. (Pause). I would have expected some information about the IV fluid.
Q. About the IV fluid?
A. Yes.
THE CHAIRMAN: Can I ask you: how basic is that?
A. Well, it is basic.
MS ANYADIKE-DANES: There was some information in the transfer patient form right up at the top, we don't need to pull it up again, but it says "500 ml of normal saline, 30 ml an hour". Would you have understood that as a fluid regime looking at Lucy or would you have

wanted some explanation for why that was her fluid regime?

A. Well, I would have wanted to really sit down and go through all the information I had and try and work out what's going on here, a sequence of events, a differential diagnosis, and then look for supporting information. So it wouldn't have been a quick reaction or a quick decision; it would have required some thought.

Q. Yes. Well, in terms of --

A. And I would have also, while not necessarily doing that myself, then other members of the team could have been doing that.

Q. Dr Crean's evidence to the coroner, which we don't need to pull up, but for reference purposes is 013-021-074 was:

"It would have been important to have had the fluid management record from the Erne Hospital. Lucy had been seen in another hospital and as much information as possible was essential."

Then in his witness statement to the inquiry, which we also don't need to pull up, but is 292/1, page 3:

"It was and still is usual practice to receive a copy of a patient's notes from the referring hospital when a patient is being transferred. A copy of the



notes can usually be faxed to PICU."

Would you agree with that?

A. Yes. The relevant section from -- the relevant section from the patient notes, because some of these patients, would be impossible to, you know, meet that requirement.

THE CHAIRMAN: You mean because they have a long, complicated history?

A. Yes.

THE CHAIRMAN: In a case such as Lucy's, which almost had no history at all, then in those circumstances it should be very simple to provide the notes or copy notes, shouldn't it?

A. Yes.

MS ANYADIKE-DANES: Would you have expected to have got the notes not just from the ward but also from the intensive care unit? So the most recent notes from her stay in the Erne.

A. Yes, that's also correct.

Q. And do you say that because it's just logical, it makes sense, or because that was pretty much established practice, that's what people did when they transferred very sick patients?

A. Well, it's logical and it makes sense. It's always nice to know, as an anaesthetist, what the other anaesthetist has been doing vis-a-vis drugs and the size of the tube



and what position the tube has been taped in and the chest X-ray of the tube in place. So these are the ideals.

Q. Going back to 2000 when this happened, in your experience how common was it to receive a child like Lucy who came with absolutely no notes at all?

A. I would have to say that sometimes ... I mean, I would say the norm was usually adequate, we usually were reasonably satisfied with the documentation that arrived. If we hadn't, we would have contacted the hospital.

Q. Yes.

A. But I can't say that there were never any situations where documentation was lacking because that's the system we work in. There are always transfer materials which is just not really adequate.

Q. But you, I think, were being contacted in the relatively early morning. She leaves at 6 o'clock, she gets to you -- not you personally, but to PICU -- at about 7.45 or thereabouts, 8 o'clock. In your view, given that sort of time lag, would you have expected the relevant portions of her notes to have, if they didn't accompany her, to be faxed over?

A. Yes.

Q. Thank you. So then, I think from how you answered my



questions and the chairman's, it doesn't seem that you had very much time to really have a discussion with Dr O'Donohoe as to what had happened in relation to Lucy?

A. No.

Q. Would that be fair?

A. Yes.

Q. If you had had more time, would you have wanted to discuss what had happened at the Erne in relation to Lucy?

A. Yes, that would have been part of the information gathering exercise, to hear particular consultants' views. It's just more knowledge, more information.

MS ANYADIKE-DANES: Yes. Mr Chairman, I'm being asked if we could have a break.

THE CHAIRMAN: Yes. Let me take one point before we break. Did I understand you to say that you were here yesterday?

A. I was here yesterday, yes.

THE CHAIRMAN: At the end of Dr Stewart's evidence, she was asked about what the point was of transferring Lucy from the Erne to the Royal.

A. Yes.

THE CHAIRMAN: You have said that, realistically, she didn't have any prospects of surviving.

A. Yes.
THE CHAIRMAN: In your eyes, what was the point of transferring her from the Erne?
A. Well, whenever a child collapses -- a sudden collapse is an extremely distressing thing for the parents and for the staff. If there's still life -- so there's a collapse and most doctors will recognise a sudden collapse producing fixed dilated pupils is a very bad prognosis, so in their heart of hearts they know that there's nothing more that can be done locally for the child.

But it's a very big decision for somebody to take, being mindful of the fact that they don't necessarily know all the information. So for somebody to say, "There you go, sudden collapse, fixed dilated pupils, let's take the patient, let's extubate the patient", and let them die from the parents' point of view. That's a very big step to take. Because always at the back of your mind you're going to ask yourself, "Have I always absolutely got this right?" It's not a thing that should be rushed into.

We're then moving into the situation where, with Lucy, she was effectively brainstem dead, but she was extremely unstable because the autonomic nervous system is impaired so heart rate and blood pressure become very



unstable, so you then have to step in and support the circulation. To do that in a very small child you need advanced paediatric anaesthetic skills, and the only place you get those is in Belfast. So if you want to give adrenaline or dopamine through a central line to a collapsed child, that's best done in Belfast.

From the parents' point of view, the whole thing has been devastating and they almost -- it helps that they have time to come to terms with what has happened, they have time to be counselled and come to terms. Once we get the patient to Belfast, we have to -- before you can actually do brainstem death testing, you have to really understand what exactly has happened before you can do brainstem death testing, and that requires a diagnostic element and CT scans and further experience from other specialists. And then, finally, if brainstem tests are done and the patient is declared brainstem dead, there is the issue of organ donation, potential organ donation, so again that is all best managed in Belfast. That is why all these patients come to Belfast.
THE CHAIRMAN: Is there also another element, which Dr Stewart said, which is the transfer helps to find out why the child has died in the first place?
A. Yes, I think I mentioned that.
THE CHAIRMAN: Sorry, that's understanding what happened?



A. Yes.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: In fact, the way that I had posed it to Dr Stewart was on the one hand it's a possibility that there could be some treatment that could reverse, in some part, the condition. On the other hand, there's a recognition that that's unlikely and, if you're going to be in that course, then the child needs to be stabilised, brainstem death tests need to be carried out, CT scans performed and so on, all to do the very thing that you had suggested.

So I had put to her, which did she think was more likely. Did she think that a child in that condition would be being moved or transferred for the former or the latter? And she was thinking in those circumstances it was really the latter.
A. The latter being?
Q. That you recognise that the child is probably irretrievable, but nonetheless there are procedures that have to be carried out, investigations that have to be done, so that you can bring the child to a condition whereby you can carry out the brainstem tests and certify what has to be certified and so forth. My understanding of your evidence is that you suspected it was more the latter reason, that a child like Lucy would



be being transferred.
A. Yes.
Q. Just finally, the question that I went on to put to her is that if you've recognised that from the transferring hospital -- because she's at a hospital now as a consultant where she transfers children -- what is it that you are telling the parents about the purpose of the trip to the Children's Hospital?
A. Your question is what I think the referring hospital should be telling the parents?
Q. Yes, in those circumstances.
A. I think you have to be honest with them about the prognosis, but you can't really take away a child's hope -- sorry, a parent's hope.
MS ANYADIKE-DANES: Thank you very much.
THE CHAIRMAN: We'll take a 15-minute break, doctor. 12.15. Thank you.
(12.00 pm)
(A short break)
(12.15 pm)
MS ANYADIKE-DANES: Dr McKaigue, you said just when I was asking you some questions a little while ago that you really didn't see Lucy for very long, you were called away, and you handed over to Dr Chisakuta.
A. Yes.

Q. And you indicated to Dr Chisakuta her condition and you had certain expectations about what would happen, foremost that he should insert a central line because that would enable her to receive the dopamine, which was an important part in stabilising her.
A. Mm-hm.
Q. Can you help me with this. Who did you regard as Lucy's consultant who had overall responsibility for her care?
A. Well, at the -- this is moving on from, what, 8 o'clock in the morning?
Q. Well, I don't know. You will have to help us with how the system works. What we do know is, when she comes in, her admission sheet shows that Dr Crean is her consultant.
A. Yes.
Q. So what I'm asking you is, so far as you're concerned -- because you have described how there's not just an anaesthetist consultant in PICU, there's also a paediatrician --
A. Yes.
Q. -- and there are a number of different people who see her. As far as you're concerned, how does the system work in terms of who has overall control or responsibility for her care?
A. Dr Crean's name on the sheet --



Q. Yes.
A. -- and I think this has maybe been said to the inquiry before -- is a surrogate marker for every external child who's admitted to PICU. That flags up somewhere in the board that a patient has been admitted to ICU. So if they're doing a search, they put in Dr Crean's name and they find out the number of patients who have been transferred in from outside.
Q. How long did that go on for or is it still the case?
A. No, it's no longer the case now in that individually we -- our names are -- there's now, for example -- I think the way it works is that the administration staff would have the anaesthetic on-call rota, so they know who is on call for ICU. So whenever that flimsy is being produced, they take information from an anaesthetic rota.
Q. Okay. But in those days, the mere fact of putting Dr Crean as the consultant for a child was synonymous with saying an ICU patient?
A. Yes but that's not saying that Dr Crean -- I suppose I haven't really explained how I see it working.
Q. Yes. How do you see it working?
A. The way I saw it working and still do see it working is that, whenever I'm on call, I'm the consultant anaesthetist on call for the intensive care unit and



I will make contributions to patient care within the unit. Whenever I finish my on-call period and another anaesthetist takes over, then I hand over my care of the patients to that anaesthetist. Now, as I see it, each patient also has another consultant who is primarily responsible for their care.
Q. What does that mean?
A. What that means is that if it's a surgical patient who's on a ventilator in ICU, I make a contribution to that patient's care. The consultant ultimately responsible for the overall responsibility for that patient is the surgeon, the paediatrician, the cardiologist or neurosurgeon. That's the way I see the lines of responsibility in ICU.
Q. So translating that into Lucy, who was responsible for Lucy?
A. Dr Hanrahan.
Q. And throughout?
A. Yes. Although whenever the anaesthetist is working in the intensive care unit, they are responsible for their actions and the treatment they provide to the patient as and when required. But it's within the overarching responsibility of who I see it as the principal specialist.
THE CHAIRMAN: Does that mean it's not as straightforward



a question as, for instance, Dr Steen being identified as the consultant in charge of Claire? When a child is taken straight into PICU from the Erne as Lucy was, then is it as straightforward an issue as when Claire was admitted and Dr Steen was identified as her consultant?
A. Yes, it is. It is as straightforward an issue, but the problem then arises whenever a patient comes in with -- for example, a surgical problem or is felt to be a surgical problem, but in actual fact really it becomes aware to the doctors looking after the patient that she should really be under the care of a paediatrician. The surgeons may well do a procedure, an operation, and then the patient has got other complex medical needs. So then even though the patient hasn't moved out of ICU, a paediatrician or a cardiologist or whatever then assumes responsibility.
THE CHAIRMAN: So in Lucy's case, although you and your successors who looked after Lucy as paediatric anaesthetists had significant responsibility for her care, the overall responsibility lay with Dr Hanrahan?
A. In my opinion, yes.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: How would anybody know that?
A. How would somebody looking back?
Q. In the system --

A. In the system?
Q. Yes.
A. I can't answer that question. If the hospital computer system was to be interrogated because ... It would come up as Dr Crean as the consultant, but in practice Dr Crean was not the patient's principal consultant.
Q. Yes. Well, I mean, if one looks through the records, actually there are three consultants whose names appear on formal records. Dr Crean's name appears on the admission flimsy, your name appears on certain of the lab results. Just for example, if I pull one up so you can see, 061-033-099. There are a number like that. You see that you're up there on the top left-hand side, "Dr McKaigue, intensive care". That might be because you requested that test be carried out. Dr Hanrahan's name also appears on certain results. His name is on the EEG, for example. He's on the virus report that's done, certain tests, and there's one document where Dr Crean and Dr Hanrahan appear. That's 061-025-083 if we pull that up.
We can see this is paediatric intensive care unit, so this is the initial form that the nurse is filling in. She's got, as the consultants, Dr Crean and Dr Hanrahan. We asked Dr Crean about how he foresaw his role. In his witness statement, 289/2, page 2, in



answer to question 2, he says:
"It was not clear to me that I was the responsible consultant and I may have believed that I was only involved in a consultative role."
And he doesn't recall formally assuming responsibility. That issue of formally assuming responsibility is one which I think the chairman just alluded to earlier, which is an issue that arose in Claire's case as between Dr Webb and Dr Steen.
Dr Webb's position was: I was providing specialist input and advice and care; I had not assumed responsibility for that child. And ultimately Dr Steen conceded that, that it had not been transferred, and she accepted, almost using Dr Hanrahan's words, in the transcript of 15 October 2012 at page 94:
"Until it's formally taken over and there's a formal transfer and Dr Webb and I discuss it, I remain the named consultant."
She was on the flimsy.
Then when we asked the inquiry's expert Dr MacFaul about that, still in Claire's case, in his report, 238-002-106, paragraph 441:
"A consultant takes responsibility for all patients admitted under their care, either by planned or acute admission and then responsibility for continuing care of



patients admitted on their day-to-day on call for ongoing care and during that admission and subsequent follow up."
And there's a discussion in his report as to how you would transfer care formally from one consultant to another and his view was that something in writing, probably indicated in the patient's notes, would be required so that you see what the line of consultant responsibility is.
So bearing in mind all of that and particularly given Dr Hanrahan's own view, why do you still think that he was the consultant who had overall responsibility for Lucy?
A. The way that anaesthetists work in the hospital setting is that patients are never admitted under the care of an anaesthetist to a hospital. The only time that can happen is in the specialty of pain medicine. That is the practice throughout the UK.
Q. Are you saying then that Dr Hanrahan should have appreciated he did have that responsibility?
A. I can't really speak for Dr Hanrahan.
Q. But if that's the system --
A. I mean, I can't speak for what his understanding of it was.
Q. I understand.



A. But from -- I mean, it's very clear in my mind. I have understanding that I am certainly responsible for aspects of a patient's care whenever I'm on duty or on call in the intensive care unit. And then I hand over that responsibility to my colleagues. And as I've said previously, there is seamless cover all year from anaesthesia.
Q. What is the relevance of knowing who is the consultant for a child? What added significance does it bring over and above that any clinician treating a child has their professional responsibilities to that child?
A. Well, it means they have this overarching responsibility to, I suppose, ensure that all the appropriate things have maybe been done for a patient. That sort of responsibility. Although they don't actually do it themselves, they would be involved in commissioning other specialists to provide a consultation or whatever.
Q. So then it is important?
A. It is important, yes.
Q. Does that then mean that there should be clarity about who that person is?
A. Yes.
Q. If that's so, it shouldn't be possible for someone to say, "Well, I didn't think it was me"; it should be clear who has that responsibility.

A. Yes.
Q. Thank you. And in the system that you've described for PICU, given that on the flimsy they're going to have Dr Crean's name, which isn't an indicator of who has that kind of responsibility, is there anywhere in the system where you can identify who that person is?
A. In the intensive care unit?
Q. Yes.
A. I don't know. That would be -- is that the PAS system you'd be referring to?
Q. No, I just wondered when you had been lead of that, if somebody's asking, "How do we know after the event who the consultant was for a given child in PICU?", is there anything that you could point to?
A. The consultant who she went under at the start of her admission would be a good starting point.
Q. Yes.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: If we then go on to aspects of her care. From the point of view of the work that an anaesthetist does, you were leaving or transferring, if I can put it that way, responsibility to Dr Chisakuta.
A. Yes.
Q. Thank you. He would have responsibility for those aspects of her care for how long on that day? This is



the Thursday, the 13th.
A. Well, I was on duty until 9 o'clock, so he was --
THE CHAIRMAN: 9 am?
A. 9 am, yes.
THE CHAIRMAN: Thank you.
A. At 9 am, Dr Crean took on the anaesthetic responsibility for the intensive care unit. I suppose Dr Chisakuta had responsibility for Lucy in the half hour, 40 minutes, that I was unable to provide that direct care because she needed resuscitation.
MS ANYADIKE-DANES: So essentially, finishing off your shift?
A. Yes.
Q. And thereafter, the person who would have that responsibility would be Dr Crean?
A. Yes. And if you like, I delegated a task to Dr Chisakuta. My responsibility was to recognise that she needed this done. I couldn't physically do it and I delegated that task to Dr Chisakuta, who fortuitously happened to be early.
Q. So then if we sort of fast forward a little bit, that means, if you're going off duty, you don't have anything more to do with Lucy's care?
A. Not until I come on -- not until I'm physically on duty again in the intensive care unit.



Q. And when was that?
A. I was never on duty again in the intensive care unit with Lucy.
Q. Yes. So the person who will have come on duty to provide the anaesthetic care would be Dr Chisakuta on the Friday?
A. On the Friday, yes.
Q. Then she died that Friday. In terms of your rota you didn't come on to be involved in her care?
A. No.
Q. Were you about, nonetheless?
A. Yes.
Q. I'm going to take you on to the autopsy request form. Did you at any time discuss Lucy with Dr Hanrahan?
A. No.
Q. Did you discuss Lucy with Dr Crean?
A. My practice -- at some stage, and I can't remember exactly when, but at some stage I remember resuscitating the other patient in the intensive care unit. I recall Dr Crean being present. So I don't have a direct recollection of speaking with Dr Crean about Lucy, but I was present with this other patient and it's quite possible I would have said something to him.
Q. At least you wanted to know how she was at that stage?
A. Yes.



Q. When did you --
THE CHAIRMAN: Sorry. I think actually it might not have been quite so much wanting to know how she was because, in fact, you thought, realistically and really, she had no prospects.
MS ANYADIKE-DANES: No, I meant the stabilising point.
THE CHAIRMAN: I'm going on to something slightly different. Would you have wanted to know if anybody had worked out what had happened to Lucy?
A. Yes, I would.
THE CHAIRMAN: And wanting to know how Lucy had come to be in the condition that she arrived in? Can you remember who you spoke to about that?
A. After Thursday morning, when I --
THE CHAIRMAN: 9 am?
A. 9 am. I then made an entry in Lucy's chart at about half one, so I would have looked at the foregoing notes in her chart and I may have spoken to staff who happened to be around then. I can't remember specific details.
THE CHAIRMAN: Let me ask you directly, doctor, because you heard yesterday's evidence from Dr Chisakuta and Dr Stewart.
A. Yes.
THE CHAIRMAN: They both said in different terms that it was recognised fairly quickly on the Thursday that the

treatment which Lucy had received in the Erne was problematic.

When you spoke to anybody on that day, later on on the Thursday, did you, in whatever terms you heard that, did you hear that?

A. No.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: You're right, you did make an entry, it's timed at 13.40, 061-018-064. It comes immediately after quite a lengthy entry by Dr Hanrahan, who Dr Crean specifically asked to come and examine her from a neurological point of view, if I can put it that way. That, in turn, follows quite a long summary of her condition as she arrived, which is entered by Dr McLoughlin. She also enters the sodium results of 127 that weren't on that transfer letter.

By this time, 1.40, the notes from the Erne have been faxed and they're there, so what's available, if you're looking to try and see for yourself a little bit more about her, there's those entries since she's been admitted, and then there are her Erne notes and the transfer letter itself, of course.

So if you're looking ahead of where you've made your entry, what did you understand from those notes as to what had happened to Lucy?



A. Well, I don't recall seeing the Erne notes. I would have read through Dr Hanrahan's note and I would have -- I noted that the sodium was 127. That was one of the first entries, I think, in her ...

Q. Dr Hanrahan or Dr McLoughlin?

A. No, the telephone result.

Q. That's the telephone result at 9 o'clock by Dr McLoughlin; you'd have noted that?

A. I believe I would have read through the notes which began by -- which were begun by Dr McLoughlin.

Q. We can pull that up just to familiarise yourself with them. It's 061-018-058. Those notes, you mean, starting like that?

A. Yes.

Q. And she goes on. We can pull these up side by side so that you have an opportunity to look through them quickly. 061-018-059. In fact, you will see there, if you were looking at that, the final line is:

"Erne notes requested for further information."

So if you read that, would you want to know, "Have we got them yet, what do they show?"

A. Whenever I was reading the notes, I would have been scanning them quite quickly. I suspect I was by that stage ... I can't say that I took on board every point in the note.



Q. No, but you would see -- if you'd scanned just from there forward, you would see that you didn't have the Erne notes at that section. And since you had earlier, when I was asking you, expressed agreement with Dr Crean that you would want to see those notes, that that would be important. If you're trying to see what had happened to Lucy as you come now to make your entry, don't you wonder, "Where are the notes from the referring hospital? I don't see them".

A. I may well have wondered that. All I can say is I don't recall seeing the Erne notes. And at that stage, I was really -- my intention at that stage was to document my own note and I can't say that I read through in a lot of detail and gave a lot of thought to those entries.

Q. But aren't you interested to know why Lucy arrived in that condition?

A. I would have been interested, but there was no ... I don't think anybody had the answers at that stage.

Q. No, but I'm trying to see what you might have read so that you could have tried to get some of your own answers or at least ask anybody what their answers were.

A. Well, I didn't read through the notes with any great detail or particular thought, that would be my recollection. My frame of mind then, I had sort of been involved in another resuscitation and I suppose there



were other -- possibly other things on my mind. But I did not get into, you know, a sort of detailed analysis of these notes.

Q. A little bit further on in Dr Hanrahan's note, 061-018-063, I think you said you did look at Dr Hanrahan's note, his summary right at the top:

"Assuming the paralysis has worn off and she has been given no sedation, findings would suggest she shows no sign now of brainstem function."

You would have known, because you believed you were told during that first phone call before she even arrived that her pupils were fixed and dilated and they're certainly recorded as fixed and dilated when she arrives in the Children's Hospital so that they have been that way for some number of hours. And what Dr Hanrahan is recording, in his view, is that assuming that her presentation is not affected by medication, she's showing no sign of brainstem function.

Then if you look halfway down the page, he has some differential diagnoses, he's not sure, is it infectious, is it haemorrhagic shock, is there something metabolic going on? Then he says:

"Cerebral oedema for other cause."

And then:

"No cause is clinically evident as yet."

So what he's indicating there on those notes is he's not entirely sure what's happening, although I think it would seem that he thought that there was cerebral oedema. So those are questions he's posing. Did that not prompt you to want to ask him, almost from a professional point of view, "Where do we think we stand now with this child?"

A. Well, I don't recall ever seeing Dr Hanrahan. It was my intention at that stage to make my note in the chart. I had read his notes, there was a list of differential diagnoses.

Q. Yes.

A. And I thought that there were investigations in process and there may not have been any answers just at that point in time.

Q. If I can put it this way: you having finished your shift at 9 o'clock and you have a bit of outstanding business to do, which is you need to write up your note which you couldn't do contemporaneously; did you regard yourself as playing no further role in either Lucy's care or any investigations to find out what had happened?

A. At that point in time, yes.

Q. So that's it. When you go off shift, then you don't have a role any more or contribute to any discussion as to what might have happened to her?



A. You would still have an interest in a patient. You would still want to find out what's happening with a patient or what the cause of the collapse was.

Q. And what did you do about that interest that you still had?

A. Well, in Lucy's case I didn't pursue it at that time there.

Q. When did you?

A. The only other time whenever she was in was whenever I had spoken with Dr Chisakuta and found out that she had died.

Q. When was that?

A. That was, looking back on it, on the Friday.

Q. So you had an interest and you then spoke to Dr Chisakuta the following day?

A. Well, the following -- I had handed over my care and I think I may have spoken with Dr Chisakuta on the Friday and had found out that she had died and that her death had been referred to the coroner.

Q. Since what your interest was was finding out what had happened, was there any discussion between you as to what had happened in his view?

A. No, I can't recall the conversation I had with Dr Chisakuta. I just had the -- I knew that she had died and that her case had been referred to the coroner.



My impression was that it was not a coroner's case.

Q. It wasn't a coroner's case?

A. That was the impression I got.

Q. Impression from whom?

A. Dr Chisakuta.

Q. Dr Chisakuta didn't think it was a coroner's case?

A. After having a conversation with Dr Chisakuta, I had the impression it wasn't a coroner's case.

Q. And why was that?

A. Well, I can't remember the conversation. I just had that impression that it was not a coroner's case.

THE CHAIRMAN: Sorry, do you know if by that stage the exchange had taken place, which led to it not being a coroner's case?

A. No.

THE CHAIRMAN: It depends when you spoke to Dr Chisakuta that day because Dr Chisakuta agreed effectively that Lucy's death should be raised with the coroner and learned later that day that there was to be a hospital post-mortem rather than a coroner's post-mortem. So the impression that you got from him may depend on whether you spoke to him after the first stage or the second stage.

A. I can't remember that.

MS ANYADIKE-DANES: Did you have a view as to whether hers



was a case that ought to be reported to the coroner?

A. I didn't know anything, I had very limited input into Lucy's care and I had very limited knowledge arising from that, so I did not -- would not have been able to make a judgment on whether she was referred to the coroner.

Q. Well, you knew that she had died relatively suddenly in the scheme of things.

A. Yes.

Q. And if matters had not progressed from the entry that Dr Hanrahan wrote, which precedes yours, which is, "No cause is clinically evident yet"; he has differential diagnoses, but he hasn't got a clear clinical cause. If that had stayed like that, in your view, is that a case that should therefore be reported to the coroner?

A. Yes, if you don't know the cause of death then you have to report that case to the coroner.

Q. Thank you. So at some stage you learn from Dr Chisakuta that there's not going to be an inquest?

A. Yes.

Q. Do you learn that there's going to be a hospital post-mortem?

A. I can't remember if there was going to be a hospital post-mortem or not.

Q. Dr Stewart, who was Dr Hanrahan's registrar, was tasked

to complete the autopsy request form. In her evidence to the PSNI, her statement to them, at 115-022-002, says:

"I stated on the autopsy form that the clinical diagnosis was dehydration and hyponatraemia, cerebral oedema, acute coning and brain death. This was the working pathogenesis agreed by Dr Hanrahan and the anaesthetists in the absence of a definitive aetiological diagnosis."

Then she goes on in her witness statement for the inquiry, 282/1, page 12, because we asked her who she meant by "the anaesthetists", and she says:

"The anaesthetists involved in looking after Lucy were Dr McKaigue, Dr Crean and Dr Chisakuta. There may have been others working in PICU who I cannot remember."

She indicates, therefore, that you were part of a group who assisted in formulating the working pathogenesis that she would include on that autopsy request form. Can you remember anything like that?

A. No.

Q. Could it have happened and you just don't remember it?

A. I don't think so, because I did not have any, really, knowledge of what was going on with Lucy.

THE CHAIRMAN: In essence, doctor, do I understand you to be saying, "I had some initial involvement in Lucy's case,



but substantively it was handled by my colleagues rather than by me"?

A. Yes.

THE CHAIRMAN: And that explains why you don't remember contributing to later discussions about the cause of death or whether it's to be referred to the coroner or referred back to the coroner?

A. No.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Can you help us with how she could have put you in that category? If we look at the top of this, you can see the question that was put to her:

"I stated on the autopsy form that the clinical diagnosis was dehydration and hyponatraemia, cerebral oedema, acute coning and brain death. This was the working pathogenesis agreed by Dr Hanrahan and the anaesthetists."

Then the question she's asked is:

"Identify the anaesthetists who agreed this working pathogenesis."

And then she says:

"The anaesthetists involved in looking after Lucy were ..."

And she names you there. It may be that she's not answered the question, she's just listed you as the



anaesthetist who, as far as she was concerned, were involved in looking after Lucy or she may mean by that you were one of those who assisted in formulating the working pathogenesis. But in any event, are you saying that you don't remember doing that and you don't think it's likely that you did?

A. Yes.

Q. Did you get to see Lucy's notes in more detail at any stage since or have you at any stage since?

A. Well, I've seen her notes on the inquiry website.

Q. Yes. Have you seen her notes at any stage after you had your discussion with Dr Chisakuta? Or was the last time you saw her notes before you saw them on the website when you made your own entry?

A. The last time I saw her notes was whenever I made my entry.

Q. And you didn't see them again until you saw them on the inquiry website; is that correct?

A. Yes.

THE CHAIRMAN: Would you not have seen them when you were asked to make a police statement? Would you not have checked them at the time you were asked to make a police statement just to refresh your memory? You gave your police statement in March 2005, which was almost five years after the event. I'm not trying to trip you up,



but I would have thought that before you made a police statement that you might have looked over the notes.

A. That's a point, yes. I hadn't thought of that.

THE CHAIRMAN: In any event, that's after what actually happened to Lucy has been revealed.

A. Yes.

THE CHAIRMAN: And after the documentary has been broadcast. Thank you.

MS ANYADIKE-DANES: Even if you didn't see them at any time after your direct involvement with her and the entry in her notes, did you know what the clinicians thought were the clinical problems, if I can put it that way?

A. No.

Q. Let's just be clear. If we look at the relevant page of the autopsy request form, it's 061-022-075. Up at the top is what has been identified as the clinical problems. I think Dr Stewart conceded that she wasn't actually putting them in the order of importance; she was putting them in the order in which they would have occurred, if I can put it that way. So the child starts off with vomiting and diarrhoea, she becomes dehydrated, then I think she conceded there's probably a gap there. Something else happens, as a result of which she becomes hyponatraemic. She then has a seizure and becomes unresponsive, leading to brainstem death. Had you had

any discussion or formed any view about those clinical problems in relation to Lucy?

A. What was the question? The question being?

Q. Had you had any discussion with anyone about those being the clinical problems? Did you yourself have any view as to the extent to which those were the clinical problems involved with Lucy?

A. At what time -- what time is this?

Q. At the time you last made your entry and were discussing with Dr Chisakuta. You make your entry on the Thursday, you have a discussion with him the following day. That seems to be, from what you said, more or less it so far as your involvement with Lucy. So I'm asking you, at that stage, had there been any discussion that you were aware of as to these being the clinical problems or did you yourself form a view that these might be the clinical problems?

A. I didn't have a discussion with anybody about those clinical problems and I hadn't formulated in my own -- I knew there was a number of clinical problems, but I hadn't formulated anything or constructed anything out of what I knew her clinical problems were.

Q. Did you have any thought that she had suffered vomiting and diarrhoea?

A. Yes, I had a thought, yes.



Q. Because you pointed out the 127 serum sodium result, so had you any thought that maybe as a result of that vomiting and diarrhoea she had become dehydrated?

A. The dehydration, yes, would have been a feature of vomiting and diarrhoea.

Q. Yes. Even if you hadn't looked at it at the time he handed you the transfer letter, it at least says that, "Slow capillary refill greater than 2 seconds".

A. Yes.

Q. So there's some suggestion of dehydration and she's on IV fluids. Had you any thought then, when you saw the result of 127, she's become a bit hyponatraemic?

A. I can't remember my thoughts, crystal clear thoughts at the time, but the hyponatraemia was in keeping with diarrhoea.

Q. Yes. And a serum sodium level of 127 is to be hyponatraemic.

A. Yes.

Q. We'll get into an issue as to the degrees of hyponatraemia and its implications and consequences, but that is to be hyponatraemic.

A. Yes.

Q. And if you'd even the most cursory glance at the information that she came with, or even Dr McLoughlin's notes, would have let you know that she was 137 when she



was admitted, so she's dropped 10 millimoles.

A. Yes.

Q. And you had thought when you first received the telephone call that you might be dealing with a child who had cerebral oedema.

A. Yes.

Q. So if you had wanted to know what had happened to Lucy, which you told the chairman you did want to know, you had some pointers there that might have started at least some enquiry with your colleagues who were treating her as to what they made of these things. Dr Chisakuta most obviously because you'd transferred your management to him and he had been looking after her on the 14th.

A. I don't recall the conversation I had with Dr Chisakuta. All I can recall is what I had learned from it, that her death had been reported to the coroner and that -- I was under the impression that there wasn't an inquest, so I had -- I didn't ... I don't recall raising these issues with Dr Chisakuta. I can't remember the conversation.

Q. Wouldn't that be even more the reason because that would mean that you're not going to find out, whatever was Lucy's problem, through an inquest? What I'm really trying to explore with you is why just at the level of professional interest or curiosity, almost, you weren't asking Dr Chisakuta, who looked after her that second



day when she then died, exchanging a view with him as to what he thought was the problem.

A. Well, I don't recall doing that.

Q. In your first witness statement for the inquiry, 302/1, page 9, you say:

"There were discussions between myself and my anaesthetic colleagues about Lucy's death, but I cannot recall discussions about her cause of death."

If we pause there for the minute, the question of course is:

"Was Lucy's death and/or the cause of her death the subject of discussions between you and your medical colleagues in the Children's Hospital?"

If we just pause there. Your answer is:

"There were discussions."

So in answer to the first bit:

"Yes, there were, but [you] can't recall any discussions about her cause of death."

So what are the discussions you think you did have with your discussions and who are the colleagues?

A. I have no recollection of the discussions with Dr Chisakuta. With Dr Crean -- this is like discussions going on possibly for, you know, over the years and following since the inquiry was set up. So there would have been discussions with Dr Crean then.

Dr Chisakuta -- I had a conversation with Dr Chisakuta and I was told that Lucy had died and her death had been referred to the coroner. That was the conversation I had with Dr Chisakuta.

Q. What it says below, it says, "See 11(i)":

"I had discussions with Dr Crean and Dr Chisakuta. I was aware that Lucy had hyponatraemia, she died, and that would of itself have been mentioned."

What do you mean there exactly?

A. Well, that, I think, referred to discussions with Dr Crean.

Q. Are these still discussions that you say happened much later on, not at the time?

A. Yes.

THE CHAIRMAN: Can I ask you this: long before the inquiry was set up, there was a belated inquest into Lucy's death; isn't that right? In fact, it was one of the points of the documentary in October 2004 that Lucy's death had been missed, to put it neutrally, and that it was only after Raychel's inquest that Stanley Millar and the Western Council had picked up a similarity between the cases. When that happened and when Lucy's death was then made the subject of a coroner's hearing, that must have been an embarrassment within the Royal, I suggest.

A. I just didn't catch the last bit of that.



THE CHAIRMAN: I suggested that must have been an embarrassment within the Children's Hospital because the outcome of the inquest was to change fundamentally the reasons which had been given from the Children's Hospital for Lucy's death. There surely must have been significant discussions in the run-up to Lucy's inquest about how things had gone wrong in the Royal, not in the sense of the treatment of Lucy, but in the sense of not recognising or making known the real cause of her death.

A. I am not aware of discussions with that theme, the second theme. But the first theme, I said that I became aware from Dr Crean there were issues around Lucy's fluid management, and I think that was in the run-up to the inquest.

THE CHAIRMAN: Well, maybe you'll correct me. It seems to me from the outside that it should have been a cause of some embarrassment to the Children's Hospital when the coroner did call an inquest into Lucy's death and he will have seen the death certificate, which Ms Anyadike-Danes is going to go on to in a few moments, and the information which was available to the Royal in 2000 to suggest what Dr Chisakuta and Dr Stewart told me yesterday, namely that there were big issues about fluid management. Was that not an embarrassment within the



Children's Hospital in 2002/2003?

A. From outside looking in, yes. Inside, I don't recall that being discussed as an embarrassment.

THE CHAIRMAN: Did somebody even say, "How on earth did we miss that"?

A. Not that I'm aware of.

MS ANYADIKE-DANES: Do you think it was missed? It was there to be seen but was missed.

A. I'm -- speaking retrospectively?

Q. Yes.

A. I think I have the benefit of the inquest and all the expert reports to --

Q. No, please don't use that benefit.

Since you have looked at Lucy's notes, which you say you have had access to because they're on the website, so you have seen the notes that came from the Erne, you did read some part of the notes before your own that were recorded in PICU and you'll have seen the notes subsequent to your own. In the light of all of that, do you not think that there are issues there that could have pointed to the concerns about Lucy's fluid management that seemed to have been missed?

A. My thoughts on the fluid balance chart are that it's difficult to say how much fluid Lucy actually got. I mean, I haven't gone -- I haven't studied it in a lot



of detail, but I've picked up from experts that that was part of the problem, the record keeping was unclear.

Q. Dr McKaigue, you don't have to pick up from the experts the fact that it is recorded in her notes that she received 100 ml an hour of No. 18 Solution. I mean, you don't need an expert report to tell you that. That much of it is clear. She was getting that rate from about 10.30 or 11 o'clock at night and, by 3 o'clock, she has had a fatal collapse. You, as a consultant paediatric anaesthetist, could work out what her appropriate maintenance rate of fluid should be and, if she was a bit dehydrated, which there are indications of on her notes, then you could work out, given a certain level of dehydration -- possibly mild, maybe moderate -- what the replacement should be. And having worked that out, you could compare that with what is recorded on her notes.

You don't need an expert to tell you that; that is exactly what you would have had to be doing if you had not been called away and her notes had accompanied her. You'd have to be interpreting those notes and formulating a plan.

A. I thought I was commenting on events after --

Q. No, what I was inviting you to do is to consider whether or not the problem with Lucy in terms of her fluid management regime at the Erne was missed at PICU.

That's what I was inviting you to consider.

So I was taking you to some of the elements that were in her notes and asking you whether there wasn't enough there for the four consultants who saw her one way or the other to have figured out there was a problem with her fluid management?

THE CHAIRMAN: Sorry, I've contributed to this line of questioning and I think it's probably not productive because the reality of yesterday's evidence is that it wasn't missed at all.

The fact is, on yesterday's clear evidence to this inquiry, the fluid management problems were not missed within the Royal. They were identified and a decision was taken to keep quiet about them.

Let's move on. To be fair to Dr McKaigue, his role in that was, if he had a role at all, is significantly less than the role of the other doctors.

MS ANYADIKE-DANES: Yes, Mr Chairman.

THE CHAIRMAN: That's why I started this morning by asking for the Belfast Trust, as successor to the Royal Trust, to consider the evidence it was going to present to the inquiry.

MS ANYADIKE-DANES: I would like to show you the medical certificate that was issued. This is the medical certificate that was ultimately issued for Lucy. As



you know, she hadn't had an inquest, she had a hospital post-mortem, and after that this certificate was produced. Can you help us with whether you think it makes sense?

A. On the face of it, dehydration -- and this is -- I'm interpreting this now with the knowledge I've acquired subsequent to Lucy's death.

Q. Sorry? Are you meaning that you needed knowledge subsequent to Lucy's death to know whether there is any difficulty in having dehydration cause cerebral oedema?

A. Well, as I said previously, I knew of specific diagnoses in Lucy's case, but I hadn't formulated -- I didn't know enough about her to formulate something.

Q. That's not the question. If you look at that death certificate:

"Cause of death [first line]: cerebral oedema due to (or as a consequence of) dehydration."

Does that make sense to you?

A. Dehydration as a direct -- cerebral oedema as a direct cause of dehydration?

Q. It's actually the other way round. It says dehydration causes the cerebral oedema.

A. Well, it doesn't -- on the face of it, it doesn't directly cause --

Q. Yes, it doesn't. So just put like that, it doesn't make



sense.

A. But indirectly it could.

Q. And how would that be?

A. Well, through treating the dehydration.

Q. Isn't that what would cause it then? Because it's not a natural consequence of treating dehydration that you end up with cerebral oedema; if you over-rehydrate you could.

THE CHAIRMAN: It's Dr Stewart's point yesterday afternoon, isn't it, that you heard?

A. Yes.

THE CHAIRMAN: It's the rehydration of Lucy which caused the cerebral oedema; right?

A. Yes.

THE CHAIRMAN: She had gastroenteritis, that made her dehydrated. She had to be rehydrated. As a result of the way in which the rehydration was carried out, she developed cerebral oedema. And what's missing from that death certificate is the fact that the cerebral oedema comes from the rehydration; the rehydration is a result of clinical intervention; and it is that clinical intervention and that rehydration which is missing from the death certificate.

And as Ms Anyadike-Danes asked yesterday afternoon, and Dr Stewart said yesterday afternoon, if that



appeared on the death certificate, it becomes a requirement to report it to the coroner because the death follows clinical intervention. I'm summarising what Dr Stewart said late yesterday afternoon. In a sense, what I'm asking you is whether you disagree with what Dr Stewart said or whether you have anything to add to it?

A. Well, I agree that -- I suppose what ... Am I being asked could you, under any circumstances, write a death certificate like this?

THE CHAIRMAN: Yes.

A. Only if you accept that dehydration indirectly could cause cerebral oedema.

THE CHAIRMAN: Right. And so you can write that death certificate if you leave out the step which turns dehydration into cerebral oedema?

A. Yes.

THE CHAIRMAN: But that's not how you write death certificates, is it?

A. Well, there's no space to write rehydration.

THE CHAIRMAN: Well, there is. Line (b), "cerebral oedema due to rehydration".

A. But rehydration is not a disease, it's a treatment.

THE CHAIRMAN: Right. So if you're saying it's indirect -- okay. We have the death certificate which was

ultimately issued by the coroner.
A. Could I see that, please?
THE CHAIRMAN: Yes. It will be in file 13. 013-034-130, paragraph 10:
"Cause of death: cerebral oedema, acute dilutional hyponatraemia, excess dilute fluid, gastroenteritis."
Does that make more sense?
A. Yes, it could cause it -- well, you're getting more information on that death certificate.
MS ANYADIKE-DANES: Sorry, what was that?
A. You're getting more information on that death certificate --
Q. It's not just you're getting more information, you're getting logical information.
A. Yes, but you're using another line to get that information, are you not?
Q. Is there anything wrong with using another line? You can insert. The purpose of the death certificate is to have an accurate record of the cause of death.
A. But under the guideline -- I don't know if you can insert a line in a death certificate. I mean --
Q. If you can't then insert a line, then the death certificate, as it was ultimately provided, that's all right? Even though, on the face of it, what it actually does is disguise the fact that there was clinical



intervention? That's actually where we're coming back to. The point about it all is what's left out is an indication of clinical intervention and that is why I was asking you. Because if there is clinical intervention, you actually can't write the death certificate, you have to report it to the coroner. That's why I asked you whether you didn't think there was a problem between the cerebral oedema and dehydration and, ultimately, you've answered that it's actually the way you address the dehydration, which is the clinical intervention. You seem to be struggling with that.
A. But there's no space in the death certificate to write --
Q. Leave aside the space. If you had formed that view, does that not mean you have to report it to the coroner?
A. If you had formed that view, yes.
Q. Yes. And is it not a consequence of having got dehydration there as a problem and the cause of death as being cerebral oedema that there must be something in between those two things? Leaving aside whether there's a space to put it on the death certificate or not, there must be something in between those two things.
A. Well, on the face of it, yes.
Q. Thank you.



A. There must be something.
THE CHAIRMAN: You're unhappy about this, doctor, are you?
A. Well, it's ...
THE CHAIRMAN: When you were saying about rehydration a few moments ago, you said you can't put on rehydration because it's not a condition, it's the act of re-hydrating.
A. Yes.
THE CHAIRMAN: The way that that has been addressed by the coroner is that it's to address the hyponatraemia, to include the hyponatraemia, which is what was omitted from the death certificate in the Royal.
A. And gastroenteritis then has been put to line 2.
THE CHAIRMAN: Yes, because that's -- the sequence is, I think Lucy gets gastroenteritis, she becomes dehydrated, which is why her GP refers her to the Erne, she then begins to receive fluid -- which is described here as "excess dilute fluid" -- it leads to acute dilutional hyponatraemia, which leads to cerebral oedema.
A. Yes, but you would need four lines, would you not, on the death certificate? You'd need 1(a), 1(b), 1(c) and 1(d) for that sequence, would you not?
THE CHAIRMAN: I'm not sure how much we want to spend on this, but I'm not sure you are ... What's omitted from



the Royal's death certificate is the critical line of hyponatraemia. What brought about the cerebral oedema was hyponatraemia; that's the one thing which is missing from the certificate.
A. Yes. Is it missing because -- I mean, I ...
MS ANYADIKE-DANES: Mr Chairman, I think we can help on this because, in fact, Professor Lucas has addressed it. It's 252-003-014. Before I go to that, I should say, first of all, he looks at the death certificate as it stands as you have just been considering it.
He says it is illogical: dehydration is not going to directly cause brain swelling. Then he looks at these different formulations. At the bottom is the coroner's one, which the chairman was taking you to. And you can see that you don't need an extra line because gastroenteritis goes into 2. If we bring back the death certificate next to this, there you are, you see there's 1 and 2 in the box for cause of death. You must have seen these sort of things before. There's 1; 1 is composed of 1(a), (b), (c). Then there's 2:
"Other significant conditions contributing to the death, but not related to the disease or condition causing it."
What the coroner has done with his formulation is he's got cerebral oedema as the disease or condition

directly leading to the cause of death. That's at (a). Then:

"Due to (or as a consequence of) (b) acute dilutional hyponatraemia."

That's on the second line. Third line:

"(c), excess dilute fluid [and], 2, gastroenteritis."

So if you wanted to convey the accurate information on the cause of death as it was thought to be, it could be done, not that that is a death certificate that you should have been sending in like that, but it could be done. Sending it in like that without having reported to the coroner.

A. I have seen Professor Lucas' report. He's formulated a different death certificate, hasn't he?

Q. I was taking you to an explanation as to how the coroner's formulation is to show you that the information that the chairman was putting to you can be inserted on the death certificate form because there are enough, to use your expression, lines on it.

In any event, this line of enquiry, if I can put it that way, only started because I was asking for your observation as to whether, in your view, it made sense to have cerebral oedema being caused by or due to dehydration, and I think you've answered that to say not



unless you're talking about the response to the dehydration.

THE CHAIRMAN: Indirectly, I think was --

MS ANYADIKE-DANES: I took that's what you indirectly meant: the treatment of the dehydration could lead to cerebral oedema.

A. Would it be possible to see Professor Lucas' ...

THE CHAIRMAN: If you take down the right-hand side of the screen and give us 252-003-015. Is that what you're referring to?

A. Mm-hm.

MS ANYADIKE-DANES: In fact, he has been able to get the rehydration for the dehydration point that the chairman was putting to you all on 1(b), and then you can put your gastroenteritis, if you want to, on line (c). So you don't need an extra line once again.

A. The guidelines that were present at the time, 2000, only allowed you to put one disease on the line. Now, I think there are new guidelines out there or clarification of the existing guidelines which allow you to put more than one cause on the line.

Q. Then let me approach it a different way so that we don't get ourselves too bogged down in the technicality of it.

If you had formed the view that the problem for Lucy was the way in which they had responded to the



dehydration, they had in fact over rehydrated her, and, as a result of that, she had developed cerebral oedema, which proved to be fatal, if you had reached that view, what in your view do you do as a result of that?

A. You refer that death to the coroner.

Q. Thank you.

THE CHAIRMAN: But on the death certificate -- do you put cerebral oedema and then, next line, hyponatraemia?

A. Under the cerebral oedema, hyponatraemia, and what would the third cause be?

THE CHAIRMAN: Well, whatever the third cause is, the critical thing which is missing surely from this death certificate, which was signed on 4 May 2000, was the hyponatraemia? I mean, whatever you put on the third and fourth lines and so on, is the critical issue, doctor, not the omission from the death certificate of hyponatraemia?

A. If you had that understanding that hyponatraemia had caused the cerebral oedema, which you then --

THE CHAIRMAN: If you had that understanding, then if that was the understanding, then that would go on to the death certificate?

A. Yes.

THE CHAIRMAN: Okay. Let's move on. Look, it's 1.30. I'm hoping that if we can sit on a little longer, we can



finish Dr McKaigue and finish for the day. Is that okay? Thank you.

MS ANYADIKE-DANES: You completed the PICU coding form; is that correct?

A. Yes.

Q. We can pull it up. It's 319-019-002. What is this supposed to indicate? What's the purpose of this form?

A. I have given evidence to the inquiry before about the purpose of this form. It was in my transcript when I gave evidence in Claire Roberts and --

THE CHAIRMAN: Yes.

A. -- without following it chapter and verse from before, this is essentially --

MS ANYADIKE-DANES: What I think you said, if I help you, because I'm conscious you don't have that in front of you. You say:

"The form have a very specific purpose and that was to improve the depth of clinical coding. This was achieved by recording information about the reason for a patient's admission to PICU and then to document various interventions, investigations and complications to indicate the severity of their underlying clinical condition and that that form could then be used by management within the Trust to better understand the type of patients we were treating."

And:

"Ultimately I believe that the goal was to make available to the Trust hard information which could be used, if necessary, in some sort of benchmarking exercise when funding was being allocated."

So you want to look at the kind of cases you're dealing with them and the incidences of them; would that be a fair way of summarising that?

A. Yes.

Q. So if you wanted to do that, you have put down the interventions in relation to Lucy, if I can put it that way, and some of her conditions, so a seizure was a condition, she had respiratory arrest, she developed cerebral oedema, brainstem coning, but she was intubated, ventilated, she had a central line, an arterial line, CT scan, and she developed hyponatraemia.

So if you were doing that -- not you personally, but if that was being done systematically with paediatric deaths, that would allow you to see the incidence of hyponatraemia.

A. Yes.

Q. That would be one purpose of it, not the only one, but one purpose of it.

A. Yes.

Q. So it would be quite important that those PICU forms are



filled in accurately so they can have that benefit. And you have put hyponatraemia there. It's dated 13 April 2000. Why did you put hyponatraemia there?

A. Because I knew the patient had hyponatraemia.

Q. In order to complete a list like that to identify what had happened, the interventions, and the results, if I can put it that way, what do you have access to?

A. You have access to her -- to find out all the relevant information about the patient, you have access to the chart and whatever other members of staff tell you.

Q. So you'd have to be looking at all her notes to make sure you had captured properly the information to make of it best use for the purpose that I have just read out that you gave to us?

A. Yes, but this was filled out, I would imagine, at the time I was -- either shortly before ... Before I made my retrospective note or in conjunction with that. So a lot of this --

Q. Sorry, before you made your retrospective note? But your retrospective --

THE CHAIRMAN: Or at the same time?

A. In conjunction, at the same time, yes.

MS ANYADIKE-DANES: What happens if more things are involved with the patient? Do you not then go on and add on to your coding form?



A. That was the intention for that to be done.

Q. So you'd got hyponatraemia by the time you were making your retrospective note at 1.40 on the Thursday, her day of admission?

A. Yes.

Q. So you had looked at her notes?

A. Yes, I knew she had hyponatraemia.

Q. Apart from looking at her notes?

A. Not apart from looking at her notes.

Q. That's what I'm saying: you looked at her notes.

A. Yes.

Q. In your witness statement, though, for the inquiry, 302/1, page 9:

"I personally did not give consideration to the cause of Lucy's death."

And then at 302/2, page 3:

"At that time I was not [and I think at that time is when you were completing this] in a position to form a view as to the sequence of events leading to Lucy's clinical deterioration and ultimately her death."

So what's the procedure then? You start off one of these forms putting in what you can from matters that have emerged up until that time?

A. Yes.

Q. And then somebody else puts in some more?



A. That was the intention of the form.

Q. And so should any more have been added to this form after Lucy died or to reflect what happened on the next day?

A. Yes, because I -- I mean, a similar type of form was filled out by me in Claire's case.

Q. Yes.

A. And from memory, I think there was brainstem death testing. That form -- it's not an exact thing and it's not meant to be totally exact. There was no, if you like, strict protocol to guide you on completing this form. So my view of what I thought was important may differ from somebody else's in the absence of a set of rules.

Q. Sorry, pause there. Why isn't there one? Because is not the benefit of it that these things would be standardised so you're comparing like with like when you're interrogating the system to look at the incidence of any given condition or any particular intervention?

A. The form from -- my recollection of the form was that it was meant to be very simple, straightforward, easy to use, free text, to try and capture in as quick and efficient a way as possible more information about the patient. It was meant to be easy to use and we didn't have any -- apart from the aspirational point of view,

we didn't have any detailed guidelines that you followed, a set of rules, a Highway Code to dictate what went on the form.

Q. That's why I was asking you that. Why didn't you have those?

A. We weren't that sophisticated.

Q. Why was it you who was completing this form?

A. Because I was the consultant on, whenever she first arrived, I initiated the form, but I wouldn't have been responsible for completing it. I initiated it up until 13.30.

Q. Sorry, does that mean as soon as she arrived, you start putting an entry on?

A. No, no.

THE CHAIRMAN: You were the person initially responsible when she arrived in the hospital?

A. Yes.

THE CHAIRMAN: Can I ask you this: since 2000, has the practice for completing these forms changed?

A. Yes, insofar as we don't use it any more. We don't use it any more.

THE CHAIRMAN: Is there an alternative system in place? If I'm taking you down a side track, tell me to stop.

A. We have another database called PICANet, which is a national database, and it's got very strict protocols



and guidelines, and the whole point of it is, yes, you can compare how you're doing with 24 other paediatric hospitals or whatever. This was amateur-ish.

THE CHAIRMAN: PICANet is P-I-C-A-N-E-T?

A. Yes, I think that's the name of the thing, PICANet.

MS ANYADIKE-DANES: How long did this go on for, this use of this system, so far as you are aware?

A. I think it was maybe on its last legs.

Q. And just finally, because you'd indicated that there was an intention to perhaps put further information on. For example, her brainstem death tests; would those have gone on this?

A. Yes.

Q. And who would be responsible for adding to that?

A. The consultant who did the brainstem death tests.

Q. So is that how it works, it's whoever perform the intervention adds on to the form as opposed to, for example, her consultant?

A. Yes. The way I would have understood it to work would have been, if I was on, on a particular day, and new problems came to light or new investigations were planned or had been done, I would update that form, so if a patient had an MRI scan two weeks later, then on the particular date I would record that because that's all more of the same.



THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Can I then move to the audit meeting? Sorry, just before I do that, I think I understood from your evidence that you didn't actually know that there had been a hospital post-mortem.

A. No.

Q. When we were dealing with Claire's case, Claire also had a hospital post-mortem, brain-only though, and there was quite a bit of evidence then that after the hospital post-mortem and perhaps some time before the autopsy report is finalised, as part of clinicopathological correlation, there are meetings between the pathologists and the clinicians. Dr Herron and Dr Mirakhur gave quite detailed evidence as to how that is, how the consultant is notified about it, it's a multidisciplinary meeting and there's sometimes a fairly robust exchange of views as to exactly what happened in terms of the patient's cause of death. Is that something that you remember? I don't mean remember in relation to any given child, but a system that you remember.

A. I wasn't actually very aware of that. I didn't think that clinicians walked over to the pathology department and took part in meetings like that. There aren't very many post-mortems, hospital post-mortems, done in



children. So it may well have gone on, but just through the very small volume I wasn't aware of it. I don't dispute what they're saying.

I would imagine there are a lot more adult post-mortems done, so the same procedure would be operating there. But I don't have any -- I never was at one myself and I don't really -- wasn't really aware that other clinicians had been to that.

Q. But in any event, you don't recollect that there was any meeting of that sort after the autopsy to try and get a better idea as to Lucy's cause of death? You're not aware of that?

A. No.

Q. Then let's move to the audit meeting. The audit meeting takes place on 10 August. There's an attendance sheet for it. If we can pull up, it starts at 319-023-003. There you are. On that, you can see your signature is there and your name is there, "consultant anaesthetist", on the left-hand side, about halfway down. Dr Taylor is up at the top. Do you recall that, that you signed that?

A. Yes.

Q. The purpose of those, in your witness statement to the inquiry, 302/2, page 2:

"My recollection of the purpose of the presentation

and discussion of mortalities at audit meetings in 2000 was to use the forum as an opportunity to present the events surrounding the death of patients in the Children's Hospital primarily to a wider body of doctors [multidisciplinary] and, further, at that time, there was a push within audit circles to establish audit as a multi-professional process -- nurses and professions allied to medicine -- before the presentation."

You go on to say:

"The presenter would have had to collate and organise in a logical way the different strands pertaining to the case. The death was not only being reviewed by the presenter, but also by peers and other disciplines who could bring a different perspective to aspects of the case and implicit in this process was the opportunity to learn and reflect from listening to the presentation and ensuing discussion."

So that, from what you could tell, is what was going to happen in relation to the five cases that were up for discussion at the audit meeting in August. Lucy's was one of five. What, so far as you can recall, is the result of a meeting like that?

A. The result meaning something official, or ...

Q. What's supposed to be the outcome? You say it is a forum, there's an exchange of views, it's



multidisciplinary, so it's very helpful from that point of view because you bring the different specialisms to it. And the intention is that there should be learning.

So if in the course of that it's identified that there is a form of treatment that has been detrimental, what happens as a result of that if something like that is identified?

A. One would hope that individuals would take note of that.

Q. But is there no --

THE CHAIRMAN: I suppose that depends on the extent of the lesson to be learned? It might be something which can be resolved at the meeting or it might be something more important, which becomes formalised?

A. Yes.

THE CHAIRMAN: Right. But in Lucy's case, on yesterday's evidence, there was a recognition that something had gone wrong and would I be naive to think that if that was recognised even before she died that that should then be discussed and form part of the discussion in the audit meeting in August?

A. Yes. If it was recognised, that would be the intention of having audit as part of the commentary to the presentation -- highlight to the meeting that here was a problem.

THE CHAIRMAN: And the presentation involves somebody



outlining what had happened in respect of each of the children who was being discussed at the audit meeting; isn't that right?

A. Yes.

THE CHAIRMAN: So is it not the case that, on any analysis of what happened with Lucy, it would have been apparent that there were questions to be asked about the treatment she received in the Erne?

A. Questions could very well have been asked, yes.

THE CHAIRMAN: And if questions are to be asked about what happened in the Erne, how is that taken forward from an audit meeting?

A. The audit meeting -- there was a ... If there were learning points, important learning points to be made, then I would imagine there must have been a mechanism to deal with those. In terms of -- I mean, whether, say, individuals or particular interests maybe said that they would take that away with them and look at it, but I don't know if there was a formal system to document and record those things.

THE CHAIRMAN: Well, you see, doctor, in a sense this one was or seems to me on the state of the evidence that I have now -- and it may change over the next few weeks -- but on the evidence that I have now this was almost easy for the Royal because nobody's pointing the



finger at the Royal for the way in which Lucy was treated; the finger's pointing at the Erne for the way in which Lucy was treated. So when the audit meeting took place in the Royal in August, nobody had to blame anybody else who was in the room who worked for the Royal for what had gone wrong. But if there was any discussion or analysis of what happened in Lucy's case, surely it must be recognised that the Erne has questions to answer or lessons to learn, to put it more positively?

A. Yes.

THE CHAIRMAN: How does the Erne learn those lessons? If the Royal thinks that the Erne has lessons to learn, how does the Royal tell the Erne what those lessons are?

A. I don't know what way things were done historically. I don't know of any reporting mechanism.

MS ANYADIKE-DANES: Was there any discussion that that might be a helpful thing to develop? Because the Children's Hospital, because it was the kind of hospital it was, the only one with a paediatric intensive care unit, it's a regional centre and so on, it's likely to receive children who have been referred from hospitals where there have perhaps been issues in relation to their care, and so you will see them and you are the experts, if I can put it that way, there in PICU. Does

that not put the Children's Hospital in a very good position to disseminate some of that learning?

A. If I can address that in 2013, it's a complete sea change.

THE CHAIRMAN: Okay, tell me about 2013 and then we'll go back to 2000.

A. In 2013, incident reporting is mandatory. That's my understanding. The Trust have got guidelines on incident reporting and they define what it is and there is an online computerised database where you report the incident and it takes about five minutes to fill that out. That then is sent initially to a local -- somebody reasonably local. If it wasn't theatre or intensive care, there's a local reporter. It goes also to a sort of governance, the governance structures in the hospital as well. I'm not -- I mean, I'm sort of telling you in a sort of conversation what I think happens next, I'm not -- I don't want this to be definitive. But essentially, the initial assessor decides how much weight or how serious it is and then obviously, hand-in-hand with that, they then look at trying to prevent things. Is there learning to be had from this? And it's actually an increasing part of our lives to actually participate in this.

THE CHAIRMAN: Okay. Let's go back to 2000. Let's not just



confine it to Lucy or to hyponatraemia, but occasionally you must have had children coming into the Royal who had been inadequately treated elsewhere; would that be right?

A. There would be sub-optimal treatment, yes.

THE CHAIRMAN: If that is recognised in the Royal, how then do the doctors or nurses in Craigavon or Daisy Hill or the Erne get told that this is the mistake you made in our eyes and this is how you avoid it?

A. In 2000?

THE CHAIRMAN: Yes.

A. That would have been, I think, a telephone call.

MS ANYADIKE-DANES: Would that happen?

A. I believe so, yes.

Q. Would you have regarded Lucy's as a case where, if the clinicians -- maybe not you because you've said you weren't that familiar with her case in order to form those sorts of views, but the chairman heard yesterday from Dr Chisakuta and Dr Stewart that in their view those who were more directly involved with her treatment did regard there to be a real concern over her fluid management in the Erne. So assuming that to be the case, is that the sort of instance which you think would have warranted a telephone conversation with her clinicians at the Erne?



A. I have to say yes.

Q. Thank you. Are you aware of that actually happening?

A. Did it happen?

Q. Yes.

A. To the Erne?

Q. Yes.

A. No.

Q. You know that it didn't?

A. I have no knowledge that it did, no. I have no knowledge that it didn't happen.

THE CHAIRMAN: Can I ask you one more thing about that? Who makes the call? Or is that agreed at the meeting?

A. At what the meeting is that?

THE CHAIRMAN: The audit meeting. Sorry, whether it's the audit meeting or even without it going to an audit meeting --

A. That would have to be the person really who is in possession of the information and can talk knowledgeably on things.

THE CHAIRMAN: And if the call is made to the Erne or Daisy Hill or whoever, is it to the medical director, to the consultant involved, or who does it go to?

A. My understanding is it would be the clinicians.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: So from your point of view -- I had



given you an incorrect reference and I apologise for that, I told you that the reference came from your second witness statement; in fact, it was your third, 302/3, page 3, and I apologise for that. That's where you set out how an audit meeting would have taken place, or at least, in your view, it would involve if I can put it that way. If we pull that up, 302/3, page 3.

It's right at the top where you say that. Then to follow up the point that you've been making, you see that, the discussions around each presentation, the contribution, questions being asked if more information is required. And then you have got:

"Suggestions were made to improve shortcomings if an attendee felt that was warranted."

There was an audit meeting for Lucy. Is there one for every child that dies?

A. Yes.

Q. So from what you now know of Lucy's case, what, in your view, are the things that you would have expected to -- sorry, I beg your pardon, I should re-frame that. When I say, "From what you now know of Lucy's case", what you have seen from her notes, so I'm not talking about what the inquiry's experts have said, but were there to be seen on her notes. What you have expected to have been the things to have been discussed at the audit

meeting in relation to Lucy's case?
A. The completion of the fluid balance chart and the lack of a prescription, a fluid prescription.
Q. So that's a shortcoming from the Erne?
A. Yes.
Q. Anything else?
A. So what is my brief again, sorry?
Q. I'm asking you to help us with the sorts of things that you would think are likely to have been discussed or would be likely to be discussed in relation to Lucy's case, bearing in mind what's in her medical notes and records.
A. On the basis of her medical notes?
Q. Well, what they would have had is that they would have had her medical notes and records, her chest X-rays, because this is what you detail is gathered together for a presentation like that, and there would have been the post-mortem report, or the preliminary one. So that's what would have been known at the stage of August.
A. Mm-hm.
Q. So on that basis, apart from better completing her fluid balance chart, what else are the issues that you think are likely to have been raised during the audit meeting?
A. It would have been -- are you saying ... I think I understand your question. Seeing the fluids which



were administered.
Q. So a clearer identification of the fluids that were administered?
A. Yes.
Q. Both the volume and the type?
A. The type of fluid.
Q. Anything else?
A. And then obviously you're correlating that with a formulation for her cause of death because you then want to be able to say that the fluids were inappropriate.
Q. Yes. And so insofar as the chairman has heard from -- let's stick with Dr Chisakuta, who was the consultant who actually was involved directly in her treatment at that level. If he's of the view that that treatment was inappropriate so there's a point to be taken up with "Let's have better recording of what's actually being administered and prescribed", is there not another point that that was -- if it's thought to be, that was inappropriate and there would be a discussion around the appropriateness or not of that fluid regime. Is that right?
A. Yes.
Q. And that takes you to, if the consensus is it was inappropriate, you have learning there, and from what



you have told the chairman, it would have been good if that could be communicated to the relevant clinicians in the Erne.
A. Yes.
Q. Then if I ask you about the Paediatric Anaesthesia Group meeting. In your first witness statement, 302/1, page 9, you said that you recalled:
"... a Northern Ireland Paediatric Anaesthesia Group meeting one evening in Musgrave Park Hospital at which issues around paediatric fluid management were discussed and the case of Raychel Ferguson was discussed. I don't recall if Lucy's death was discussed, but there may have been reference to her."
If Raychel's case is being discussed then obviously that's some time after Lucy's death. But what I want to ask you now is: what are the fora where the sorts of issues that you started your evidence with, which is that led to a change in your practice in relation to prescription for maintenance fluids and the sorts of concerns that were expressed to the chairman about the treatment that people thought that Lucy had received at the Erne -- where's the place where you can discuss those sorts of things? Is it there, for example?
A. Well, it was very much there. This was the -- the Northern Ireland Paediatric Anaesthesia Group was a way



of building links with our colleagues in the district hospitals who are adult anaesthetists, but a substantial number of them have paediatric responsibilities.
Q. When was that group established?
A. That group was established in 1998 or 1999. I'm not certain about that.
Q. So if we just pause there with that. If it was established then, is there any reason why the sorts of issues that you had been mentioning that led to a change in your practice and so forth couldn't have been discussed there?
THE CHAIRMAN: Solution No. 18.
MS ANYADIKE-DANES: Solution No. 18 and maintenance.
A. Yes. I think -- did we not make reference to that? Did we not discuss that at the Raychel Ferguson one?
Q. Yes, but that's some time --
A. Yes.
Q. It depends on when you think you were first starting to change your practice. That's a forum for doing that.
A. The question is what fora are there?
Q. Yes.
A. That's one. That is one. This is outside the hospital, of course.
Q. Yes.
A. This is outside. Do you need more than one?

Q. Is there not a thing called the Sick Child Liaison Group?
A. Yes, there is, yes.
Q. Dr Taylor was involved in that, wasn't he?
A. Yes.
Q. Did you participate in that?
A. No.
Q. Is there a reason?
A. No. No, there's no particular reason whatsoever. I was participating in this one here.
Q. In his witness statement for Adam at 008/1, page 9, he said he founded that group:

"Paediatric anaesthetic and Accident & Emergency consultants, they met two to three times a year at the Antrim Area Hospital, and the purpose was to improve the quality of care to critically-ill infants and children being transferred to the paediatric ICU mainly by better communication."

And he says he chaired those meetings and that he kept his clinical director at the time, Dr Hicks, in the loop and informed of discussions. That's a forum, isn't it?
A. Yes.
Q. And depending on when it was actually established, that might have been something when some of these cases could



have been discussed; would you accept that?
A. I'm not -- I mean, I would need to just see what Dr Taylor thought was the purpose of his group and --
MR UBEROI: The witness has said he wasn't involved in the group, so I'm not really sure how much further we can take this.
MS ANYADIKE-DANES: Were there conferences of the UK Paediatric Intensive Care Society?
A. Yes.
Q. Would the consultant paediatric anaesthetists at the Children's Hospital be members of that society, typically?
A. Not typically. Dr Taylor was a member of that.
Q. Were you?
A. No, I was not a member. I was a member of the Association of Paediatric Anaesthetists.
Q. And that would have regular meetings?
A. Yes.
Q. And topical issues would be discussed there?
A. Yes.
Q. Were your other colleagues also a member of that?
A. Yes.
Q. And Dr Chisakuta talked about the inaugural meeting of the Western Anaesthetic Society; were there other regional groups, if I can put it that way?



A. There was a sort of South of Ireland link, where I think there's an annual meeting once a year with our colleagues in the south.
Q. So in terms of finding outlets, if I can put it that way, for what the clinicians at the Children's Hospital were learning, researching, developing, there were ways in which to communicate that to your colleagues in the district hospitals?
A. Yes, there were.
Q. Perhaps you should express your thoughts on this. Obviously that's something that individual clinicians can do and some of you in your individual statements have said the things that you were doing in that way. Is that something that the Children's Hospital thought was part of what it might do as a body, if I can put it that way?
A. My understanding on that is, no, this was very much directed by the individuals to lead it.
Q. Is that still the case?
A. No, the Children's Hospital now is, I think -- corporately has provided money and resources for telelink medicine to facilitate the very ideas which you're highlighting. So they have put resources in place, but I can't really talk very sort of corporately about it.



MS ANYADIKE-DANES: Thank you.
THE CHAIRMAN: Mr Quinn, any questions?
MR QUINN: No questions.
THE CHAIRMAN: Any questions from the floor? Mr McAlinden?

Doctor, thank you very much for coming again to help us. Unless you have anything more to add, your evidence is complete and you're free to leave. Thank you very much.

(The witness withdrew)

Housekeeping discussion

Ladies and gentlemen, just two bits of housekeeping before we finish.

The first is that, Mr Uberoi -- if you can hobble to your feet. In terms of the issue which has been raised on behalf of Dr Taylor about the extended role of Professor Kirkham, what I'm arranging to do today is to circulate the letter which came from your solicitor, I think it's ...

MR UBEROI: It's 3 May, sir.
THE CHAIRMAN: Thank you. We'll circulate that to the other parties in this segment of the inquiry and in the other segments and, at some point next week, when people have had chance to consider their position, we'll raise it in the chamber.
MR UBEROI: Thank you, sir.

THE CHAIRMAN: Secondly, Mr Simpson, about the Raychel governance. I know it's Mr Lavery; I think you might not be here for Raychel governance.

Mr Lavery, we've expressed our concerns and the Western Trust has responded about the role of Miss Brown. I have reservations about it, but we can't delay any further. So what we're going to do is we're going to issue the request for witness statements between today and tomorrow in Raychel governance. I remain concerned that Miss Brown appears to be the only point of contact, but what you will see, as they come out, is those statements are tighter and shorter than previous requests for information. That's partly because we've already touched on some of these issues, sometimes quite extensively in the hearings before Easter. So what I'm very anxious to emphasise today is that we need these statements back as soon as possible. The fact that they are shorter and more restricted will facilitate that.

Also, could I ask you one more thing: sometimes previously DLS has waited until they've got a batch of statements and then returned a group rather than return them in ones and twos. On this occasion, as soon as they reach DLS, we would like them to be forwarded to us. I have to do a week's hearing in Raychel governance



starting on 2 July and, in order to achieve that, I need the statements back as soon as possible; okay?

MR LAVERY: Certainly that message will be forwarded. I should say, Mr Chairman, there is a letter of 21 May which the DLS wrote about the point about Miss Brown's involvement. You made some comments the other day in the chamber, but there was never any substantive reply to that letter.

THE CHAIRMAN: If it needs to be followed up beyond today, I will, but --

MR LAVERY: There was an issue, Mr Chairman, which arose previously on 12 February. There was another letter in which the inquiry had questioned the roles of both Miss Brown and Dr Nesbitt.

THE CHAIRMAN: Part of my concern is this: Miss Brown is an interested party in Raychel governance and I think it puts her in a slightly invidious position for her to be the point of contact for other witness statements and also to be -- for the provision of information to other people who are going to provide witness statements while she is also an interested party. That's been avoided in the Royal and there have been very helpful exchanges involving the Royal, where there are two other ladies who are points of contact. If that's what I'm being told from the Western Trust I can't coerce any other



person to be appointed but I think it is an unattractive position for Miss Brown to be in, even from her own perspective, never mind mine.

MR LAVERY: I hear your comments, Mr Chairman.

THE CHAIRMAN: It's Dr O'Donoghue tomorrow morning?

MS ANYADIKE-DANES: Yes, it is.

THE CHAIRMAN: And then followed by Dr Auterson?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: So we'll start at 10 o'clock tomorrow morning. Thank you.

(2.17 pm)

(The hearing adjourned until 10.00 am the following day)



I N D E X